A problem for the many elderly women who do not wear suspender belts or corsets is that the thigh part of their stockings comes down and hangs loosely around their knees. For them, lightweight elastic below knee stockings should be considered. These can be ordered only in net and have to be made to measure.

Elastic stockings should be taken off at night before the patient gets into bed, and they should be put on in the morning before she starts to walk. Ideally, they should be kept by the side of the bed and the patient should put them on while she is still lying down.

The stockings should be turned inside out, except for the foot up to the heel. The foot should then be inserted into the stocking until the heel of the stocking corresponds with the heel of the foot. The stocking should then be worked up over the ankle, pulling it up in folds a little at a time. It should be removed by peeling off, not by rolling or pulling at the ankle (Scholl *Hosiery and Dressing* booklet). The fingernails should be free from rough edges, which might cause damage to the stocking or, more seriously, to the fragile skin of the leg.

Prescription guidelines

- (1) Explain to patients why elastic stockings would be helpful.

- (2) If they agree to try them suggest that they should take the prescription to the pharmacist and that they should ask him for a measurement form. Patients can measure their ankles and calves at home. However, surgical appliance suppliers usually have staff on their premises who will take measurements.

- (3) If you think a patient can manage standard weight stockings and is used to wearing suspenders prescribe *standard weight, thigh length*.

- (4) If not prescribe *lightweight, thigh length*.

- (5) For women who do not wear suspenders or for men, prescribe *standard weight, below knee*.

- (6) Prescribe one pair and ask the patient to return after two weeks for reappraisal.

- (7) If the stockings are satisfactory prescribe a second pair, explaining the need to wear them permanently and to have them replaced every three months, or when the elasticity deteriorates.

References

- 1 Burnand KG, Clemenson G, Morland M, Jarrett PGM, Browse NL. Venous lipodermatosis: treatment by fibrinolytic enhancement and elastic compression. *Br Med J* 1980;280:7-11.
- 2 Burnand KG, Laver GT. Graduated elastic stockings. *Br Med J* 1986;293:224-5.
- 3 Horner J, Fernandes E, Fernandes J, Nicolaides AN. Value of graduated compression stockings in deep venous insufficiency. *Br Med J* 1980;280:820-1.

Conversations with Consultants

Paediatricians

TONY SMITH

This is the fifth in a series of recorded interviews with consultants. On this occasion four district hospital paediatricians were interviewed together. Their districts are all RAWP losers.

Medicine has become a high tech business, in which changes have to be made quickly and efficiently. That can happen only when doctors' morale and job satisfaction are maintained at high levels; yet the new style management seems to be achieving exactly the opposite. As clinicians we have become more and more isolated from influencing or contributing to change. The Cogwheel system, however cumbersome it was, did allow us some influence. But now management has frozen us out.

For example, one idea we thought had been agreed by the Griffiths inquiry was that money saved under one heading could be transferred to another in the same year. In practice this has proved extremely difficult. In one unit we saved about £30 000 one year and we wanted to use that for equipment which we badly needed. It was said that there was another unit in the hospital which was short of money; and that's where the money went.

The new ideas and proposals that management were supposed to produce have not surfaced. Either the managers are just not bright enough, or maybe the back pedalling economic squeeze has stymied them. Certainly they have never been able to give us any of the perks of good management—let's put it that way. They have been able to give us only the toughness.

Our ability to influence matters has been lost. If we want to change something we go into this management abyss, which apparently cannot respond. It doesn't seem to have a soul. For example, we have had a farcical dispute about a photocopier. We said that we would pay for the photocopier out of our funds and from money we would collect. The management refused to allow our secretaries to have a copier because they said they wouldn't have any control over the amount of paper used or where it was stored. So our secretaries were going up six floors to get their notes copied and having to queue for hours. The frustrations are unbelievable.

A problem we don't actually have in this hospital, but might be included if we are going to talk about paediatrics, is that throughout the country there are still children in adult wards—and that despite the agreement that it is wrong by everyone under the sun, including the Department of Health. If the managers really were managers, surely that is a thing they could sort out. It doesn't require money, in fact it could save money.

