if nursing agencies closed tonight then hospitals would start closing tomorrow. As the gaps have been opening up agency nurses have been filling them. Two health authorities surveyed their nurses last year and found that four fifths of their nurses had extra jobs, most of them for nursing agencies.¹⁸ A chief nursing adviser told her management board that her authority "is highly dependent on agency nurses; without them ward closures would be necessary. Our own staff form a substantial core of agency staff, using holidays, days or nights off or working an extended day. While this arrangement has advantages for the continuity of care it cannot be considered desirable on personal grounds."¹⁹

The millions of pounds that hospitals are paying agencies each week are not being "wasted": cost conscious hospitals hire nurses from agencies rather than employ them directly because it saves them money. In a system built on the exploitation of nurses the hospitals' use of agencies still stands out as cynical. As the chief nursing adviser confirmed, most agencies now place staff back in their own hospitals, often on their own ward. To employ nurses directly the hospital would have to pay them overtime rates for any time over 37½ hours a week. Not so the agencies, which pay the basic rate (see box). The agency pays the employer's contribution for national insurance, but does not pay for superannuation, sick leave, maternity leave, annual leave, or expenses related to the provision or cleaning of uniforms. The nurse working overtime through an agency earns less per hour than she does in regular NHS employment. "Overtime" rates do not enter into it.

Do agencies give an idea of how a free market in nursing labour might operate? Not really—free market forces are not allowed to operate here. The amount an agency can pay is fixed by law (unlike medical agencies). Competition is permitted, however, among agencies in setting their rates of commission—usually 10-12%.

A penny for the nurses

Nursing salaries are a scandal—one in five qualified nurses now has one or more additional jobs, in 70% of cases solely from need.²⁰ If good reasons exist why nurses deserve lower salaries than either policemen or firemen then the public, which seems to value nurses

equally highly,²¹ should be told what these are. In return for no strike agreements made in the late 1970s policemen and firemen enjoyed large salary increases and then subsequent index linking of their salaries.¹³ If such arrangements are good enough for policemen and firemen, then surely they are good enough for nurses.

Such a solution would not come cheaply. For enrolled nurses and staff nurses (and pupils and students) to track along the same salary path as constables (fig 2) would cost an additional £1250m each year, or an extra one penny on income tax.²² What would the public think of that?

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Conversations with Consultants

Mr Q the surgeon

TONY SMITH

This is the second in a series of recorded interviews with consultants (the first appeared on 2 January, p 45). Mr Q is a surgeon in a teaching hospital 100 miles away from London. His district is a RAWP gainer.

I've looked at your questions from three angles: from my own personal point of view, as part of a unit of three consultant surgeons, and as part of being a paid consultant at the hospital along with everyone else.

On a personal basis I've been very fortunate. I used to be an adult

urologist with a great interest in paediatric urology and for a variety of reasons I am now a full time paediatric urologist. Because it is a relatively minor specialty I don't need vast numbers of beds so I'm well off in comparison with the adult side of our service. I do clinics throughout the whole region and thus I do a lot of driving. I see the children with paediatricians in the outlying hospitals and bring them back to my unit to operate on them. So from my own personal point of view my morale hasn't deteriorated; indeed, it has gone up as it is a very satisfactory job I now have. If I go away I tend to postpone the clinic as I don't want anyone else making decisions about the children which may not be helpful. Job satisfaction is enormous and morale high.

From the unit point of view we have myself doing paediatric urology and two other urologists dealing with the adults. The adult

service has suffered some major setbacks which go back 10 or 15 years.

I think deterioration first began with that very unpleasant dispute with the National Union of Public Employees (NUPE), which demoralised an awful lot of people. The medical pay dispute (when we threatened to withdraw services) turned the screw a bit further. The reorganisation of the NHS didn't help in terms of morale. More recently we've had severe financial cuts on both the university and NHS side.

