consciousness and increasing detachment from the surroundings. Agitation is not uncommon, and in those who are unconscious pain should be assumed to be the cause, and they should be treated by analgesic suppository or injections. A distended bladder or impacted rectum should be treated appropriately. If no cause can be found sedation with a phenothiazine can be used to avoid distressing relatives.

Few patients die dramatically, but it is wise to have morphine 10 mg and chlorpromazine 25 mg to hand in a syringe to be given quickly by a nurse (or competent relative if the patient is at home) should there be any dramatic distress or terminal event—for example, massive haemoptysis. Hyoscine 0.4 mg is a useful addition to help the “death rattle.” Most patients prefer to die at home, and their wishes should be respected whenever possible.

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Conversations with Consultants

Dr G the neurologist

TONY SMITH

This is the sixth in a series of interviews with NHS consultants and academics; articles have appeared most weeks since 2 January. Dr G is a neurologist in a regional unit in the north of England.

For the most part I am as enthusiastic about clinical neurology as I was five years ago. Nothing that has happened in the health service has affected my clinical enthusiasm, but, like an increasing number of colleagues approaching the age of 60, I have begun to look at the prospect of retirement—and at the real possibility of retiring before the age of 65. After more than 25 years of clinical work as a consultant I find that the outpatient department has lost some of its charm and the challenge of the inpatients is also a little less stimulating. I believe this response is similar to that of the surgeon about to undertake his 300th gastrectomy, who almost certainly finds it somewhat mundane.

Yet in terms of morale concerning the clinical service and the facilities within this part of the health service I am as happy about things as ever I was. The role of the clinical neurologist has changed considerably with the advent of imaging. Those of us brought up in the era of the air encephalogram, ventriculogram, and angiogram acquired—through concentrated training—certain clinical skills. These have now been replaced by modern imaging techniques, and it has become almost fashionable to refer any problem of topographical localisation for a scan rather than rely on clinical skills to determine the nature and site of a particular lesion. This I might add is to the enormous benefit of the patient.

The hospital doctor who spends his career entirely as a clinician tends to take on a slightly different role as he approaches 60. One of my main functions now should be to pass on, in so far as is possible, clinical experience and other matters to do with medicine through

the ward rounds and formal teaching sessions but also informally. I see for myself an increasing responsibility not so much for the day to day care of patients (which of course does continue) but for the junior staff. Our junior doctors face worsening problems in their promotion, job opportunities, contracts, and terms of service. In many ways I see my most important task as supporting the juniors in their ambitions and trying to ensure that they succeed in their own aspirations. Many extremely well qualified and able registrars and senior registrars are currently frustrated, and it is the departmental head who must do his best to ease that frustration by giving them as much support as he can.

On looking back over the clinical years I realise that a consultant neurologist can choose very many compartments into which he can place his time. They include clinical work itself, investigational work leading to original writing, and opportunities to support clinical research, to review, and to spend time working for the various specialist journals. There is the responsibility to try to keep up to date with recent developments, private work, and teaching of both undergraduates and postgraduates. There is certainly enough available opportunity readily to fill every day.

Committee work

With an ever increasing demand for management within the health service most of my younger colleagues will be expected to undertake work as committee men, and if they find this interesting and fulfilling then no doubt they will be elected secretaries and chairmen of local committees and eventually undertake more work locally, regionally, and even nationally. If they aspire towards this work they should be encouraged to undertake it as early as possible in their careers. I was fortunate enough to be appointed to the various secretariats and chairmanships of this and that committee at an early stage and was able to go through the local, regional, and, to some extent, national medical political scene in mid-career with an opportunity later of returning to full time clinical work before the age of 55. I feel in this respect it is important

that we all fulfil the aims of Cogwheel and move sideways within the divisional system to allow younger colleagues to undertake these responsibilities.

