doing well and that the changes I went through were helpful to the only people that matter, my patients. I may not be all that interested in how much easier life is for anybody else. Does anyone know where the resources to help me do this will come from?

I need some time. Now, this is the big one. I need time to reflect, consider, and then change my practice. So, looking around, I see that my clinical workload is too high. I do not have the hours to invest in such a cerebral approach to medicine. Does the NHS really expect me to evolve into the careful, thoughtful, constantly questioning clinician it envisages while I attend weekly three outpatient clinics, two theatre lists, one labour ward session, teach students and registrars once a week each, respond to inquiries, perform general administration, attend managerial committees, accrue my continuing medical education points for specialist accreditation, do my bit towards the developing research and development culture of the new NHS (which is not included in the clinical governance scenario), and try to fit in a bit of private practice (remember I am rewarded for this sinful activity by the NHS reducing my salary by 10%)? And don't forget the on call commitment that I do for no extra charge.

Perhaps you think I'm exaggerating. I suggest you read the documents and do the sums yourself. I haven't included other aspects of the clinical governance package, such as developing my "clinical leadership skills" (whatever they are), risk management, sorting out my poorly functioning colleagues, organising health needs assessments of my local population, and finally participating in systems to ensure that lessons learnt are implemented. I think I'm being rather conservative.

> *"The sad fact is it cannot be done within available resources"*

But we are between a rock and a hard place. Who could possibly argue that the aims of clinical governance are not worth pursuing? If we object we run the risk of looking and sounding like the self serving dinosaurs some sections of the media accuse us of being. Most doctors would see these aims as laudable and worthy of our serious attention. But I wonder how seriously the government is taking the effective implementation of these measures? Be in no doubt that the effective implementation of clinical governance will require two sessions a week of my time. I would suggest that I lose one outpatient clinic and one theatre list. There are six consultants in the department. That is 12 sessions. That is another two consultant jobs to be created in our department alone—£100 000 a year. How many directorates are there in this hospital? What do we multiply that figure by? Ten? Probably. That's £1 000 000 for Warrington. Multiply that nationally. What would you estimate? £200 000 000? And I haven't taken into account the costs of improving information access in libraries, audit staff, and data collection systems to underpin these changes.

But of course it's all covered by that innocuous phrase at the beginning of this piece: "Within available resources." The sad fact is that it cannot be done within available resources. I know it, you know it, and Frank Dobson knows it.

I have no doubt that it will eventually be done, the way that audit has been done and the way that research and development is being done. Badly. And another opportunity to match vision with reality will have been lost.

Still, no doubt before the next election, someone will come up with another idea to occupy us. It is hard not to come to the conclusion that the function of the NHS upper echelons is to find things for NHS staff to do under the guise of improvements.

Malcolm Frazer, *consultant obstetrician and gynaecologist, Warrington*

When I use a word . . .

Grapes

In recent years we have all become familiar with the names of grapes commonly used in wine making: cabernet, chardonnay, Pinot, Riesling, Sauvignon, and Shiraz, for instance. Others, less well known, include catawba, haanepoot (or honeypot), Merlot, scuppernong, and zinfandel. So what about some medical grapes?

In Latin a bunch of grapes was racemus. In 1822 Kestner isolated an acid from grapes, and Gay-Lussac called it racemic acid. Racemic acid was in all respects chemically identical to tartaric acid, except that it did not rotate polarised light, a phenomenon described by Jean-Baptiste Biot, who postulated molecular asymmetry. Later Louis Pasteur crystallised racemic acid and saw in his microscope that it contained two types of crystal, left handed and right handed; when he physically teased them apart he found that a solution of one behaved like ordinary tartaric acid, while a solution of the other rotated light in the opposite direction. Racemic acid, being a mixture of the two, was neutral to polarised light. So the term racemate was adopted to describe a mixture of equal amounts of two stereoisomers.

The Latin word for a single grape was uva, which gives us uvea, uvula, and pyruvate. Pyruvate (Greek πρ, pur, fire) is formed by distillation of racemic acid, the acid got from grapes; in comparison lactate (Latin lac, milk) seems rather tame, but it is lactate that is formed from pyruvate when you burn up energy in your muscles.

The uvea was originally the choroid surface of the eye (because it looked like the skin of a grape), and later the layer of pigmented cells forming the posterior covering of the iris; now it is the iris, ciliary, and choroid taken as a unit.

The uvula at the back of the palate looks like the little grape that its name implies. But there are other uvulas around the body: the rounded elevation at the neck of the bladder (uvula vesicae) and a small rounded structure in the cerebellum between the pyramid and the nodule (uvula vermis or cerebelli).

Inflammation of the uvula, uvulitis, is also called staphylitis, from the Greek word for a bunch of grapes, σταφλ (staphule). From the same word we get staphyloma, an inflammatory protrusion of the cornea or sclera. And under the microscope staphylococci cluster in bunches like grapes.

Uva and staphylos combine in the tautologous bearberry, *Arctostaphylos uva–ursi* (Arctostaphylos = bear + grapes; uva–ursi = grape + bear's). Uva–ursi contains an astringent substance called arbutin and was at one time listed in the *British Pharmacopoeia* as a diuretic and urinary antiseptic.

The Greeks had another word for a bunch of grapes, βτρυς (botrus), from which we get the name of a fungus, Botrytis cinerea (Latin cinereus, ashen), that causes noble rot, producing the richness of certain wines, such as Sauternes and Tokay. And botryomycosis is another name for a pyogenic granuloma.

Bagassosis, a coniosis (see *BMJ* 1997;315:292), is caused by the inhalation of a dry refuse formed in sugar making, from the Spanish word bagazo, the husks of grapes left after pressing.

And there are pharmacological grapes, too, although of a different kind. The sympathomimetic alkaloid ephedrine comes from *Ephedra*, the sea grape, so called because it grows in clusters.

But I'd better stop there—I'm getting too intoxicated.

Jeff Aronson, *clinical pharmacologist, Oxford*

We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.