Locally, with closure of a hospital, we've lost a number of beds and this has meant cutting our urology unit from 36 down to 29 beds. We had an enormous throughput of prostates and other urological procedures and to be told that we were to lose seven beds when we were already working very close to the bone really was a major disaster. It's brought us, I believe, right to the very edge of safety limits. It is not only a potentially dangerous level but is also an incredibly inconvenient level.

Waiting for a bed

Let me explain. Every "booked" patient has to ring in the morning to ask if there is likely to be a bed available. The patients come in, and they sit in the day room waiting for a bed. They may sit from 10 o'clock in the morning until 6 o'clock in the evening waiting for the staff to decide whether another patient has stopped bleeding sufficiently to go home. The beds are never cold. And, of course, if the patient who's bleeding doesn't go home then the patient who's been waiting has to go home instead. I don't think that this is an acceptable way to run a unit.

In terms of surgery other limiting factors are the number of anaesthetists and the number of theatres available. Another factor is the laundry. For some reason in our hospital the laundry is periodically in chaos. Backup services are scarce. If, in fact, we were to be given two more beds, we would then probably need one more anaesthetic session (which would be impossible anyway) and also another theatre session—which, in turn, would overstretch the availability of theatre staff. To fund a new surgeon on a basic salary together with all the various backup facilities costs over £150 000. I suspect that the supply of anaesthetists is used as a brake on the system in many hospitals.

Yet with all this pressure we are not actually doing badly. We have kept the waiting lists reasonable by increasing the throughput. We have appointed more urologists in the region so that few patients have to wait many months for a routine prostatectomy. It used to be up to two to three years' waiting time. Waiting lists are poor indicators of clinical need. I can appreciate that someone with a very painful hip needs to get in quickly, but someone with an enlarged prostate who is getting out of bed perhaps twice a night with a minimal or moderate residual urine may actually be no worse a year later.

One of the things I have noticed over the years is that a patient on the waiting list for prostatectomy almost never comes in with acute retention of urine. The ones who do come in with retention have never seen a doctor with their urinary symptoms. By contrast the patient who complains, sees a doctor, and gets on a waiting list rarely goes into retention. So I'm not sure that to have a patient on a waiting list for a year or two for prostatectomy is necessarily such a disaster. Obviously, a patient with a carcinoma comes in very quickly.

It may sound as if our unit does not have any major problems. But that is only because we have increased our efficiency. However, we now believe that we have reached a point with 29 urology beds in a teaching hospital at which we cannot really become more efficient.

Financial problems

In recent years our hospital has run into debt—at times up to £2½ million in the red, and we have all made enormous efforts to reduce this debt. This, particularly, has affected morale. For instance, at one time, when things were critical, we made an effort to try to save

£1 million to balance the budget. We formed an "economy committee" which looked at every aspect of expenditure. I personally looked at the disposable items, which is a big slice of the budget. It's all too easy to ask for a syringe and be given a 5 ml syringe, when you need a 10 ml one. That's two syringes opened when only one was necessary. We looked at the type of needle and intravenous cannulae that we used, and managed to save about £80 000 or £90 000 a year just by changing the brand of needles, catheters, bags, and other disposable items. Then suddenly during the NUPE strike they decided, for political reasons, that they would not allow any more private practice in the NHS hospitals. Now we only have nine or ten private beds in the whole system, and they are used sensibly. For eight or nine months we weren't allowed to use them at all, and I calculated that the hospital lost roughly a quarter to half a million pounds in revenue during that time. And there we were scratching around changing the types of needle in order to save a fifth of this amount that was lost to the system! That is the sort of thing that totally demoralises people. Then we had an enormous row about the cleaners. The problem continues and the hospital is still thought to be less smart than it was. We actually had a note on our secretary's desk last week saying "Please do not leave bits of paper on the floor as they are a fire risk, signed cleaner." Maybe the new way is cheaper but I do not believe it is as good.