Training managers

The chairman of the division does have regular meetings with management, but a lot of the advice given is not heeded. It is frustrating that the manager has no previous experience in our discipline. And as clinicians we feel impeded because we can no longer initiate anything. This particularly applies to community paediatrics—things like immunisation and the general care of children. We have to do everything through management now, but it seems that unless management initiates an idea it does nothing

about it. We have meetings and come out with sensible suggestions but management won't play. Our administrators seem to stay a very short time; once they begin to know the job that they are doing they then move to a different field or move to a higher grade, where they are taking on different responsibilities. We teach them all they know about the specialties and start to get them to think, and then they move on. We go through the agonies of getting them to have a feel of what we are doing and why—because they are the people who are actually going to pass the information to their bosses to influence change. But if we bypass them it creates friction.

We have got a very pleasant manager and it's not his fault that he hasn't had experience before. He has in his heart a wish to produce a good service for patients. But with these good intentions his problems are lack of training as a manager and lack of experience in the particular areas that he manages. And sadly when he does get to understand it he will not have an adequate budget anyway. Indeed, we have to understand the inevitable frustrations for the managers and administrators. The cuts and the rationalisations are making it impossible to be a positive manager. If you are always walking backwards there is no way you can start to create something positive in front of you. And that has now become impossible, which helps explain why the relationships are so bad.

None of us has ever turned his back on the need to be efficient and economical. Indeed, we have saved enormous amounts of money. For example, we saved the hospital paying any money for its milks, and that has saved thousands of pounds at a stroke. Not buying nappies was an idea from us. We have initiated all of these savings and we can't be accused of rampant spendings. Of course, doctors being the beasts they are, they will always try to defend a working arena which suits their training and their temperament. And if it all becomes too impossible, then inevitably not only will the patients seek the private sector but given the choice doctors will choose it too. One has to have some scope to practise a reasonable standard of medicine.

Patients and boundaries

You asked about patients crossing boundaries and so on. To give you an example; with enuretic alarms and nebulisers for young children with asthma and so on we reached a point where we could no longer supply and service children outside our districts because of the financial constraints. So we have an incredible state of affairs where consultants' clinical referrals are not based on a catchment area, but when it comes to providing patients with equipment the catchment areas are applied rigidly. The district managers will not pay for these alarms at £30 a time. On the other hand, if somebody goes to a central London hospital and the consultant there says the patient needs a special sort of bed then that bed is provided in the community off our budget because the patient happens to live in our district.

About three years ago the therapists said they would no longer treat patients who were outside our health district. They did this because they had applied for an increase in staff and had been told that a third of their patients came from outside the district: "Send them back to their own districts and then you'll have enough staff." We have had many patients sent to hospital by general practitioners from just down the road but it just happens to be in a different district. The hospitals are not providing care for the communities around them.

Secretaries

A major cause of dissatisfaction is medical secretaries. One of us was almost prepared to leave the health service last year because a consultant was denied a secretary. The reason the management can't supply good secretaries is that the pay is so low in relation to the going rate in industry. So when the girls have just come out of college and are inexperienced they are willing to come and work for the pittance that they can get, but as soon as they can type, after a year or so, they go.

How can we ask a young girl of 16 or 18 to come and try to organise a very complex system which requires specialist clinics, multiple decisions about where letters go, and what's organised? And when we were at our worst and we had no secretaries whatsoever, the final insult was to see a brand new word processor arrive and be put into an office without anyone to operate it. One and a half years later nobody has typed anything on it, partly because nobody can think of what to do with it.

We are intensely frustrated by this because we have had two new managers put in, but the lack of secretaries has not been addressed. One of us went to the manager recently asking if the administrator could arrange that the summaries are done. In the past few months there have been as many as 150 summaries untyped, and we weren't getting letters out of the hospital for a month. We were told that the administrator had far more important things to do.

One of the things that made some of the last secretaries leave was that within three months their office was changed twice, and each time they were given only a couple of hours' notice that they were going to move. All the consultants were present when we told the administrator, "That is not the way to treat people, just to tell them to move that afternoon." Experienced, mature, loyal secretaries just fold up in these circumstances—being treated like pieces of paper after 10 years of loyal service.

