less, some problems did occur. Discomfort was experienced at some time by 30%, and 29% had difficulty putting the footwear on. Nineteen per cent were dissatisfied with the style or colour. Supply arrangements were complained of by 13%, especially the long delay between being measured and receiving the finished footwear (34% waited over two months). Thirty five per cent considered that they did not have enough pairs of shoes.

The range of footwear available has slowly improved in recent years and patients should be given as much choice as the constraints of their underlying foot problems allow. An understanding of what is required and close cooperation between the prescriber and orthotist should ensure that the patient gets maximum benefit from the most appropriate footwear.

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Conversations with Consultants

Dr Z the teaching hospital physician

TONY SMITH

This is the seventh in a series of recorded interviews with consultants, on this occasion a group of physicians working in an inner London teaching hospital.

Compared with five years ago, patients are getting medical treatment which is technologically more advanced but is inferior in caring terms. The system has been squeezed so much that the margins are unacceptably tight—too few beds, too rapid a turnover. It is very demoralising for patients to be on a waiting list, to be called up for admission, and then to have the admission cancelled at the last minute. And nowadays this may happen not once or twice but four or five times.

The hardship caused may be substantial; it is not just disappointment—a patient may have made arrangements for someone to look after children, or may have had to ask for time off work. And if the whole thing has to be repeated time and time again the individual patient may lose credibility with an employer.

The "in today and out tomorrow" system that has been adopted to cope with the pressures may be all right for routine, straightforward procedures such as the repair of a hernia; but for many other conditions the patient really should be in hospital long enough for adequate discussions about reasons for investigations, their implications, and how they will assist with diagnosis—some sort of counselling.

The same speeding up process has occurred in outpatients; in many instances patients are no longer routinely seen when the results of their investigations become available, so that an interpretation can be made by the doctor requesting them to the patient. Instead, a letter is sent to the general practitioner or the referring consultant—or sometimes directly to the patient. And a further sign of the times is that many consultants now, in effect, run their own individual appointments system to bypass the overstretched clerical support services.

Referral rates

In virtually every specialty the numbers of patients being referred to hospital are rising—despite the population served being constant. This rising referral rate is due to greater awareness by general practitioners—and by patients—of what modern medicine (and modern technology) has to offer. Every specialty has identified new aspects of illness and aging that warrant treatment or has devised new treatments for established conditions. One of the consequences of the new, much needed appointments of consultants with general and specialist interests to district hospitals is greater recognition by them of diagnostic and therapeutic need in their districts. Their own departments, often run by a solo consultant, cannot cope with all these needs, and many of the newer diagnostic and therapeutic procedures are more appropriately done in larger departments in specialist centres. So the appointment of new, young consultants may lead to an increase rather than reduction in tertiary referrals.

Patients are sent to underfunded regional specialties in teaching centres, and to so called "hidden" specialties, hidden because they are not recognised in financial terms. With the upgrading and increased staffing of district hospitals the role of university hospitals is changing, but, if anything, the rate of tertiary referrals has increased. Some regional administrators still seem to cling to a naive belief that making the service more accessible progressively lessens demand.

You ask about private practice. Many of the new young consultants see private patients; they do so partly to earn more money, but they also enjoy seeing patients for a few hours a week in a pleasant working environment, and particularly when there is not the same relentless pressure as in most NHS clinics. It gives a boost to morale for once not to restrict the patient to the briefest consultation time.

War style economies

The hospital has made a mass of economies in recent years, but it has to make immediate further savings with the prospect of major

financial reductions annually. This will mean further substantial bed closures.

The ways that have been found to save money include policy decisions on drugs—such as that prescriptions are now hardly ever provided for outpatients (the patient will almost always have to get the prescription from the general practitioner) and that sometimes cheaper and “nastier” therapies have to be used. There are often protracted delays in the appointment of replacement staff of all grades; and some almost incredible housekeeping economies have been devised. These include the reuse of kidney dialysers up to 15 times, and the slicing in half of reagent strips used in diagnostic tests. This level of economising is, however, reminiscent of the harshest days of war time austerity with only five inches of water in the bath and 25 watt light bulbs in passageways—in a country which is said to have the strongest economy in Europe.

Paint free hospitals

Another economy obvious to the most casual visitor is that much of the hospital is in a very poor state of repair. Visitors are sometimes appalled and comment on it. In part, the filthy state of the corridors, the outpatient department, and so on results from the attitude of the British to litter: the hospital becomes dirty because of the behaviour of patients and their relatives—and of the staff. But it stays dirty because there are so few cleaners; and those who have survived the cuts in staff sometimes are demoralised.

