obtained at favourable charges. Limited residential accommodation is available for fellows' use. There are several lecture rooms within the college and these are regularly used for anaesthetic lectures in addition to the large meetings in the Edward Lumley Hall. The library facilities are excellent and the Hunterian Museum is unique. Fellows in the Faculty of Anaesthetists are able to use all these facilities as of right. It is theirs, shared on conditions of equality with the surgical and dental fellows.

What has the independent college of anaesthetists to offer in comparison with all this? At present the Association of Anaesthetists has rented offices, with cramped accommodation and no private office for the president, editor, or other officers. The Edward Lumley Hall at the College of Surgeons has its critics as a venue for large meetings, but it is noticeable that the Association of Anaesthetists has not been able to rent better accommodation for its scientific meetings in London.

It has been suggested that anaesthetists are paying too much in their annual subscription to the College of Surgeons. But is £20 per annum a large sum in these inflationary times? It is no more than the present subscription to the association. We suggest that, contrary to the belief of many advocates of the independent college, the ordinary anaesthetist will be paying much more in subscriptions and have less benefit than he does now if the plan comes to fruition. It will still be necessary to maintain and pay for a separate association structure, as the charitable status of a college would prevent it from negotiating with the Department of Health on terms and conditions of service.

Others have emphasised the political advantages of unity within the Royal College of Surgeons. We subscribe to the view that a combined voice is more powerful than separate individual voices and see no reason to believe that an independent college would lead to a greater representation of anaesthetists on national bodies. In any future political controversy it is surely obvious that the power or influence exerted by anaesthetists, fully backed by the College of Surgeons and its council, would be far greater than such power wielded independently by a new college, which, in its early years at least, would be lacking in prestige and tradition, relatively unknown, and therefore held in only moderate esteem.

We submit that both faculty and association are doing an excellent job in their respective fields at the present time. The ink is hardly dry on the revised charter of the Royal College of Surgeons. The specialty has already been honoured in the election of one of its members to the important position of vice-president of the college. It will take time for other changes to become apparent. It is clear, for example, that anaesthetists will have more influence on matters relating to the college funds in the years to come. In 1969 few would have foreseen the changes which have occurred within the college in the past decade. Who knows what can happen by 1989? In our view the new charter must be allowed time for its results to become apparent. The real enemies lie not within the profession, but without.

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Pay and parity

SIR,—No one, surely, will dispute the evidence on pay scales provided by Dr B D Scott (27

January, p 271), but we trust that these figures will not be used for pay parity arguments by our negotiators. These figures relate only to similar Government-repressed salaries. Mr David Ennals was recently heard on television news to state that Health Service workers should have pay parity with private industry. One of us has argued¹ that salaries should be comparable to those of other professional groups such as barristers. We would like to update those figures and would remind readers that many legal fees are paid by the Government for legal aid cases. We are informed that a barrister in the first five years after qualifying may expect to receive £5000-£8000 while senior partners earn around £20 000, against which many expenses may be claimed, and at this stage are comparable in professional status to a hospital consultant. Likewise, solicitors of the same seniority have a similar earning capacity. It is important to realise that the fees that make up these salaries have not been increased for seven years and are soon to be reviewed, no doubt leading to a considerable increase in potential earnings. Thus, while accepting Dr Scott's figures, we must press our Review Body to compare our levels of remuneration with those of professional groups whose incomes lie in the free sector, unfettered by government policies.

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¹ Reece, I J, *British Medical Journal*, 1975, 4, 523.

Industrial anarchy in the NHS

SIR,—The current industrial unrest requires firm leadership, not only by Government and unions, but, as you suggest, by the medical profession. I was therefore extremely disappointed by your leading article (10 February, p 364). Having correctly pointed out the low pay of ancillary workers in the Health Service, you then proceeded to offer as a solution to higher pay a reduction in staffing because "the NHS is overmanned (at virtually every level)." Such a comment would suggest that you have not seen the inside of a hospital for a great many years. The pressures on staff are numerous, and, while I have no doubt there are a few jobs which could be made more efficient and productive, for the vast majority of personnel, in this hospital at least, there is a constant pressure which requires a performance of duties far in excess of the optimum. The cry to "cut out administrators" is often heard, but this would lead to minute savings compared with the total cost of the Service. Your writer offers nothing in the way of constructive proposals to solve the industrial unrest.

I submit that we should support the justifiable grievances of the Health Service workers—while not supporting their industrial action—and we should be considering, as a profession, ways of incorporating ancillary staff into the care of the patient as part of a working team in order to increase job satisfaction, and from this to improve productivity.

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Resignation from the NHS

SIR,—During the lull in our medicopolitical affairs we ought to be thinking about what happens after the Review Body reports. Whether this body recommends an acceptable level of remuneration for the new contract seems to me to be irrelevant. It is the second and third reports which will be vital. From past experience our "independent" Review Body has slowly let our standard of living fall while the various Governments have given us sharp downward prods. The question is whether or not we are going to take any action in protest. The 1975 imposition of a 40-hour week was a fiasco. Only a minority of hospital doctors followed the advice of their leaders. Opinion polls indicate that the public are fed up with industrial action and I think that highly paid doctors would be sitting ducks for the media to pick off.

Thus we are left with accepting passively that which we are offered or considering resignation from the National Health Service. The latter is, I believe, the only honourable course and would be understood by all men who have left uncongenial employment. Resignation would have to be carefully planned with agency arrangements, as most consultants would be terrified of taking such an action unless they were assured that the BMA held the requisite number of signed but undated resignations.

As a member of the Northern Regional Committee for Hospital Medical Services I gain the impression that militancy increases centripetally, and, as in our previous forays, our leaders at centre will find that the troops at the periphery will fail to follow.

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GPs and casualties

SIR,—This practice is 26 miles from a district general hospital and its accident and emergency department. We care for the casualties which arise in our practice area at our surgery, because it is not practical to send them to the district general hospital and because it is not practical to leave our practice premises to treat them at our community hospital, disrupting the work in our own premises by our absence. This way of providing casualty services for remote areas is recognised by the Walpole Lewin report (para 6.4 page 23) but is not recognised financially and the General Medical Services Committee is not at present negotiating for the remuneration of general practitioners who provide casualty care for their own patients.

Doctors who feel compelled to provide casualty care for their patients because of isolation from casualty departments should be financially rewarded for doing so and I believe that the GMSC should negotiate for our proper remuneration.

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Millom, Cumbria

* * *The Secretary writes: "The GMSC has recently completed negotiations with the Department of Health for new arrangements for remunerating general practitioners providing casualty services in cottage hospitals. These new arrangements are presently being priced—by the Review Body. The Secretary of State has a responsibility to provide adequate