Academic cuts

My colleagues in full time academic neurology have felt the frustrations of the cuts and restrictions on their academic budgets much more than we have in the NHS. The young clinical neurologist in this region is still enjoying an enormous range of clinical freedom, and we do enjoy the environment in which we are privileged to work with very attractive and friendly patients who are grateful for what is done for them. Litigation is still not common in this part of England. It is still possible to find soft money for research and other programmes, and I feel that because of this the department as a whole is still forward looking and confident.

I fear, however, that we are about to lose a considerable degree of clinical freedom—for I have little doubt that the recent challenge to the government from the profession on standards and resources will lead to a determination from the Department of Health to ensure that consultants do fulfil their contractual obligations to the full. I just wonder whether clinical meetings outside the region, attendance at college meetings, council meetings, BMA meetings, clinical and scientific conferences at home and abroad, will require always to be declared—with remuneration from the neglected NHS session deducted from the consultant's salary. Perhaps those who spend a large part of their time managing the affairs of the profession while enjoying an income from the NHS may be challenged.

Bed closures

In our hospital we have had threats of bed closures; we have been accused of low occupancy and underusage, but in the neurological department we have always defended ourselves by explaining that we have our own pattern of usage in neurology, in which it is unnecessary to keep patients in the ward at the weekends. We attempt to discharge those who can go home on Friday and readmit them on a Monday, with the result that our occupancy figures seem lower than the national norm. This is our policy and we have not as yet suffered from it.

My own waiting list for outpatients is two to three months, which is outrageous for routine appointments. We have in the department always agreed, however, to see an urgent patient on the ward on demand from the family doctor—and he will be seen not necessarily by me but certainly by a senior registrar. So there is no delay in acute problems receiving neurological help. Mostly the patients waiting on the list have what one might call chronic neurology—that is, longstanding headache or giddiness, for example—but always we are constantly aware of the possibility that lurking in that two to three month waiting list there may be a surgically remediable problem.

Clinical practice has certainly changed. When I was first appointed the established neurological clinics were developed in areas hitherto not served by neurological sessions and those clinics were full of rare and often very advanced neurological problems. Patients had never seen a physician let alone a neurologist. There are still such pockets of neurological pathology in this region, and these are now being picked by my younger colleagues. Unfortunately, with the appointment of more consultants the trend has been towards the clinics being of less general interest, and many of our patients now have little in the way of organic disease. Most of us work from the regional centre and patients are attracted from the whole of the region.

One of our particular local difficulties is in placing the disabled patient. This region is very badly off for rehabilitation services, and if we do admit a very dependent patient to the neurology or neurosurgical ward it is frequently very difficult to place him. We have tried to devise a scheme whereby a patient coming from a district general hospital is readily accepted by that hospital after diagnosis and treatment, but frequently head injured patients and

those with acute problems come directly from home or from the streets and then their rehabilitation or disposal can prove very difficult. There is a desperate need for rehabilitation beds in the north of England. We have been fortunate in appointing a senior lecturer in rehabilitation in the department and we hope he will be able to establish such a rehabilitation unit.

Nurses

You ask me to comment about nurses. From what I have seen and heard in the day to day conduct of the clinical department some of the nursing staff are demoralised, but most are still continuing to get great satisfaction from their work. But those who are ambitious have risen in the Salmon hierarchy to posts where they appear to be less than happy; they spend their time walking the corridors with arms full of paper achieving very little. Often such nursing officers have been very good bedside nurses and ward sisters, and I believe that those who have remained on the wards, although now more junior, are obtaining much more job satisfaction. We all hope that all the nurses will be better paid when this is generally realised.

Some of the sisters are very young, and I think that they find the pressure and responsibility sometimes overwhelming. The salary structure is such that they are doing an enormous amount of work for which they are not properly rewarded. It is no solution to offer various courses and an academic veneer, for this will not give them job satisfaction. Without being specific, I have a general feeling that the standard of bedside nursing has deteriorated in the years since I was appointed. It seems that the ward sister is no longer allowed the responsibility for the standards which she enjoyed in the past, and she appears to be overseen by the nursing administration and given the impression that she is no longer directly responsible. Comments from the nursing sister about the cleanliness of the ward and the catering services are no longer acceptable; these issues have become the responsibility of the supervisors of these other ancillary services.