Undoubtedly morale has suffered among cleaners and ancillary staff and medical staff because of frequent disruptions and discontinuity of management. The turnover among administrative staff has been amazingly high; they have stayed for a year or two and then moved on. The various reorganisations that the NHS has undergone have contributed, with virtually every administrator having to apply either for a new job or for his own. The end result is that this hospital has none of its old administration left. The new administrators or managers are usually bright and keen people, but can they fully identify with the hospital to the extent of feeling that they belong, or are recognised as belonging and trusted by the staff, within the present management climate? Managers are not really cast in the role of leaders.

Nurses

It has been shortage of nurses rather than underfunding of nursing or administrative decisions that has closed some beds. The main problem, without doubt, is pay—which is linked to the unsatisfactory career structure.

And yet the nurses we have are as good as ever. The sisters doing high quality clinical work are still getting a lot of job satisfaction. In this hospital the response to the introduction of the nursing process has been mixed: some like it, some do not. Those who like it believe it has increased the professionalism of nurses, and they think it improves the career attraction of nursing.

Long term, however, the prospects for nursing recruitment look bleak—for, despite the high reputation of the nurses' training school (and the retention of the nurses' home), the hospital is all too aware of the demographic changes that are reducing the size of the pool of potential recruits. Up till now the quality of nurses has been maintained despite a fall in their numbers. Whether this will continue seems uncertain.

Pay is the key; and pay is also very important in the recruitment of clerical staff and secretaries. In inner London no hospital can hope to compete with commercial employers in terms of pay, fringe benefits, or the working environment. Our linked hospitals nearer the green belt can still get reasonable secretaries—mostly married women who don't want to trail in and out of London every day. But here in the middle it is hopeless with pay scales at their present level. Sometimes the shortfall can be made up by the consultant paying for work connected with non-NHS activities—or in academic units with “soft” research money—but mostly the secretaries are underpaid, overworked, and exploited. Their vital worth to the

service has never been adequately appreciated. Hospitals have always relied on dedicated individuals. Their plight in recent years has worsened. Their jobs are more demanding and pressurised, and they require more special knowledge than their equivalents working in administrative departments.

This sort of comment makes us wonder, as clinicians, whether we are being over sensitive and over-reacting. Certainly we feel that the pressures under which clinicians work have increased and are less well appreciated and understood than they were a few years ago. There is less readiness to give the sharp edge of hospital work—complex as it is with humanity at its most vulnerable, threatened, and frightened—the support that it needs to work well and to most patients' satisfaction. A thrust of the new management should be to make the performance of clinical work easier for the clinician, whereas undoubtedly the reverse has been happening. Instead, administrators give an impression of remoteness, sometimes verging on indifference, when it comes to the actual consequences of financial stringency on sick patients. For instance, there seems less concern than there used to be when patients have to wait in the accident and emergency department for hours for transfer to a suitable bed.

Effects on teaching

A very disturbing aspect of the economies, cuts, and retrenchments has been their impact on the undergraduate teaching of medicine. Cutbacks in the university budget have meant fewer medical teachers; cutbacks in the NHS (and shortage of nurses) fewer inpatients. And those patients who are admitted do not stay long (increased turnover and rapid throughput ironically sometimes wipe out expected savings from bed closures). The result is that the embryo clinical student is likely to find the pace too fast; he or she has too little time to clerk the patient properly and many academic staff cannot devote adequate time to teaching. It is difficult for consultants to catch up with some patients during brief admissions.

The cutbacks in academic staff and in research funding are also making it much more difficult for registrars and senior registrars to spend the traditional one or two years in full time research. Most senior staff are convinced that if the research pedigree disappears from the training of the coming generation of consultants they will be the worse for it.

Which of the available licensed vaccines should be used for active immunisation against hepatitis B: those made from recombinant (“genetically engineered”) techniques or those derived from purified plasma?

Two hepatitis B vaccines are licensed for use in the United Kingdom, the plasma derived H B Vax (Merck, Sharp and Dohme), licensed in 1982, and the recombinant Engerix B (Smith, Kline and French), licensed in the United Kingdom in September 1987 but in use for over two years in the United States.^{1,2} From the extensive clinical experience with the licensed plasma derived vaccines world wide and the more limited experience of the recombinant vaccines abroad there is no evidence that either type differs greatly with respect to safety, side effects or immunogenicity in the healthy or immunosuppressed vaccine, requirement for, and spacing of, multiple doses or necessity for follow up,^{1,2} and interchangeability of booster doses after initial vaccination.^{1,3} Data on long term protective efficacy are lacking for the recombinant vaccines but on available evidence should not differ greatly from the results with the plasma vaccines. Engerix B is not, as yet, licensed for use in paediatric practice in the United Kingdom.

The choice of vaccine will ultimately depend on cost and availability and the cost has already been reduced considerably with the advent of a recombinant vaccine in the United Kingdom.—ELIZABETH FAGAN, lecturer; ROGER WILLIAMS, consultant physician, London.

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