



Conditions, cults and consultants

Jon Garvey explains his theory as to why junior hospital doctors seem unable to reduce dramatically the hours they work

In recent weeks the matter of junior doctors' hours has once more come to the fore, including an article by a consultant in *Doctor*, that *New Statesman* of the medical press, in which the worthy gentleman suggested that all this talk of long hours was largely exaggerated.

He knew from experience, he said, that few consultants actually work the 60 to 70 hours per week that their own representatives claim, and are able to enjoy their hobbies and relaxations at home or much of the time they are on call. The same is probably true, he reasoned, of the junior doctors, who after all make up the majority of their UMTs in on call time, rather than actual working time. The writer even tells his own housemen to call him if they are in trouble, which they hardly ever do, and from this concludes that they must seldom be busy themselves.

I don't know why it is that the major opponents of the attempt to achieve civilised working conditions for hospital doctors are hospital consultants, though I have a theory about it. The basic thesis is that the medical profession is in effect a tribal cult, holding a body of arcane knowledge which needs to be hidden from the outside world. Therefore, it is vitally imp-

ortant to those in authority that new initiates are fully committed to the cult and its priesthood. To this end, they make sure that a system of initiation ordeals is perpetuated, at the very heart of which is a term of enslavement to the cult leaders, which is intended to break all ties with the novice's previous life.

Far fetched? Perhaps. But if so, what other explanation can one suggest for the unwillingness of the consultants to co-operate in obtaining humane conditions for their junior colleagues? The consultants themselves argue along the lines that hard work never hurt anybody, and is essential to producing excellence in medical practice. Well, if that is so, why do so many of them abandon this healthy ideal as soon as they get shot of their last SR post, and reduce their hours to whatever fraction of 60 or 70 hours they actually do work? Unfortunately, the junior doctors are their own worst apologists, since they overstate their case. There are few doctors who actually work 120 hours every week, though there would be if the juniors hadn't fought tooth and nail to abolish one in one rotas, and there are still times when many housemen approach this figure via that innocent little clause

in their contract which states "you agree to be liable for duty in emergency or unforeseen circumstances." How often this in fact means working every evening until 10p.m. to do blood sugars on the diabetic unit, or spending half of every Sunday, on or off duty, clerking a ward full of surgical admissions, whom the consultant insists be completely worked up for his 8.30 round on Monday, by his own houseman (oceans of invaluable experience in this!).

Having finished with hospital medicine two years ago now, partly because of the number of registrars' marriages I saw sacrificed on the altar of the search for time-expired senior registrar status, I feel I can now stand back and review my experiences somewhat dispassionately. To nail my own colours to the mast, I estimate I now work somewhere between 48 and 60 hours a week, or about the same as many ambulance-men. I have always felt myself to be a fairly resilient sort of person. I don't need a vast amount of sleep. I'm not averse to giving extra time to my work, and I have a wife who takes late arrivals for meals and cancelled social engagements in her stride.

Bad medicine, bad life

Nevertheless, during my time in hospitals, I was for a large part of the time on the brink of "acopia", which manifested itself not in suicidal depression or falling asleep on the wards, nor in very many important clinical errors (though how many infants suffered multiple contusions because of the inability of the shaking hand to find the scalp veins is anybody's guess). More often, it showed itself as an alarming detachment from events both at work and at home, erupting into unpredictable irascibility on the slightest pretext.

This is not good medicine, and it is not good life. Others of less bovine constitution found life less bearable. This cycle of work alternating with coma effectively obliterates any other areas of life which may have been important before. During my years in hospital, I hardly read anything, medical or otherwise. I hardly touched a musical instrument having played semi-professionally before, and I largely withdrew from those organisations in which I had previously been active. "Congratulations on your marriage," my friend was told. "However, you should refrain from too much of the joys of marriage whilst you are on this job: not good for the stamina."

Even so, I would have lived contentedly enough but for two additional factors, universal to the houseman's existence, which if they are not part of a deliberately planned initiation rite must have some even more diabolical purpose.

The first is unnecessary extra work. When you are already stretched a little beyond your limits, the clerking of your consultant's private patients, without payment, awakens socialist tendencies which would never otherwise have seen the light of day. Along the same lines, take this example from my own experience. I am called at 2a.m. by the private ward staff nurse, who tells me that one of my consultant's patients is not very well. I explain that the patient is paying good money for constant consultant care, and that if her condition is worse, the NHS house physician is the last person

to call. But nurse does not want to disturb consultant, and so against my better judgment, and thinking of the reference I shall need in a month or so, I get out of bed and through the bleak mid-winter to the ward: (What a potent stick is

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the consultant's reference. When the UMT system was introduced, a colleague was told that if he applied for them he could forget the idea of a reference, as his pay would equal the consultant's own private earnings. This would be anathema!

Back on the ward I find the patient is in fact terminal, and advise the nurses that the consultant will certainly want to know if she deteriorates further, but that I shall not. At 4.30a.m. I am called to certify death. This is invaluable learning experience, and it would clearly have damaged my clinical training if the specialist had done his own work. Or paid me for doing it. Another area for unnecessary work is the do-it-yourself locum situation. Whenever one of you dares to take leave, it will be found that nobody has bothered to arrange a locum, or if they have, it will be a Mongolian, Moscow-trained dyslexic who has, prior to this paediatric locum, spent the last twelve years in orthopaedics. You don't mind following his every step to help him out, nor doing two weekends on the trot to enable him to settle in. But when the third weekend comes, and you have already travelled from home to give cytotoxics to your leukaemics because you can't trust the locum not to give them subcutaneously, it rankles to be told that he can't cope, that none of the on-call, or off-call, consultants can be reached, and that the senior registrar will not come in because he does not work weekends.

And then, of course, there are bank holidays. At Christmas, a sheaf of little circulars comes round, informing you that since the phlebotomists/lab staff/X-ray staff/porters will be having a well-earned rest from their 37½ hours per week

labours for the next six days, their tasks will have to be done by. . . guess. Oh yes, and the canteen will be closed.

The second life-shortening factor is simply the combined efforts of the entire hospital organisation to teach the junior doctor his place. When a student, I was talking to a houseman at my alma mater, who, tired of watching the cockroaches eating the fallen plaster in his broom-cupboard home, asked the administrator if he could be transferred, bearing in mind that the hospital electrician, who was hardly ever on call, had a newly-decorated flat at his disposal. "Electricians are hard to get, replied this prime-mover of the health service. "We can find another doctor any time."

Survival

Hospital canteens might be thought to exist mainly for doctors and nurses. False. They are for cleaners and canteen staff. Dare to answer an arrest call whilst clerking an acute admission at 12.30, and what will you expect when you arrive at the canteen? Leftovers? A hot snack? A cold snack? Zilch. Or if you are one of the many Moslems holding the health service together, and dutifully observing Ramadan despite full operating lists, what can you expect to be offered at supper, when the sun has set? Why, roast pork, gammon and pineapple, or ham salad.

O fortunate consultants! You have passed all this by now. But how can you justify the continuation of such things without shame! Many consultants say that they survived far tougher conditions, for minimal pay, and so their successors should expect the same. We find a similar attitude in general practice, in baby batterers, wife beaters and so on. Besides, I keep hearing reminiscences about waiter service in messes, and playing tennis while on call—they wouldn't repair our tennis court.

What does seem clear, from my own as well as other people's experience, is that the system supported by the consultant bodies at the moment does not produce excellent hospital doctors. It produces excellent general practitioners.*