One of the problems in our own particular hospital is the low standard of portering. The men now employed have little interest in their job and the general standard and turnout of the newly appointed porters is about as low as I've ever known. Occasionally we are lucky with someone who is enthusiastic and efficient, but the average casual porter no longer seems interested in what should be the prime purpose of his job—looking after sick people. A recent reprogramming of the portering services in the hospital has produced nothing but delays, seen particularly in the postal services. The same can be said of the domestic staff in the hospital.

Dirt

Our unit is dirty. Cigarette ends lie around in the foyer, the lifts often contain rubbish in the morning, and, although the unit is not necessarily bacteriologically dirty, it is sociologically very scruffy. It is often useful to ask patients on discharge their impression of the unit, and those who have been inpatients often report the same problems—very superficial cleaning of their cubicles and a general standard of dirty domestic husbandry. I think this reflects on the management and direction of the hospitals; one has the impression that no individual is prepared to take responsibility directly to criticise mediocre work. Low standards appear to be acceptable, and I fear that this acceptance of poor standards may be straying from the domestic and catering services of the hospital into the clinical area. There is a risk that very soon it might spread into medical attitudes.

Secretaries

You ask me to comment on hospital secretaries. I think the NHS is extraordinarily fortunate to be able to employ thousands of girls who are working for very limited pay and yet remain devoted to the hospital service and the people for whom they work. I think a further move to have our secretaries properly rewarded is essential.

Many have just been elevated from personal secretary to higher clerical officer, but this has added very little to their pay. New girls coming into the unit are often scarcely trained and semiarticulate and do not have the necessary qualifications. This is reflected in the type of job offered to them and the fact that very often a shortlist consists of only one applicant. In industry such girls would not be employed. I have been very fortunate. I have a secretary who has been in the health service for some 30 years and her experience and managing capabilities are invaluable to me, but she has a basic salary of only £6300 a year. No busy consultant can function without an able assistant, and the journals have contained over the past few years many justifications for secretaries being paid a more realistic salary. The secretary is not simply a typist but an assistant who readily assumes considerable responsibility.

Service to patients

In technical terms the patient is better treated now than, say, five years ago but, by contrast, in terms of caring, comfort, and communication he is probably worse off. This problem of communication is something about which I have always been concerned. In litigation it is often the basis for any problem that arises—that is, the claimant will say “no one took the time to explain even in the simplest terms what was going to happen.” We talk about informed consent and attempt to define it, but if things go wrong what is needed is a full and immediate explanation as to what went wrong and how it went wrong. It is my impression that on most occasions this would satisfy the patient and litigation cases would not increase at the rate we are observing currently.

Although the standard of practitioners is now considerably improved and patients in primary care are getting a far better service, the same is not necessarily true in the hospital. Technically the hospital staff are far better informed than ever before, but we still see ward rounds conducted where the patient is scarcely addressed, where the team may pass by the end of the bed scarcely acknowledging the patient in that bed and frequently not explaining in simple terms what is likely to happen to him. The excuse is often made that the increased throughput and the shorter stay in hospital are responsible for this lack of communication, but I believe it is something to which we should all pay attention, both medical and nursing staff. The patient in today, angiogrammed tomorrow, and

out the day after is not being properly cared for. Frequently he may have no idea what has happened to him when he reaches home.

Private medicine

This city has never been a great centre for private practice. The academics have always eschewed it until recently, when there has been a very obvious change in their attitude. More and more of the young consultants are taking part time contracts and undertaking some private work. This is especially true of the surgeons. We have in this city a recently expanded Nuffield Hospital and the authorities seem very happy with the local hospital consultants using its facilities. The services offered by the NHS in its hospitals for private patients are no different from those enjoyed by patients in the public sector, and very few of us would admit a patient to a private bed in an NHS hospital unless that patient were covered by some health insurance. Resting in the same ward, in a similar bed, and being treated by the same medical and nursing staff, eating the same food, and enjoying the same restrictions is not something for which the patient should be charged a large daily fee.