Nurses

You ask about nurses. There is, of course, a major shortage of nurses, and it may be marginally worse in a university town which offers other types of employment for young people. The nurses we do get do as good a job as they ever did, but I think most doctors believe that two things haven't helped: one is Salmon, which has meant that now we rarely get the really devoted career ward sister, since if she is to earn a decent wage she has to move into teaching or administration. The other thing is the "nursing process," which seems to require the nurses to write long essays on the patients each night when they should be doing more useful things. I think that this is nonsense from the medical point of view.

I am, then, a bit unhappy that nursing has become an academic career instead of a caring profession. Nevertheless, I think the nurses do an incredibly good job and that most of them are totally devoted. One thing that would make a huge difference would be the provision of crèche facilities for nurses with small babies.

You asked about the service from the laboratory; again it is pretty good but they are always saying they are short of staff. As with the anaesthetists or operating sessions the provision of laboratory services is often used as a brake on the system when money is short.

Secretaries: a disaster

By contrast, secretarial services are disastrous: they really are terrible. I've heard of consultants who have been appointed and then haven't had a secretary for two or three months and have to write their own clinic letters.

Many secretaries are shared and there is no feeling of having a personal assistant type of secretary, but just a typist. Someone better than that is needed to run a proper practice, someone who is capable of answering the phone and sorting out problems day to day; but again this is purely a money problem. Job satisfaction is excellent in the hospital service but Sainsbury and Mark and Spencer offer better money.

What actually happens is that consultants with a part time contract have a private secretary, who ends up doing much of the work that should be done by the NHS secretary. They don't type the clinic letters but they will organise the student rotation, the teaching, meetings, and such matters that always used to be done by the NHS secretaries. I think it is sad that we are having to subsidise the NHS in this way.

If you asked me what can we do about it I would answer that we must stop the terrific wastage in the NHS. The reason for the wastage is that there is virtually no incentive to save in an enormous

organisation like this. In your own home you are paying the electricity bill and you turn off the light as you walk out of the room, but in a hospital you don't. Even though many of us may turn out the lights as we walk out of the department in the evening when we come back in the morning every single light is back on. The cleaners have been in in the night and left them all on.

I suspect there is an enormous amount of pilfering from hospitals. I heard a story the other day told by a patient who was on a Mediterranean beach and noticed a girl using a towel with a hospital's name on it. It turned out that she had brought a whole set of sheets with her for the flat she was renting. He said, "Never mind, you'll be taking them home," and she said "Oh no, I can't get them in the case so I'm leaving them here." I'm sure this isn't deliberate stealing, it's just that people regard such activities as part of the perks of the job.

I believe that if the NHS wants us to save we would happily do so if we were told that for every pound that we save (by being extra careful of economies of disposables, being more efficient, watching for electricity, turning the pipes off in the evening, and all that sort of thing) we were given 10 or 15p towards my research funds, we would try jolly hard.

It is sometimes argued that one of the problems is that there isn't any incentive for a surgeon to increase his throughput—by contrast with systems which have a fee for item of service. I don't totally agree with that, because I think that part of one's job satisfaction is to do a job well and efficiently.

There is still an immense variation in bed stay, for example, but that depends on the speed, ability, and fads of individual surgeons. You could never have a norm for a hernia operation: one surgeon may take an hour and a half, and another may take 20 minutes. But I've never known anybody that I've either worked with or for who didn't want to get through the work. Maybe that's because I've always worked in places where there have been big waiting lists, but I couldn't identify much lax in the systems.

University finance

You asked about how the cutbacks in university finance have affected me. What it has led to is a search for alternative means of funding. We turn to the university for teaching and research funding and it no longer can help. University funds seem to have been cut year after year.

We are interested in the possibility of picking up ureteric reflux in

the neonatal period before it actually scars the kidneys—so possibly reducing by 15% the numbers who end up having dialysis and transplantation. It's an important project but we have had to set up an appeal fund to finance it. This never used to be the way research was funded. Appeals should never be necessary. If a project is good enough it should be funded by NHS sources.

