hospital treated patients, and obviously not "marginal."

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1 Sturge R, Bulstrode F. Low back pain: comparison of chiropractic and hospital outpatient treatment. *Br Med J* 1990;**300**:1648-9. (23 June.)

## Ethical problems of prison doctors

SIR,—Minerva rightly draws attention to the ethical problems facing prison doctors working in countries that still retain the death sentence.[1] I agree that national medical associations should state clearly where they stand on such issues and should give every support to doctors who find their ethical standards compromised.

The Third World congress on prison health care was held in Bristol in August 1988 under the auspices of the International Council of Prison Medical Services and was attended by 116 delegates from 23 countries. Resolution number 3, adopted at the end of that congress, reads: "This congress opposes any and all participation by health professionals in any action which could be interpreted as cooperating with the execution of the death penalty."

It became apparent in the debate on that resolution that prison medical officers in many countries find their government employers remarkably insensitive to doctors' views on ethical matters as well as to professional advice on the more obvious principles of provision of health care for inmates. Prisons are penal institutions and not medical ones; sadly, the provision of medical services within penal systems is seldom given a high priority.

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1 Anonymous. Views. *Br Med J* 1990;**301**:248. (28 July.)

## Traveller mothers and babies

SIR,—Drs Gene Feder and Ruth Hussey highlighted the finding of the recent survey on the provision for travellers by metropolitan authorities that almost one third of responding authorities would evict pregnant mothers close to birth.[1,2]

Though the survey gives useful information, what we really need to know is the policies of the authorities that have large populations of travellers. These authorities are the ones in which policies about travellers will have the greatest impact, positive or negative, on access to health care. In particular, the areas where the unauthorised encamped travellers live should be identified. This population is often highly mobile, most vulnerable to eviction, and particularly likely to have problems with access to care. Environmental conditions on these sites are often poor, although conditions on council sites may also be found wanting.

Data about where travellers reside is available from the twice yearly census of gypsy caravans compiled by local authorities.[3] Although this is not a census of people and it may underestimate the true count (most but not all councils send in returns), it does provide a picture of where travellers live. The census classifies caravans according to whether they are on a formal council site, private site, or unauthorised encampments.

The most recent figures identify the district councils that have large numbers of illegally encamped travellers. These are the councils whose policy about evictions should be identified in the first instance. Over 100 unauthorised caravans were recorded in Chelmsford, St Albans, Kings Lynn and West Norfolk, Hinkley and Bosworth, Malvern Hills, and Wychavon; and over 50 unauthorised caravans were recorded in Sevenoaks, Swale, and South Buckinghamshire. In addition, the London boroughs of Hackney and Southwark and the metropolitan boroughs of Wolverhampton and Bradford had over 50 unauthorised caravans recorded in the census but did not respond to the metropolitan authorities' survey. The policies of designated authorities should also be investigated.

*Number of travellers' caravans recorded according to type of council*

| | January 1984 | January 1990 | % Change from 1984 to 1990 |
|---|---|---|---|
| *Unauthorised encampments* | | | |
| London | 294 | 318 | 8 |
| Metropolitan | 324 | 545 | 68 |
| District | 3263 | 3011 | −8 |
| Total | 3881 | 3874 | 0 |
| *Authorised council sites* | | | |
| London | 582 | 610 | 5 |
| Metropolitan | 404 | 664 | 64 |
| District | 3430 | 3925 | 14 |
| Total | 4416 | 5199 | 18 |
| *Authorised private sites* | | | |
| London | 3 | 25 | |
| Metropolitan | 204 | 323 | 58 |
| District | 1425 | 2123 | 49 |
| Total | 1632 | 2471 | 51 |

The table gives information from recent censuses. It shows that over three quarters of the illegally encamped caravans recorded in the census this year were parked outside London and the metropolitan areas. The importance of the finding of the Maternity Alliance that "the Association of County Councils and Association of District Councils seemed unwilling to give any priority to investigating their members' policies with regard to traveller mothers and babies" now comes into sharp focus—the non-metropolitan districts are where most travellers live.[2] The metropolitan authorities have been most successful in increasing the provision of council sites over the past six years (table), but, overall, private sites have provided most of the increase in authorised sites over the past six years.