One might say that such clumsiness was the mark of an inexperienced administrator the first time. When he was told, in the presence of all the consultants, that's not the way to behave and then he did exactly the same thing again one must conclude that he thought that what we said was of no importance.

Another frustrating thing has been the lack of recognition by the managers and administrators that medical secretaries do not just do the typing and the summaries but they actually provide a very useful link between the hospital, the community, the doctors, and the patients. In paediatrics in particular anxious parents are often phoning the secretaries to find out results. Secretaries spend a lot of time doing public relations. Management has not been able to appreciate the fact that a secretary's time is not just spent typing. For five years we were having secretary time assessed on how many letters or summaries they got out.

We don't think you can sustain people's morale if you replace the cleaning arrangements in a hospital with something different but awful. Or if you take away the domestic staff who have built up relations with the staff in children's wards. We have always had staff who've been members of a team. It is terribly important to have a caring team of people who want to work with children. If you take them away and put in strangers over whom you have no influence—then you have one of those exercises in management which have eroded morale and not produced any obvious economic compensation.

Privatisation

In one of our hospitals the privatisation of cleaning has been terribly disappointing. Some staff have been kept on under the new arrangement, and they were always good, but the new replacements are not. We have all had some very painful experiences.

Until we actually shouted and thumped the table and got very angry we never saw anyone walking around the ward, outside or inside, to see what the standard was like. Eventually we made the most horrific scene—which we certainly didn't like—and called the manager down and said "Come and look at the ward." It was a disgrace to let patients be admitted there. There was litter everywhere. The prime example was that all the sacks for all the refuse in the hospital were left outside the children's ward. Not only was that a disgrace, but it was a great danger, because children will try to climb into these things. It took us nearly a year to get a suitable container outside to put these things in safely.

We walk in and out of this hospital and see litter all over the entrance. What an advertisement to people coming in to be ill! One of us phoned up and asked who was responsible, only to be switched around from one department to another—catering to domestic to whoever—with no one accepting the responsibility to

clean the front door of the hospital. No managers walked through that door to see what it was like.

Blood on the walls

We can give further examples such as the cleaning of the lifts in the maternity ward in that same hospital. Some time after the new cleaning company began work the medical and nursing staff began complaining about the increasing state of filth in the lifts. This wasn't just litter, it was blood on the walls, which was there for days and days. Finally when the management who were supervising cleaning looked into it they realised that the lifts had not been included in the description that had gone to the companies tendering for the contract. The answer came back that the only way the lifts could be cleaned was by taking time away from other areas of cleaning. There was no flexibility in the contract originally drawn up, so that other areas are now getting less cleaning. The lifts are still constantly filthy, and we are getting more and more graffiti all over the walls.

If an area is dirty and somebody starts to deface the walls the vandalism increases. There's nothing more likely to encourage people to cast their litter on the floor than to see it there already. In the past doctors, nurses, and domestics and so on had a community conscience about the place they worked in. When a sister saw something that needed to be cleaned up then she got it done. But now sisters have no control whatsoever over the domestic staff. The domestic manager has to be called to speak to the staff. It doesn't help for a doctor or nurse to pick up litter three days running, it doesn't achieve anything.

Neonatal care

But let's talk in detail about neonatal care. The number of maternity beds in our hospitals has been reduced by between 15% and 20%. In the past women could decide whether they wanted to come in for a short stay or a long stay. For practical purposes now they don't have that choice, and at particular peak times a patient may have to be sent home whether the community midwife has had time to assess whether she is suitable for an early discharge or not. And that means more work for the community midwives, who have to see more patients for a longer time. They also have to assess patients. Previously patients were only allowed to have an early discharge if their home conditions were satisfactory. Now early discharge has become almost invariable many more assessments are needed, and these have mostly gone by the board.

So what is happening is that the same number of patients are being cared for by fewer midwives in a smaller space with fewer beds. That means each midwife's workload is being increased at a time when we know that the nursing profession is becoming more and more dissatisfied with the job and fewer people are going into nursing.

