uncertain). At least this helps to confirm that anaesthetic juniors want a separate college. In addition, many young anaesthetists feel that the establishment of a college can only serve to strengthen anaesthesia and establish it as an independent specialty. Perhaps then something may be achieved to correct the provident societies' view that treatment should be undertaken by consultants except in anaesthesia, where anyone will do. What effect has the "prestige, tradition, and esteem" of the faculty had on this? In the same issue of the *BMJ* (p 638) there is an assessment of the distribution of distinction awards to the different specialties. Does this represent the esteem in which anaesthetists are held? Or perhaps they do not deserve distinction awards for the quality of their work? A new college will not cure all the problems, but it may give the next generation of anaesthetists a fighting chance.

Many of the arguments have been succinctly analysed, though with a different emphasis, by Spence and Norman[1] and Zorab[2]; and I feel that the Anaesthetists' Academic Foundation may in fact achieve far more support once it becomes certain that the college will be established. Finally, the signatories of the letter are less than fair to the Association of Anaesthetists' offices, for all the benefits of the BMA are available to supply common rooms and food; and they also failed to describe the cramped offices of the Faculty of Anaesthetists, and the fact that it is only when you reach these offices that you realise that you are no longer in the Royal College of Surgeons but in the adjacent building.

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[1] Spence, A A, and Norman, J, *British Journal of Anaesthesia*, 1978, **50**, 313.
[2] Zorab, J, *Anaesthesia*, 1979, **34**, 72.

## Distribution of general medical practitioners

SIR,—Mr M J Buxton and Professor R E Klein (17 February, p 465) rightly point out that the nine Family Practitioner Committee areas (FPCs) with the most inflated lists are in the London area, with Kensington, Chelsea, and Westminster (KCW) at the top. They note that these FPCs (with one exception) also have low nominal list sizes. This is particularly true of inner London, with KCW again being in first place.

They then go on, however, to make the logical suggestion that nominal list size figures understate the inequalities in the distribution of general practitioners—with the implication that inner London is overdoctored in comparison with the rest of England and Wales. Although from the published figures this would appear to be the case, it is not the experience of those working in the area—for example, the annual reports of the three Community Health Councils in KCW have contained evidence of difficulties experienced by patients, particularly the elderly, in finding a general practitioner to accept them on his NHS list.

Average list sizes mask the considerable variations in list size of individual doctors, and the difficulty apparently experienced by patients is partly explained by a survey carried out by the administrator of the KCW FPC: it showed that 119 of the 260 doctors (46%) for for whom the FPC was responsible were not accepting new patients. The reasons for this apparently contradictory situation are various. KCW has the largest proportion of elderly GPs (13% aged 70 years and over compared with 3% nationally in 1977) and of single-handed GPs (56% compared with 16% nationally) in the country.[1] The patients they deal with have predominantly psychological and social problems.[1-3] There are high proportions of elderly living alone but, in an area with the highest population density in the country, there are difficulties with traffic and parking problems when visiting patients. It is particularly difficult to estimate the true population of the inner London areas owing to its rapid mobility, but this very mobility means that it is difficult for a GP to get to know his patients, for whom he may have no previous notes.[1]

General practitioners in London are reported as having the lowest average net earnings under schedule D in the country.[1] Yet London is one of the most expensive places to live, and some GPs may need to maintain small NHS lists in order to carry out other professional commitments.

Even though the number of patients needing to be "allocated" to GPs is low (it being FPC policy to deal with the matter informally when possible), the number of telephoned and written inquiries dealing with assignment of patients to doctors' lists is high.[1] This evidence, together with that from the CHCs, tends to indicate that for patients looking for an NHS doctor in the KCW area the published statistics used by Buxton and Klein are misleading.

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[1] Jarman, B, *Journal of the Royal College of General Practitioners*, 1978, **28**, 598.
[2] Imber, V, *Statistical and Research Report Series*, No 16. London, HMSO.
[3] Farmer, R D T, Preston, T D, and O'Brien, S E M, *British Journal of Preventive and Social Medicine*, 1977, **31**, 171.
[4] *General Practitioner*, 21 April, 1978, p 1.

## Nursing at a crossroads

SIR,—I enter the "Nursing at a crossroads" debate with some trepidation but, as a junior doctor who works daily with nurses below the rank of sister (and who is married to a qualified nurse), I feel that the views of those "on the ground" have not really been covered by the higher echelons of medical and nursing staff who have so far contributed.

Only one of your correspondents has mentioned the effect of salary on recruitment, yet everybody one asks feels that this is surely the crucial factor. The harsh fact is that people leaving school, however dedicated to nursing they may be, compare salary scales in different jobs; and nurses, like so many other workers in the National Health Service, have clearly fallen far behind.

The reasons for the near 30% drop-out of nurses before the completion of training are not so clear. Certainly in my experience (as other correspondents have suggested) the outdated, authoritarian attitude of many of those involved in training student nurses can be held partly to blame. Secondly, although much is made of the responsibility, many believe that general nurses are now allowed less responsibility than in the past—and indeed that decision-making is almost discouraged in the modern nurse (except, of course, on night duty, when the coin is turned and the responsibility can be terrifying).

Following on from this is the question of educational requirements. Most of those I have spoken to feel that the acquisition of 5-6 O levels is necessary, but there is considerable scepticism over the requirement of A levels, which now seems to be the norm in some areas. Many believe that nursing is not an "academic" discipline but one needing common sense and practical ability (not that these are necessarily mutually exclusive); they feel that nursing managers are trying to change it in to something which it is not. At a time when initiative is apparently being restricted on the wards surely higher examinations are inappropriate, and nurses who have passed them are among those who are most disillusioned with practical nursing.

To sum up, the nurse's lot must be made a happier one. The training should be made more human; there should be less interference from nursing administrators; and, most importantly, the pay situation must be rectified. Unfortunately, Mr Ennals's continued lack of support for this cause, despite pleas from the Royal College of Nursing, only serves to publicise further the present deplorable situation and can do nothing but harm to nursing recruitment and thus to the National Health Service as a whole.

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## State of community medicine

SIR,—I have read with much interest the report (17 February, p 503) of the meeting of the Working Party on Community Health Doctors and the suggestions for training and career structure. I am delighted to learn of the positive progress being made to improve this aspect of the medical services provided by the National Health Services.

I read with great care the proposed training programme. While it appears that a comprehensive programme of general paediatric training is envisaged, I note that there is no reference to any postgraduate training in gynaecology. There will I think be an increasing demand for "well-women clinics" and there will be a need for family planning clinics in many areas, partly to meet patients' preferences and partly as necessary training centres for staff and foci for research projects. It is imperative for doctors working in these clinics to have postgraduate training and continuing education in non-surgical aspects of gynaecology, especially as the time spent on gynaecology by undergraduates in some medical schools has been so drastically reduced.

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## Next year's pay

SIR,—You published a letter (3 March, p 626) from Dr Michael Wynn about the Review Body's recommendations for 1979-80.

The evidence submitted to the Review Body is confidential until the report is published, and I am therefore unable to comment on the detailed submissions made on this occasion. I would, however, like to point out that the Review Body in its eighth report said that *at*