general practitioner to read an annual total of 5100 pages would take about 85 hours a year, or almost two hours each working week (assuming six weeks' holiday a year). It must be remembered that BUMPH does not include paperwork related to patients or time for reading medical journals.

There are 32 271 general practitioners in Britain so the time needed for all general practitioners to read all their BUMPH would be about 2.74 million hours. Using the government's assumption that general practitioners work 24 hours a day and 365 days a year, the total time spent by general practitioners reading BUMPH is about 313 GP years in a calendar year. Allowing for a career length of 25 years, reading BUMPH uses up about 12.5 GP careers each year.

If the average weight of a page is 5 g then the 5100 pages received by each general practitioner weighs about 25.5 kg. Across the whole country, general

practitioners would have received about 822 911 kg of BUMPH, or 823 metric tonnes. In practice, much of this paper mountain is moved directly from desks via waste bins to paper recycling collection points (T Kenny, personal communication), but the amount actually read is unknown at present.

Although the minister of health has set up working groups to look at ways of reducing patient related paperwork, there does not seem to be a similar group looking at ways of reducing BUMPH. There is clearly an urgent need for further research; perhaps a working group could send general practitioners a questionnaire?

1 Rout U, Rout JK. Job satisfaction, mental health and job stress among general practitioners before and after the new contract—a comparative study. *Family Practice* 1994;11:300.

2 Chambers R, Belcher J. Work patterns of general practitioners before and after the introduction of the 1990 contract. *Br J Gen Pract* 1993;43:410-2.

Of no fixed abode: homeless house officers

Susan Pembrey

Many years ago when I was first a ward sister a young house surgeon committed suicide and I became aware of how vulnerable we all are. Last year I had the opportunity to talk individually with 10 house officers in a provincial teaching hospital six months after they qualified. These doctors were caring, able people committed to providing a good service to patients and they were some of the most thoughtful, sensitive, lively, and intelligent human beings I have met. Most of them loved medicine—the challenge, the autonomy, and helping people to get better—and they hoped to be rewarded by belonging to the medical team, practising and learning medicine, and “being the patient's doctor.” Instead they were commonly exhausted, stressed, and frustrated, and they felt themselves to be unproductive; on the whole, as they looked at their seniors, they could not see it getting better. What had gone wrong?

“I never have more patients on one ward than any other . . . mostly I have patients on over 10 wards,

very rarely less than 10. I have no ward . . . I would not know where to leave a coat if I brought one with me.” All the house physicians, and to a lesser degree, the house surgeons, were homeless; trailing all day throughout the hospital like itinerant travellers. This homelessness was a striking change to the traditional pattern of medical firms attached to designated wards. It was caused by a policy of bed scatter, through which a patient was admitted not to a designated ward but to any bed available in the hospital. Bed scatter creeps up like an insidious virus, gradually breaking down the ward boundaries and with them the crucial ward team of house officer and nurses. Doctors followed their patients throughout the hospital; the nurses made up the ward front line teams alone; and both groups were more vulnerable.

I have long been struck by the dismay of senior medical staff over the loss of the traditional ward sister; their *cri de coeur* has been for someone who is in charge or, as one of the house officers said, for “someone who knows.” I think there is more. Nurses and doctors act as a talisman for each other against the—often unacknowledged—anxiety of caring for ill patients. The actual presence of their counterpart, or at least knowing where the other person is in case you need them in a hurry, is the key to the talisman effect. The nurse or doctor may not, in fact, be much in control or “someone who knows,” but they represent that ideal to each other. For example, nurses believe that doctors know how to control and treat disease, and doctors sense that nurses “know the patients” and will not let them get out of hand. House officers are obviously not experienced—but they are doctors and have an important talisman effect for nurses, and nurses for them. Further, most of the immediate concerns about patients can be solved by the house officer and nurses.

The loss of the ward team therefore has major consequences, which the house officers I interviewed described graphically: “It's a mixture of exhaustion, being on your own, and coping. I think nobody knows anybody really. . . . The other thing is—it sounds daft—you never get offered a cup of tea or coffee by the nurses.” When the mutual presence of house officer and nurse was broken, a series of difficulties arose—as well as the practical problems of getting things done,

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Perhaps it was a golden age—when nurses and doctors worked together as a “ward team”

staying in contact took greater effort, interrupted work, and increased anxiety. The homeless house officers were "invisible" to all the nurses: if they were not actually on the ward it was as if they did not exist. The doctors frequently referred to this invisibility and constant bleeping: "I might be in the next door ward and coming to them and get bleeped . . . it's not their fault they can't see me. They think if we are not on their ward we are watching TV. When I was on [a designated ward] I could have thrown my bleep away. I was always on the ward, they knew where I was, and I knew all of them within a week. The difference is unbelievable."

The homelessness of the house officers greatly reduced their ability to function as "the patient's doctor," which had been anticipated as a major source of satisfaction, as they were exposed to the impossible task of trying to maintain contact across 10 or more wards: "You think as a doctor that you are spending a lot of time with the patients. As far as you are concerned you are spending 10 hours a day running round. You are actually only spending 10 minutes a day with each patient. A lot of the time you are moving all the time, but you are not actually with the patients, and that's a bit of a shock. The patients, I think, relate to the nurses; they get the thanks."

Recently nursing has been trying to provide each patient with a "named" registered nurse who is responsible for their care. The doctors observed how well the nurses knew their patients but they also noted the difficulty of finding the right one; and, working across 10 wards, they could be in contact with some 150 nurses: "Mostly they are extremely helpful and extremely knowledgeable about their own patients. The only down side from our point of view is finding the right one . . . it is almost impossible ever to find the right nurse unless you hang around. Equally for them I know it is almost impossible for them to find the right doctor—so I can see both sides."

Finding the right nurse was made worse by a lack of overall ward coordination. The need for someone to be in charge and for "a person who knows" was vehemently expressed: "There has to be somebody in charge—not only in charge—somebody who knows what is going on. There needs to be a coordinator of some description; some of the wards don't have coordinators and it's a nightmare." These house officers did not mention ward sisters, or only as mythical figures who used to "knock heads together and negotiate between the two sides," but their call for someone in charge was insistent.

The house officers mentioned many stresses: "It is hard to prepare yourself for it—what it feels like to be desperately incompetent. Sometimes there is such a sense of feeling I am out of my depth that I don't know what to do. It is important that I look competent . . . therefore I will not admit fallibility." A number of the doctors voiced concern as they watched themselves "becoming a horrible person" or "becoming a person I hate": "I feel as if I am completely altered. I'm probably not, but it's just that there are so many stresses on us that you just think you've got to keep yourself going and, you know, sympathy kind of just flies out of the window a lot of the time. It is really bad actually; we shouldn't be pushed to the extent that that happens."

I was moved by the vulnerability of these young staff. Recognition of this vulnerability is the starting point towards a healthier and more efficient system. Doctors and nurses know what is needed: conditions that make possible supportive relationships and effective work; a secure "home" ward base; clear boundaries to individual work and responsibilities and enough continuity; and someone who is clearly in charge and able to hold the tensions of ward life. It is about a human scale and human values; speaking of which, I suggest the reforms should begin with the nurses inviting the house officers to tea.

Cold frames

Photographer Julia Hember printed these photographs from glass plate negatives that were found in a caravan, where they had lain undisturbed probably from the mid-1950s. They are believed to be RAF medical officers, probably from the late 1940s and early 1950s. They had been "anonymised" before being given away, often to gardeners for use in cold frames.