One of the great attractions about private practice is that it is possible to devote as much time as you feel necessary to the history, examination, and explanation. Undoubtedly at the end of such consultation you the doctor have a much better idea of the problem, and we hope the patient has a better understanding of what is about to happen. It is simply a question of the availability of time.

It will be very interesting to see the evolution of the health service over the next 10 years, for I think evolution is the correct term to use. I believe that the Griffiths changes and the great change in the structure were moves in the wrong direction and that the health service will need to move back to more central and medical control and that the administrators will have to recede. The private sector is inevitably going to grow, and I fear we shall finish with two competing services. The private sector is at present a very useful adjunct to the NHS, but I would not like to see it increasing to the point where the two are competing directly.

In the long term we all need to accept that there is no possible way that we can fund an adequate health service out of taxation. Some changes will have to be made to attract money from elsewhere, whether this be hotel charges, for example, or a direct contribution towards the cost of the service. Both deserve consideration.

MATERIA NON MEDICA

Lament on a sheep's tale

On the long awaited day of the official opening by our bishop of the new midwifery unit in our hospital our New Zealand reared midwife decided to buy another sheep from the bazaar to live in the garden alongside the young male sheep, with the hopes of producing a lamb in the spring. When we were up to the eyes in speeches and guests it was discovered that not only was the newcomer pregnant, she was shortly to produce. However, the day passed without our getting an urgent obstetric call to the garden. The next day the sheep appeared to be in some distress and pushed out a large uterine prolapse. The midwife hovered anxiously, anticipating an abnormal labour and getting the tame gynaecologist to promise to be willing to do a caesarean section if necessary. A series of vaginal examinations carried out by midwife and doctor eventually indicated that labour was progressing, and at 9.15 pm a small male lamb popped out on to the bathroom floor. The watchful midwife was still not happy about her patient. The cervix was torn and the placenta was retained and had to be removed manually; and what about the huge prolapse, which was bound to get infected?

The next morning we were entertaining the bishop and his wife to coffee in the garden. Mother sheep and little Skippy, clad in a green and yellow jersey made for the newborn, were adorning the lawn. The pastoral sight was somewhat spoilt when the sheep turned her back to us, blatantly demonstrating that her prolapse, now decorated on top by the largest ring pessary that could be found, with pad and T bandage attached, would not be controlled by conservative means.

When the bishop and his wife had gone their way a quick telephone call was made to England to get advice from a colleague's father who happened to have experience of sheep. What now? An operation was recommended, so a little while later docile mother sheep was held outside the kitchen while the gynaecologist stitched the thing back inside under local anaesthesia—an experience that gave her courage to do a similar operation a few days later on an extremely old and frail lady who had a large prolapse of her rectum.

All went well for several days. Mother sheep learnt to tolerate Skippy's butts for milk and the prolapse operation had been a success. We were wondering when to remove the stitches when, to our horror, on a dark night screams were heard from the garden, and both the mother sheep and her lamb were found to have been savagely attacked by a couple of dogs. The chloroform bottle had to be produced to put them out of their misery. Two of the sisters dug their graves while the midwife and doctor were busy with a delivery in the hospital.

The next night we determined to kill the dogs. A placenta covered in poison was laid in an inviting place, and the night watchman had his gun at the ready. Shots from the gun injured the dogs, which had ignored the placenta, and a bloody battle ensued until the dogs were finally dead. Police, having heard the shots fired, arrived on the scene to say that shooting was forbidden at night.

How do people normally rear sheep without the facilities of a hospital at hand?—RUTH E COGGAN, gynaecologist, Bannu, Pakistan.