Combining the data from the recent survey with those routinely available from the Department of the Environment helps to focus thinking; identify deficiencies in information available; and direct attention, questions, and resources to those areas that are a priority in the attempt to ensure equal access to health care for travellers.

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1 Feder G, Hussey R. Traveller mothers and babies. *Br Med J* 1990;**300**:1536-7. (16 June.)
2 Durward L, ed. *Traveller mothers and babies: who cares for their health?* London: Maternity Alliance, 1990.
3 Department of the Environment. *Count of gypsy caravan sites 17 January 1990.* London: DoE, 1990.

## Stress in junior doctors

SIR,—Professor H A F Dudley makes the point that an "in my day syndrome" exists among consultants[1]: they recall the stresses of their own training but also have many happy memories. This is why the "initiation rite" is maintained and something that all doctors have to go through. He correctly points out, however, that in their day junior doctors were supported, whereas now consultants turn a blind eye to junior doctors' distress. I have no suggestions as to why this is the case.

An important stress factor that he did not consider is the very real fear of unemployment. This fear causes several problems. Firstly, there is anxiety about a reference. If support is not offered a junior doctor would not dream of asking for help as this may indicate unhappiness with an aspect of the job. This would be admitting failure and is just not done as it might affect his or her reference. After all, the boss would have coped in this situation: "In my day things were much tougher." So junior doctors work on in silence, becoming distressed and resentful. They practise a poor standard of care and learn little.

Secondly, the fear of unemployment leads to unhealthy competition among junior staff. Competition is a good thing, but it is currently out of hand. Junior doctors are suspicious of each other, worried that their colleagues might publish an idea before they do. This leads to a lack of cohesion among juniors and lack of morale in the common room. It also leads to poor research and a neglect of the need to learn clinical skills. The number of papers produced becomes important, not the quality. The aim is to look good on paper in the hope of achieving nirvana and a senior registrar appointment. Once nirvana is attained stress in junior doctors becomes a research interest of the past.

Are we producing doctors who are clinically poor, performing poor research, and unable to relate to their peers? I might add that training in my own specialty, psychiatry, seems to be light years ahead of any other. There is a willingness on the part of superiors to educate, monitor progress, give feedback on a regular basis, and also give support when necessary.

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1 Dudley HAF. Stress in junior doctors. 1. Stress and support. *Br Med J* 1990;**301**:75-6. (14 July.)

SIR,—In her editorial on stress in women doctors Dr Fiona Godlee rightly denounces the additional barriers confronted by women pursuing medical careers largely because of dual responsibilities to their families and their professional lives but, it must be remembered, in part because of attitudes held by the male dominated medical hierarchy.[1]

General practitioners have indeed already felt the bite of the changes of the new contract. I would like to emphasise that under this contract renegotiation of hours of availability has to be made with a woman general practitioner's partner(s) not just (as stated) with the practice's family practitioner committee. Many women general practitioners who were previously full time on a minimum of 20 hours' availability to patients have had a 26 hour minimum imposed on them against their wishes. For some, flexibility of attitudes in a group practice has allowed them to reduce their commitment to a fractional partnership with a minimum of either 19 or 13 hours' availability. For others, if their partners decide that the practice cannot cope with someone working part time this ruling has led to resignation. The financial implications for such women are serious; they also lose professional status and job security and are forced once more into the time honoured trap of the professional female—that of sessional and assistant work.

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1 Godlee F. Stress in junior doctors. 2. Stress in women doctors. *Br Med J* 1990;**301**:76. (14 July.)

SIR,—Dr Jenny Firth-Cozens's study of stress in women doctors indicates that stress is more