He is right to define his terms and separate psychogeriatric units (which can be any ward with elderly patients with a psychiatric disability) from joint assessment units where psychiatrists and geriatricians work hand in hand and with equal responsibility for the same patients.

I would disagree with the relative emphasis he places on joint assessment, not in importance, but in the size of the bed allocation. This opinion I base on experience gained in Exeter in the unit for which I am responsible in collaboration with two geriatric physicians (Dr. W. B. Wright and Dr. J. H. Simpson). I must therefore outline the Exeter service. The joint unit (30 beds) was opened in November 1967 in the Exminster branch of Exe Vale Hospital (1,000 beds), which had been a "psycho-geriatric" hospital for admission and long-stay cases, including "graduates" from 1961. There are approximately 115 admission beds for the elderly, the remaining 885 being long-stay. An active boarding out scheme has been in operation from 1962 and has largely removed patients who can be cared for in the community. In the presence of these and collateral geriatric facilities the joint assessment unit (the Hallett Clinic) took the form of the small unit for specialized problems that Dr. Arie mentions, but without the responsibility of the indigenous sick in acute and long-stay wards for which separate provisions were already in existence. Geographical factors limited the use of the unit to a sub-population of 300,000 out of the total catchment area population of 560,000. Twenty per cent of the total population are elderly.

Our experiences is that joint assessment is beneficial over a broad front, largely, but not exclusively, in the field of organic psychosis (85% organic: 15% functional in the Hallett Clinic admissions). With the co-operation of the local geriatric physician joint care is shortly to be extended (though less intensively) to the larger general psychiatric admission wards for the elderly. In total this will represent joint care over a much wider front than Dr. Arie suggests.

I believe in community and hostel care wherever possible, but I cannot agree to either when mentally disabled patients are persistently incontinent. I would like to believe the community hostel could care for the irritable, wandering, nocturnally restless, or sexually disinhibited patient, but like Dr. Arie I am realistic.

It is imperative that new acute psychiatric units in district general hospitals are balanced by sufficient long-term community provisions, including hospital nursing if necessary. Failure to provide a balanced service will result in perpetuating institutionalism and two standards of care—I am, etc.,

G. E. LANGLEY

Exe Vale Hospital,
Exeter

The Ward Sister

SIR,—The views now clearly expressed (3 July, p. 45, and 7 August, p. 368) by senior and responsible clinicians that the Salmon structure leaves the devoted, experienced, and senior ward sister, graded No. 6, unrewarded and undervalued vis-à-vis personnel (perhaps younger) graded Nos. 7 and 8 is gaining general support. In my view this

has always been so. When the nurse-administrators were titled rather than numbered, many a much respected and valuable ward sister had only the great love of her work and thanks of her patients as reward.

However, there is no reason for this state to continue. The provision of promotion for clinical personnel could and should be agreed. Thus a ward sister, now usually promoted very quickly after State Registration, say, as a second sister on a ward, after seven years should be promoted to the grade of No. 7 (Clinical) and after 15 years as ward sister to the grade of No. 8 (Clinical). This would ensure that during the further 15 to 20 nursing years to pension-age her most valuable services are retained for the patients, and she would have a more suitable salary and pension.

This would make for equitable financial reward and deserved and recognizable status, and thus be more attractive in recruitment. These views are expressed from my long experience in a large general hospital, and, until recently as matron of a large chest hospital.—I am, etc.,

S. M. WOODAGE

London N.14

SIR,—I support Professor Roy Calne's views on nursing (3 July, p. 45) after Salmon. Twenty-five years of experience as a hospital consultant in surgical work has completely convinced me of the impossibility of running a successful inpatient unit, or ward, without the help of an experienced and active ward sister, backed up by her staff nurses.

We simply cannot afford to lose these valuable people to less important, but better paid, mainly administrative posts. I would like to see a ward sister's salary increased at once, to at least that of a Salmon No. 7; this would encourage the sisters to stay on their wards rather than drifting into administration, and also encourage the staff nurses to continue a nursing career.—I am, etc.,

H. S. SHARP

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SIR,—I see that the General Nursing Council has proposed the concept of the clinical nurse consultant to balance the Salmon structure in nursing administration.¹ Is it not a reflection of misguided current thinking, which so leans towards management, that the G.N.C. of all bodies should find it necessary to use the adjective "clinical" to describe a grade of nursing?

In 1953 the preregistration year was introduced for doctors acknowledging that qualification alone did not fit them for unsupervised patient care. With the increasing complexity of medicine, it is now widely believed that an even longer period should be advised. I find it curious that ward nurses on qualifying should still be accepted as suitable to take charge of wards in the absence of the sister (which now occupies a longer period than ever before), and that the next promotion on the ward is to sister. With the acknowledged increase in complexity of nursing duties in many wards it seems logical that the status of ward sister should be increased, with consequent increase in training, competition, and grading, and that one or more intermediate grades of junior

sister be introduced to take the responsibility now undertaken by junior trained nurses. Such senior sisters would not necessarily be required on all wards though a few even more senior posts might be required for certain duties such as sister-in-charge of intensive therapy wards. The idea that while responsibility for the medical care of a ward requires the highest medical status the nursing care of the same patients warrants only the 6th grade of a 10-grade scale seems illogical. To suggest that more senior clinical nursing posts than the present ward sister should have responsibility for several or all wards of one specialty in a hospital group makes little sense, and the part-time supervision of wards by such nurses seems unlikely, in my view, to contribute to improved patient care.

Naturally, increasing the grade and status of many ward sisters and their assistants would cost money; however, the fact that nursing is becoming more complex automatically implies a higher standard of training for ward sister status, and that this will cost more in terms of salaries is axiomatic.

The simple fact remains that if the Service requires personnel with more skills it will cost more. No amount of juggling with the names of posts will conceal this, though if we are not vigilant some enthusiastic manager will seek to achieve it.—I am, etc.,

C. M. VICKERY

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¹ Royal College of Nursing, *Evidence to the Committee on Nursing*, London. R.C.N., 1971.

SIR,—Like many nurses I am grateful to Mr. Walpole Lewin for his efforts in Leicester (*Supplement*, 31 July, p. 63) to put the record straight about the recommendations of the Salmon Committee. I would make two further points.

Gone are the days of the doyens (or battle-axes) of ward sisters whom we all knew so well in our student days. Some see this as a matter for rejoicing; others for regret. The older spinster has almost vanished from the ward scene, to be replaced by a much younger woman—often with a family and always with domestic commitments. Marriage is more frequent and the marriage age is falling. Nearly half the trained nursing staff in hospitals in some regions are part-time. This greatly increases the administrative problems of providing a 24-hour service, seven days a week.

Mr. Lewin deplors the lack of career structure in clinical nursing. In its evidence to the Briggs Committee on Nursing the Royal College of Nursing made proposals which included a "third arm," which at present nursing lacks—the establishment of a career pattern for the clinical nurse specialist. The Committee on Nursing showed great interest in this idea and accordingly the Royal College of Nursing has set up a working party to give detailed consideration to the concept to see how clinical nurse specialists after adequate preparation could fit into the present structure. The working party (of which I am chairman) already has two distinguished medical men as members, but it would be greatly helped by any constructive ideas, suggestions, or proposals that any of your readers might care to make.

In conclusion, however, I would ask for