where floors are carpeted. Previous correspondents are right in asserting that a proper programme of incontinence management will reduce the incidence of incontinent accidents and consequent smells. However, I have learnt that such accidents will occur from time to time despite the most effective programmes of care. Nevertheless, I have chosen to champion the use of carpets in geriatric and psychogeriatric wards for a number of reasons.

(a) Vinyl flooring is objectionable acoustically and aesthetically, and adversely affects the milieu of the ward. This is likely to affect the behaviour of patient and staff.
(b) Some types of vinyl flooring adversely impair the gait of elderly people whereas carpet does not (Willmott, 1986).
(c) Vinyl flooring, when wet, increases the risk of falls and their personal and financial costs. Falls which occur in carpeted areas are probably less destructive than those which occur on vinyl floors.

With a local carpet manufacturer, I have developed a cleaning process which eliminates smells emanating from biological products deposited in carpets in psycho-geriatric wards. As yet, this is an assertion since we have been unable to persuade the carpet industry to develop a research programme to test the efficiency of cleaning methods on their products. It seems ridiculous that a carpet and/or cleaning system that eliminates smells has not yet been developed. Everyone, including Dr Jolley, would probably agree that the most appropriate floor covering should be carpet if it were possible to solve the problem of offensive smells. Our proper concern should therefore be how best to develop an acceptable method of carpeting and cleaning such areas, rather than accepting vinyl, very much a second best solution, for wards which house patients who are already treated as second best.

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Reference

WILLMOTT, M. (1986) The effect of a vinyl floor surface and a carpeted floor surface upon walking in elderly hospital inpatients. *Age and Ageing*, **15**, no. 2.

Junior doctors' hours

DEAR SIRS

Current attempts to reduce excessive hours for us junior doctors will never succeed, as evidenced by the recent unsatisfactory and predictably deferred 'agreement' that has been reached. The simple reason is that the thrust of our campaign is misplaced. What is needed (and note the example of our Irish colleagues) is a demand that we be paid at least equal rates for overtime hours instead of the archaic one-third. Only then will the financial motivations which maintain these excessive hours be removed. Our successors will not thank us for our myopia, even if it is overtime-induced.

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