carried out before extubating patients in the intensive care unit.[4] Although we might have to be more selective in Britain there is little doubt that patient management would be improved by the greater use of this instrument.

R K KNIGHT

Chest Department,
St Bartholomew's Hospital,
London EC1

[1] Sackner, M A, Hirsch, J, and Epstein, S, *Chest*, 1975, **68**, 774.
[2] Sackner, M A, *et al*, *Chest*, 1976, **69**, 164.
[3] Sackner, M A, *Chest*, 1972, **62**, 70S.
[4] Kenkichi Oho, personal communication.

Physicians in training

SIR,—Our surgical colleagues recently set up an association aimed at representing the views of surgeons in training to the royal colleges, DHSS, and the various bodies concerned with postgraduate education. The question of a similar association representing physicians in training was discussed by the Standing Committee of Members of the Royal College of Physicians of London. For many years this committee has been privileged to represent the views of members to the college and to receive copies of all major documents for comment. Although it is concerned with all members, not just those in training, it is always willing to consider suggestions and recommendations from physicians in training for transmission to the college or the Joint Committee on Higher Medical Training. In recent years the committee has initiated study and discussion of topics of current interest—for example, its recent lead in the care of the elderly. It intends to continue to do so. While it will continue to represent the views of all members it would welcome the opportunity to act as a forum for those who are still in training. Matters of concern can be sent to the chairman or honorary secretary at this address.

JEREMY COBB
Chairman,

BRIAN J KIRBY
Honorary Secretary,
Standing Committee of Members,
Royal College of Physicians of London

11 St Andrews Place,
Regents Park,
London NW1 4LE

Related ancillary staff in general practice

SIR,—I was most interested to read the recent report by Dr B L E C Reedy and others on nurses and nursing in primary medical care in England (27 November, p 1304). It contains one statistic which particularly brings itself to my attention.

In a letter to Dr David Owen in January of this year I wrote: "I have never come across a comprehensive survey either of the number of people (related ancillaries) involved, nor of the estimated cost to the NHS of paying related ancillaries who actually work in their husbands' practices on the same footing as other ancillary staff who currently attract 70% of their salaries into the practice. . . . What I suspect, you see, is that there are relatively few wives who work in their husbands' practices, apart from normal wifely (non-qualifying) duties, which I agree with you have to be excluded. I think this has come about for a variety of reasons. . . . Anyone arriving in general practice since 1966 would have seen the financial disadvantages of getting involved. . . . Some of those who were involved before 1966 have left."

I do not therefore find it tremendously surprising that "very few nurses were the wives of general practitioners," but even to me the figure is small. What is surprising, and appalling, is that so much time, energy, and money can have been expended over the past 10 years by the BMA in discussing and by the DHSS in resisting the claims of some 145 women, all of them trained nurses, to be paid for doing a legitimate job in the field of primary medical care. I am told (Dr David Owen, 5 April 1976) that "we have always feared abuse if doctors could employ members of their own family, and we have never so far been able to find any way of completely avoiding this unless we had a disproportionate system of inspection." Might I suggest that what is "disproportionate" is the amount of concern and fear present in the DHSS about the moral standards of 145 professional women?

While I accept that the figure of 145 will probably be augmented by a certain number of women who are not qualified nurses but hold other legitimate qualifications and by a few who did not reply to the survey, the cost to the NHS of paying currently employed relatives would be very small. Is it not now time for the Elephant and Castle to withdraw gracefully from their intransigent position and allow reimbursement of currently employed related ancillary staff?

Incidentally, I think that I should voice my disagreement with the conclusions reached by Dr Reedy and his colleagues concerning the reasons for employment of practice nurses. In my own experience attached nurses are perfectly adequate and the two categories can and do complement each other. District nursing sisters are better geared to carry out nursing procedures on the district, while other activities such as nursing tasks on surgery premises, screening, and supervision of record keeping within the practice can be more efficiently undertaken by a practice nurse. The only field in which, through no fault of their own, attached nurses are "inadequate" is the small one of immunisations, which the bureaucrats have decided is a highly dangerous procedure which must be supervised by a registered medical practitioner.

JULIA STAFFORD

Kirkby in Ashfield, Notts

Points from Letters

Liver damage due to paracetamol

Dr F E DE W CAYLEY (Bevendean Hospital, Brighton) writes: I am continually attending clinical meetings on liver damage due to paracetamol and I wonder if the time is ripe to consider whether this drug should be obtainable only on a doctor's prescription as it seems a much more dangerous drug than was originally thought.

"Nurse consultants"

Dr D M BOWERS (Neasham, Darlington) writes: . . . This situation is completely out of hand. The Salmon scheme was instituted specifically to grant nurses the illusion of "professional equality" with doctors and at the same time doctors are conventionally required to practise a complex ritual of flattery and self-abasement in order to "maintain a good relationship" with nursing staff. In many hospitals "reporting on medical staff" is part of a nurse's duty, and in the event of a dispute between a doctor and a nurse it is absolutely inconceivable that the nurse would not be officially upheld, even though it might be privately admitted that the doctor was right. In casualty departments it is a bigger crime to be disliked by a nurse than it is to kill a patient. We can read in a handbook that "procedures outside ['the nurses'] general training remain the responsibility of medical staff, but nevertheless they are done to a standard which often exceeds anything that medical staff are capable of."[1] No less an authority than my own medical defence organisation once advised me that "it is now generally accepted that casualty officers work under the clinical supervision of nursing staff.". . .

[1] Hardy, R H, *Accidents and Emergencies—A Practical Handbook for Personal Use*, p 40. Oxford, Dugdale, 1976.

"Part-timer"

Dr ANNE SAVAGE and others (London N8) write: All publicity (they say) is good, so we are grateful to Minerva (4 December, p 1395) for her reference to the newsletter *Part-timer*. However, she does seem to suggest that our aim is to be a cross between Universal Aunts and a marriage guidance council, whereas it is much wider than that. Correspondence has already revealed a considerable interest in part-time appointments, and not only from potential employees. There is clearly much variation in different parts of the country. . . .

War service

Dr J SHAW (Cheltenham) writes: I see that your statement with regard to war service (27 November, p 1337) applies only to the 1939 war. While not wishing to make an issue of it in the present economic state of the country, shouldn't the volunteers of the 1914-18 war be considered?

Deputising services: GPs and consultants

Dr S J JACHUCK (Newcastle upon Tyne) writes: . . . Dr T F Davies (4 December, p 1376) questions the quality of primary care when one-third of the practitioners use a deputising service. He has lost his identity by being in the solitary confinement of the hospital. He has not even realised that all hospitals run a very efficient deputising service for all their consultants which has gained national acceptance. All patients are referred to or admitted under a consultant, but a good proportion of referrals and most emergencies out of hours are dealt with by deputies to the consultant who are often not even registered practitioners. I am sure Dr Davies must have acted as a deputy without realising that he was working with an organised deputising service for hospital practitioners. At least the doctors working for the general practitioners' deputising service are all qualified and fully registered medical practitioners. . . .