You asked about the expansion of the private sector. When I first arrived in 1972 there was one cardiologist and one general physician who did private practice, and I think there were two surgeons. Now, all but about two of the physicians have a private practice and so does every surgeon.

I think it has flourished in a healthy way. We have two very viable private hospitals, and, although I said earlier that the 10 available beds in the NHS hospital are used fairly fully, I have never had any difficulty in getting in the odd patient, which suggests that they are not full all the time. One of the criticisms often made is that once a consultant has a good private practice he will neglect his NHS commitments. I have always found that totally untrue. Indeed, the basis of a successful private practice is to give the general practitioner, and hence the patient, a good service on the NHS. I don't know what the proportion is but I suspect that 80% or 90% of the people who go privately in this country have insurance. Oddly, many patients who are insured still go initially to an NHS clinic instead of seeking private treatment directly.

But, to go back to the NHS, what really worries me—and worries everybody about economies—is that if a unit is seen to be very efficient the administrators will say the next year that it obviously has some slack in the system and asks it to cut back further. What is the point of becoming ultra efficient only to be told the next year or so that you've actually got to take a further cut? The succession of cuts leads to a feeling that someone else maybe isn't trying as hard as you—and that destroys morale. If the medical staff are unhappy this then filters down to all staff until everyone is unhappy.

Car parking

Silly things matter; old fashioned things sometimes, things like where do you park your car in the mornings. If I don't get in by 8.15 in the morning I cannot find anywhere to park. It shouldn't be like that. I go off to another hospital and come back only to spend another half hour looking for somewhere to park.

I don't want a Rolls with my junior staff all lined up in the morning to meet me, but I do want to find somewhere to park, and somewhere to eat and talk to my colleagues. Don't we all?

MATERIA NON MEDICA

Wheel deals for women

All branches of the motor trade seem to cater exclusively for male doctors. I have visited all the local showrooms seeking my ideal form of transport.

I was looking for a small four wheeler (less than 12 feet long) for easy parking, that, as well as being reliable, looked as nice inside as out.

The glossy brochures have pages of "Technical specification and equipment" with items that I consider essential, like radio/cassette, auto wash/wipe, headrests, sun roof, squeezed into the bottom inch of the second page. The acceleration in "seconds" and rev counter matter less to me than that I have places to put my dictaphone, radio pager, extra pair of shoes, and make up. Why does the passenger (mine is usually a male junior doctor) always get the sun visor mirror? Other nice touches would be a carpet that does not damage high heels and an interior light in such a position that you can actually read road maps and directions after dark. I like a clock I can see at a glance, not an "analogue quartz," and seats I can get on to without negotiating a raised side edge; this and the small seat undoubtedly hold the male pelvis of a grand prix driver perfectly in place.

Most small cars offered to the public have a poor finish. They are bought by husbands for wives who take their turn in driving their own and other

people's children to school/swimming/ballet/cubs etc. Cars with good interiors tend to be in a much higher price bracket and are unobtainable without powerful engines—fine for motorway driving but not suited to visiting urban estates. Surely there is something in between for professional ladies who find, perhaps for the first time in their lives, that they can afford some luxury.

Cars, like dogs, get to look like their owners. (Or is it vice versa?) Men see cars as an extension of themselves, wanting them to look good (nothing wrong with that) and leave the other fellow standing both at traffic lights and on the inside lane of motorways, definite competitive qualities. They also enjoy a certain amount of noise and a somewhat flashy exterior. I am competitive too but I like, between home visits and at the end of the day, a relaxing atmosphere in cosy surroundings with essentials near at hand. Guidance from sons can be extremely misleading as they tend to hope that (as has happened in the past) they will eventually fall heir to the conveyance.

Incidentally the car I have settled for looks like a cross between a hearse and a delivery van, but you can't have everything and no doubt I'll get used to its appearance and learn to appreciate its performance.

JOYCE L DUNLOP, consultant psychiatrist, Hull.