As far as the special care baby unit is concerned the work has become increasingly complex and labour intensive. In the past 10 years the national perinatal mortality rate has dropped very substantially. Somehow it has been reduced, but nobody seems actually to have thought about what it would cost to reduce it. We are now paying that cost—because there is a different standard of intensive care to that of 10 years ago.

Ten years ago we didn't ventilate babies under 1000 grams. Now we have no limit on size. More care is being offered to smaller and smaller babies, and they are surviving and therefore requiring intensive care for longer and longer periods of time. And so as a result we need more skilled nurses.

But the skilled nurses we need are not paid enough. As a result many of them moonlight either in other hospitals or in their own hospital; and it has become acceptable that they should do double shifts. In the end working in this way is going to be bad for their health. The numbers being trained in neonatal intensive care are not enough to provide all the skilled trained nurses we need. Even those who do train have no incentive to stay in that branch of nursing. As

Tony Delamothe explained (2 January, p 25), there aren't enough nurses actually in the neonatal intensive care units; this leads to stress and low morale, and so they are leaving and going back to less stressful sorts of nursing. At times we can't accept babies or we have to send mothers in premature labour to other hospitals—not because we haven't enough beds but because we haven't enough nurses. We get to the stage when the nurses say we will not take another baby in because there aren't enough nurses *tonight* to manage another baby. So we have to keep a bed empty.

Critical mass

We've shrunk below the critical mass that can cope with what traditionally has happened in terms of young women developing their careers and taking time to have children. If you have got a big enough mass of nurses then women can leave and return and you can keep the whole thing going. But when you shrink to below the critical mass then every change makes things worse. Once people become overstressed the downward trend becomes irreversible. We are now having ward closures on account of not having enough student nurses—because the nurse training school is not recruiting enough school leavers each year. This is beginning to happen all over Britain. We know of no neonatal intensive care unit in the country that has anything approaching the recommended ratio of nurses to patients. That in itself means that the babies are almost always receiving suboptimal care.

And the other thing in relation to these closures (not just paediatrics but the hospital generally) is that initially the closure of wards was said to be going to be temporary because there weren't sufficient staff. There are obvious savings to be made by closing complete wards, in terms of running costs as well as the nurses. But within three or four weeks the management announced that these were going to be permanent closures. And this despite the fact that the hospital has been turning away more and more emergency admissions. Clearly there are not enough beds actually to cope with the clinical needs in the community, but the management is now closing wards to save money and make the books balance at the end of the day. Every temporary closure has become a permanent closure within a very short time. Some of our hospitals have lost as many as a fifth of their beds. In paediatrics losing beds is a new thing which happened for the first time in December 1987. The management is now planning to close one of the children's wards at weekends to save £35 000.

We have seen a vast expenditure on computerisation for management, accounting, and costing and so on. By contrast, we clinicians have pleaded through the years to have a system of visual display units on the wards and clinics that would deliver the results—blood counts and urines—within a reasonable time. That has not been possible even though we know that millions of pounds have gone into computerisation. So again the clinician's needs seem to come at the end of the line.

Two or three years ago the management decided to have centralised supplies within our region for several hospitals. Unfortunately, people weren't told what the codes meant, and the codes got mixed up, and even now two or three years later it's not sorted out. As far as we know it is totally impossible to discover how much this exercise is costing. It does seem appalling that management can involve itself in enormous costly exercises with no one to control or supervise.

Equipment bought by charities

Another big change between now and 10 years ago is that virtually all our equipment is bought by charities. We don't even expect that the hospital will pay for anything other than certain very big pieces of equipment such as the ultrasound. Even that has come from the regional health authority and not from the district authority at all. Very little equipment in the neonatal intensive care unit is provided from the district budget and there has not been any attempt realistically to assess how much money would be needed to maintain

the equipment in the neonatal intensive care unit from within the district budget. Most of the equipment has been bought by charities and donations.

Having said that, there is a new climate of opinion among the population. They have begun to see it as their duty to provide us with charitable money for equipment. We set off each year knowing that we will have no money for equipment that we really do need to have. That's fine in this part of London, which is fairly prosperous. But what happens to hospitals in places such as Tower Hamlets? The more deprived the area the higher the neonatal needs—the whole thing is outrageous.

