graphy. During the oral treatment period the increased blood flow was maintained or improved further, as shown by the following fluorescein angiograms. Tolerance to these high doses, both intravenous and oral, was excellent.

A similar trial is also running in advanced cases of chronic ischaemic legs, unsuitable for reconstructive arterial surgery, using high doses of intravenous hydroxyethylrutosides. We have about 20 cases in this study to date; and most results, both clinically and with serial fluorescein angiography are similar to those reported here for Raynaud's syndrome. These results will be reported in full when we have finished a detailed analysis of the material.

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- ¹ Schmidt-Schönbein H, et al. *Vasa* 1975;4:263.
² van Haeringen NJ, et al. *Bibl Anat* 1973;12:459.
³ Lund F. *Acta Chir Scand* 1976;60, suppl 465:60-70.
⁴ Lund F, et al. In: *Gefässwand, Rezidivprophylaxe, Raynaud-Syndrom*. Baden-Baden: Witzstock, 1979: 480.
⁵ Lund F. *Bibl Anat* 1979;18:322.

Not a career for academic high fliers?

SIR,—The Finniston Report on the engineering profession¹ illustrates a serious deficiency in the way we manage our affairs. A technologically based society—and all advanced societies and most others have to be—needs good technicians, scientists, and engineers. Of course, medics are also important, but—like their nostrums—only in moderation. We must moderate our desire for ever more and brighter students, and for two reasons: firstly, because medicine has the jobs for only a few academic high fliers—bread-and-butter medicine does not use or satisfy their special abilities—and, secondly, because (as the Finniston Report demonstrated) there is a much greater need for the bright ones in other branches of science and technology. Society cannot afford a medicine which scoops up too many scientists, particularly academic high fliers.

The fact that medicine is so attractive to our bright school leavers has less to do with the merits of the subject, or the needs of society, than to medicine's high rating as a career. Our deans must act with unaccustomed humility: the corollary to Finniston is fewer medical students and three Cs as the going grade; a special case must be made for taking more than a few with higher grades.

Medics like to take credit for a concern for individuals and society: now is the opportunity for us to show we deserve it.

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¹ Committee of Inquiry into the Engineering Profession. *Engineering Our Future*. Cmd 7794. London: HMSO, 1980.

Patients first

SIR,—I write to point out what appears to be an error in the title of the consultative document *Patients First*. Should not the title be *Hospital Patients First*? With this correction

the document reads well and the changes suggested seem reasonable. If, however, the title is not in error I must express concern about other than hospital patients in the care of the NHS—for example, those who are the responsibility of the primary care and preventive health services.

What is not clear from the consultative document is how the NHS, particularly at local level, will serve all patients and not just those in hospital. It is suggested that there will be a triumvirate at the district general hospital, or its equivalent, of senior and experienced people, paid accordingly, to administer the hospital. Will they also be responsible for the majority of patients who are cared for outside hospital, or will there be a second triumvirate to promote the health of the total community of the catchment area of the hospital, with a responsibility for the primary care and the community health services (for example, the child and school health services)?

The suggested philosophy of the consultative document is to bring health services nearer to the patient. It is therefore essential that local administrative and management arrangements are right. It would seem that insufficient thought has been given to this by those who have prepared the document. Although there has been much criticism of the reorganised Health Service, there appears to be an acceptance that one of its benefits has been the bringing together of previously fragmented health services. We need to build on this important advance and not by new (some may say a return to old) administrative changes create a partite structure within the reorganised health service.

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Cleaning hospital wards

SIR,—In your leading article (22-29 December, p 1610) you make a plea for the ward sister again to have responsibility for the day-to-day control of the ward cleaners; but let me add a word of support for the hospital cleaning departments, which have a responsibility for training domestics and providing them with the necessary equipment. Surely the best arrangement would be for the domestics to be on the sister's staff for day-to-day control, but under the general supervision, so far as standards of work are concerned, the domestic supervisor. In the good/bad old days the matron's staff was responsible for buying the cleaning equipment, and this was far from satisfactory. Today at least domestics have the appropriate equipment for cleaning and are instructed in its use.

There is another aspect to this problem beyond the control both of the ward sisters and of the domestic supervisor. Going round a number of London hospitals last year I noted with dismay the numbers of wards and, even more, kitchens where there was a high-tide mark at six feet (1.8 m). Below this level the walls can be cleaned by the domestics, but above they may be washed only by the painters.

With the continuing problem of cross-infection there is a medical aspect and there should be good liaison with the hospital consultant hygiene officer. I remember a patient in a side ward who damped down the enthusiasm of the ward cleaner who had set to

work on a cupboard: "Hi! Stop! That's where I keep my streptococci." He was right, and unhappily he almost died from a severe postoperative wound sepsis.

There are simple answers, such as long-handled mops with self-squeezing mechanisms, or re-establishing the routine of pulling the beds out and having the walls washed down. I remember this was done in half a morning at Bart's, where under the eagle eye of Professor L P Garrod the wards really were kept clean.

Clean hospitals are important. Like Minerva (5 January, p 53), I look forward to the time when the DHSS awards a handsome prize to the domestic supervisor of the hospital judged to be the cleanest in England and Wales.

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Medically qualified preclinical academics

SIR,—I fully agree with Mr N A Green and Professor R E Coupland (12 January, p 116) that medically qualified preclinical teachers are essential for the medical direction of education, particularly in anatomy. In these days of shortened anatomy curricula there is an enormous advantage in having medically qualified staff who are able to select the clinically relevant facts from the vast amount of anatomical knowledge. Furthermore, as the late Professor W J Hamilton frequently pointed out, medically qualified staff are usually much more versatile than their non-medical colleagues, being able to teach cytology, histology, embryology, and neuroanatomy as well as gross anatomy.

I also agree that a clinical presence in pre-clinical courses can be of great value, particularly in motivation of students. I have been co-ordinator for a number of years of a clinical neuroanatomy course which includes contributions from neurologists, neurosurgeons, otolaryngologists, and ophthalmologists; and have participated in limb anatomy courses which are jointly run by the departments of anatomy and orthopaedic surgery. I willingly acknowledge the value of these courses.

I am not, however, convinced that by doing clinical sessions preclinical staff would in any way improve their teaching standards; nor do I believe that clinical sessions would be of any value in improving recruitment and retention of junior staff, for the simple reason that the basic salaries of preclinical and clinical lecturers do not differ greatly. The major difference is in the payment of UMTs, which presumably would not be paid for two sessions a week. The problem is not unique to pre-clinical staff but has also severely affected recruitment to paraclinical laboratory disciplines. Unfortunately it seems likely that the new consultant contract will aggravate the situation by extending the salary differential in laboratory disciplines to the consultant grade.

There are numerous practical difficulties involved in finding appropriate clinical sessions for the majority of preclinical teachers. Many clinicians argue that it is not possible to develop clinical expertise where clinical contact is restricted to one or two sessions a week and would strongly oppose clinical involvement of preclinical staff at anything higher than SHO level, a point of view which is understandable. The most valuable type of