about the timing of the decision, the alternatives considered, and the stage at which career advice was formerly available or informally sought. Next, the questionnaire attempts to separate out the different factors which might have influenced the doctors' decisions, asking how important each of these was, and to find out what aspects of particular specialties attract doctors towards them and away from others. Finally, the questionnaire seeks opinions as to the reasons why it is sometimes hard to fill posts in the less popular specialties.

The survey is only one part of the study, but it is the single most important part of the research and will, if the response is good, provide the basis for the conclusions. The sample of 7500 doctors to whom the questionnaires are being sent has been very carefully chosen so that the opinions of particular groups, even in the small specialties, are adequately reflected. It is therefore very important, if valid results are to be obtained, that doctors who receive a questionnaire do complete and return it. The institute's study is sponsored by the Department of Health and Social Security and the Scottish Home and Health Department and is taking place with the active co-operation of the BMA and many other medical organisations. The importance of achieving a better understanding of how qualified doctors' career decisions are made is accepted by all of them as being of central importance in improving health care from the point of view of the patient, the individual doctor, and the profession as a whole. The results will help both to improve career opportunities and to alleviate shortages.

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Obdurate politics

SIR,—In your issue of 24 September (p 785) you publish a leading article castigating the Department of Health and Social Security for their policy of reducing finance to acute hospitals, resulting in "deterioration . . . of hospital services, lengthening waiting lists, and a further drop in staff morale." On p 799 of the same issue you publish a study by Dr S N Donaldson and others, which, confirming the results of two previous studies, suggests that acute hospital beds are over-used in that admissions to hospital are not infrequently unnecessary. It has also been found that the length of stay is often unnecessarily long.¹

You do not refer to these studies in your article, but surely they are very relevant. Could it be that more efficient practice by hospital doctors might reduce conflict with those whom you describe as obdurate politicians? Is the fault entirely on the politicians' side? What is your answer to this question and why did you ignore it in your article?

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¹ Logan, R F L, Klein, R E, and Ashley, J S A, *British Medical Journal*, 1971, 2, 519.

*.*Certainly we have published many papers drawing attention to wasteful use of hospital resources, but that is not inconsistent with a criticism of the DHSS for allowing the service to decline. Despite a shortening in the average length of hospital stay and the greater use of outpatient surgery—clear evidence of improved

efficiency—waiting lists are longer for conditions such as hip surgery. All the effort seems to have come from the doctors so far.—Ed, *BMJ*.

Attachment of community nurses to general practice

SIR,—In his recent document "The Way Forward"¹ Mr David Ennals suggests that the time community nurses spend on professional duties could be increased if general practitioners practised within defined geographical areas. Much as I have come to value the professional support of attached community nurses in this practice I have no wish to see my freedom to practise constrained to suit the geographical convenience of any nursing officer in charge of community services. Has not Mr Ennals thought of increasing the time that community nurses spend on their professional duties by allocating them to defined geographical areas? This practice used to be called "district nursing."

Having practised in both rural and suburban areas my own experience was that with a good district nurse we got just as much help and interchange of information as we do with the present system of attached community nurses. The profession must as ever beware of these increasing restraints on our freedom to practise as we wish that are being put forward in the name of common sense and economy.

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¹ Department of Health and Social Security, *Priorities in the Health and Social Services, The Way Forward*. London, HMSO, 1977.

Ethics and etiquette of doctor-managers

SIR,—Doctors will undoubtedly be expected to help the Department of Health and Social Security to effect the severe economies it wishes to introduce in parts of the NHS. Those of the profession who see it as their public duty to act as agents for the Department in these matters may find themselves increasingly involved in the age-old medical ethical conflict between the public good (interpreted in this case by the DHSS and its medical agents) and the interests of individual patients as determined by their doctors. This is essentially the same conflict as that which excited the professional quarrels leading to Thomas Percival's famous code of etiquette in 1792. To what extent should ethical codes, designed with the individual doctor-patient relationship in mind, apply to that substantial section of the profession which does not have patients to whom it has a primary loyalty?

Administrative doctors and others with no patients to whom they have a primary duty and loyalty may have little difficulty in believing that they are acting for the public good in committees which are asked to make disagreeable decisions. But what of the good of the patients of their clinical colleagues? More particularly, is it ethical (or etiquette) for a clinician who is also in "management" to initiate or further policies which might harm individual patients who are his first responsibility or that of his colleagues?

It is very easy to believe that one is acting for the public good when deciding in committee that there should be, say, restrictions on the prescribing habits of one's colleagues,

or "redeployment" of the facilities which they have for their patients. But are such decisions really in the public interest? Whose authority is sufficiently binding on a member of the medical profession that he should decide what is good for another's patients? The easy, academic answer from Brunel would presumably be, "the consensus's." But since it is still not at all clear, three years after reorganisation, what "the consensus" amounts to in practice its ethical status must be in even greater doubt.

In short, will doctor-managers always be acting ethically? What should be their etiquette? There seem to have been little if any consideration of these questions and I can find no mention of them in the BMA booklet on medical ethics (1974). Please may we have some discussion?

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Training for general practice

SIR,—Though I am a member of the Regional Committee for Hospital Medical Services and of the Council of the Hospital Consultants and Specialists Association, and Honorary Secretary of the Medical Women's Federation, the following is my own view.

Recently proposals for regulations in connection with the National Health Service (Vocational Training) Act 1976 have been prepared and circulated by the Department of Health and Social Security (11 June, p 1549). Two matters of major principle arise.

(1) It has been generally accepted that the essence of a profession is that it is self-regulating. For the medical profession this has meant that the requirements for specialist training have been decided by the royal colleges. It is now proposed that the requirements for specialist training in general practice should be decided by the DHSS, albeit with the advice of the Royal College of General Practitioners. It is conceivable that at some time in the future the DHSS might dispense with the advice of the RCGP. I submit, sir, that the proper authority in this matter is the RCGP alone and that the acceptance by that royal college of a merely advisory role may in the long term destroy the college. Similar regulations could at some future time be laid by the DHSS in relation to other specialties. The royal colleges may wish to consider where the interests of the profession lie. Further, should the royal colleges wish to surrender their traditional role as regulators of postgraduate training requirements I question the desirability of this being taken on by the Department. The DHSS has a strong commitment to staffing the Health Service. This might at some stage be in conflict with the maintenance of satisfactory standards in postgraduate training.

(2) The proposals for regulations for specialist training in general practice enshrine a new principle (in clause 6)—namely, that experience gained is of no value after the lapse of a period of time. This is a principle which has not been accepted in other specialties. It may or may not be a proper view to take, but I suggest that a wider consideration should be given to the principle before a potentially dangerous precedent is set.

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