And also it means the staff are going round to dinners, race nights, and barn dances to show their faces and collect cheques. Sometimes it is marvellous, but it is another element of our life-style that has changed. It can be very tedious and time consuming. Every week somebody presents a cheque and one has to show appreciation.

When our unit manager was appointed two and a half years ago he started with the idea that he wanted to know how much it was going to cost to replace equipment each year so that it could be budgeted for, but he had no idea realistically what that meant in terms of finance. If we set up a neonatal intensive care cot from scratch with new equipment it costs about £30 000-£35 000. Most of the cots in our unit are for infants needing special care, but five of them are for highly technical intensive care. All of the specialised equipment for those five cots needs to be replaced about every three to five years. If you say it lasts five years, which is the maximum, it's going to cost £30 000 a year just to replace equipment for the intensive care cots. Yet the budget for equipment for obstetrics, community and

paediatric, is about £25 000—and we haven't begun to talk about massive capital investment in obstetric hardware. The managers have never come anywhere near making financial allowance for the actual maintenance or replacement cost. They have always looked at it and then run away!

We haven't got optimum equipment for each cot, and what we have has virtually all come from charity. Even so there are often crises when there is a sudden influx of babies needing intensive care when we literally do not have the equipment that we need. We haven't got five fully equipped cots. That's what it comes to. And if there are breakdowns there may be a time when we have got full equipment for only two cots.

Job satisfaction

All these pressures and frustrations obviously have an effect on the paediatrician's job satisfaction. We are now constantly taking decisions about whether we will accept babies, which sort of babies we feel we can sustain, and we're constantly having to compromise. We may not be able to do the blood gases every 15 minutes, and with too few nurses they are going to miss a change in a baby's condition—or be half an hour slower spotting it. As doctors we have to reduce our standard of care in relation to the nursing availability. Two things have come together. There's been the gradual loss of nurses—and at the same time the gradual increase in demand because new technology has enabled us to do better and has reduced the perinatal mortality rate. We have, in fact, had an increase in staff—but not enough.

New Drugs

Centrally acting drugs

D N BATEMAN, S CHAPLIN

Since the last series of *New Drugs* several new drugs that act on the central nervous system have been introduced. In this article we will consider four groups—namely, the antidepressants lofepramine and fluvoxamine; the antipsychotic sulpiride; the antiemetics domperidone and nabilone together with “high dose” metoclopramide; and the newer opioids meptazinol and nalbuphine. Some of these, including, for example, the antiemetic domperidone, also exert effects outside the brain. For others, such as the cannabinoid nabilone, the precise mechanism of action remains unclear.

Wolfson Unit of Clinical Pharmacology, University of Newcastle upon Tyne, Newcastle upon Tyne NE1 7RU

D N BATEMAN, MD, MRCP, consultant physician and senior lecturer in clinical pharmacology

S CHAPLIN, MPS, MSC, staff pharmacist, Northern Regional Drug Information Unit

Correspondence to: Dr Bateman.

This series is edited by Professor John Feely.

Antidepressants

Though imipramine and amitriptyline were first introduced about 30 years ago, no antidepressant introduced more recently has been shown to be more effective, in part because of the difficulties in defining and measuring depression and its response to treatment. Attention has therefore focused on the incidence of adverse effects and the acute toxicity of newer agents in comparing them with the established—and inevitably cheaper—tricyclic antidepressants.

The precise mechanism of action of the tricyclic antidepressants remains unclear, though they are believed to affect the reuptake by neurones of several monoamine neurotransmitters as well as postsynaptic receptor function. Attention has therefore been paid to developing antidepressants that are more selective in their actions.

Lofepramine (Gamanil) was introduced in 1983 with the claim that it caused fewer of the anticholinergic side effects—dry mouth, blurred vision, urinary retention—that prove to be troublesome in up to half of the patients taking tricyclic antidepressants. It was also claimed to be less toxic in overdose, with no known fatalities from suicide attempts, despite several years' use in Europe. After oral administration only 7% of the parent drug reaches the systemic circulation, and about 40% of the dose is rapidly converted to desipramine.¹ During long term treatment desipramine accumulates