keeping a patient in the hospital to which he was admitted 64 times rose from £53 to £98 per week over this period, and the 1000 days which he spent in Edinburgh hospitals must have cost the N.H.S. about £10 500. What is even more alarming is that the graph appears to be rising exponentially.

Conclusions

Patients of the type we have described may number several thousands, and they must account for a sizeable proportion of N.H.S. expenditure, particularly in the hospitals of our major cities and towns. It is difficult to see how such patients can be handled differently in a democratic society, but the problem they present is clearly one which should engage the attention of community medicine specialists.

We thank the many consultant physicians who have treated this patient for their permission to make this report and Miss J. Williamson for secretarial help.

Reference

[1] Asher, R., *Lancet*, 1951, **1**, 339.

Conversations with Consultants

Non in Arcadia Ego

FROM A SPECIAL CORRESPONDENT

British Medical Journal, 1975, **2**, 134-135

"When I read your talk with Dr. Pinkerleigh five years ago,[1] it struck a responsive chord in me," said a consultant physician. "I'm also one of those men 'at the end of the line,' where nobody from the D.H.S.S. ever visits and it's a question of which comes first—one's initial coronary or a C merit award. But if you'd talked to Pinkerliegh today you'd find the hospital picture much bleaker than he painted it; in fact, I know that he would agree with this, for I identified him without much difficulty and talked to him about current problems only a few weeks ago." Wasn't his disillusion, though, part of the current malaise in society in Britain general—in effect, waiting for North Sea oil? "Certainly we consultants are disgruntled about pay," he said. "When I'm called out to the hospital, say, six times over a weekend on duty I get nothing extra—whereas the laboratory technician whom I have to call in to help me gets about £40, and his senior in the department is on a regular salary of over £6000 (well over the earnings of a junior consultant, who might well be the senior technician's titular boss). But there's a much more serious cause of our malaise, which the press has played down, seeing the present crisis entirely in its normal black-and-white terms of only another union claim for more money. The fact is that hospital doctors are totally disillusioned, and the events of the last six months have lowered morale to a level from which it will never recover."

But surely, I said, morale was impossible to measure, and sweeping statements like this had been appearing in the medical press ever since the Health Service started. Certainly, he replied, it was always difficult to distinguish mere sabre-rattling from true mobilization, the braggadocio from the serious argument. The evidence, however, was in doctors' behaviour: five years ago his housemen and registrars had got their Membership and then left for a London teaching hospital to start on the ladder; now they went into general practice or to Canada or Australia, and "I'm not surprised to hear that the B.M.A. has been deluged with a record number of inquiries about emigration prospects. Even men in their 50s have left the hospital service, and it's no idle threat that once my children are off my hands I shall look seriously at the prospects in somewhere like Vancouver myself."

The Reasons Why

The physician was at pains to re-emphasize that poor pay was only one of several factors for hospital doctors' discontent: in particular, the gross underfinancing of the Service meant that there was no light at the end of the tunnel—that projects which had already been talked about for five years and given priority would now never be realized in the remaining 15 years of his professional life. "The result is," he said, "that consultants won't sit on planning committees any more: they say, quite justifiably, that their time would be better spent on the golf course. Because there's never likely to be enough capital money for new wards and outpatient departments we can't attract new consultants, and in my area we're busy raising the money to build a private hospital on a site we've already got—though personally if there was a new consultant contract I'd be happy to go full time."

I mentioned anecdotes I had heard about the effect of nursing shortages—of consultants in teaching hospitals doing ward rounds without a nurse in attendance and finding helpless patients unwashed or even unfed with their breakfast still in front of them; of an ex-nursing sister who, finding that only one S.E.N. would be in charge of an acute surgical ward for the night, had, Eastern-style, arranged to stay at her son's side as he recovered from his operation so that she could ensure that he didn't aspirate any vomit into his trachea. "Certainly many of our wards are staffed by one S.E.N. and one nursing auxiliary at night," he told me. "We reserve such qualified staff as we've got for our intensive care unit. I don't want to be the usual bore about the effects of the Salmon scheme, but, combined with the nurses' 40-hour week, the extra holidays awarded by the Halsbury report, and block release scheme for those in training, this has meant a tremendous decline in the number of nurses available—it's unusual, for instance, for me to do a round with my ward sister more than once a week: she's always legitimately off duty. These facts have also particularly affected the distribution of nurses: there's a relative posse around between 10 a.m. and 2 p.m., but few outside this period. But, on the bright side, our present economic slump has had one good effect: in our area, staff such as porters and cleaners are now flocking back to the hospital in search of secure jobs."

All Snakes and No Ladders

I objected that the withdrawal of the physician and his colleagues from committee and medicopolitical work was bound to make matters worse rather than better. Surely Cogwheel and Reorganization had been introduced to enable "ordinary" doctors to get such difficulties across. Why weren't they lobbying those

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responsible? "The trouble is," he replied, "that now 'those responsible' are difficult to identify. A few years ago one could go and harangue the regional hospital board—at least it was a recognizable entity. Nowadays, with its lack of capital, the regional authority has no role at all. Our district medical team is out of contact with the feelings of most clinicians, and in any case the progress of any proposal is now so lengthy and tedious that its instigator usually despairs long before a decision is taken—which may take years. I can't rival your academic's recent account of how to appoint a senior registrar,[2] but one of my colleagues has described our system as being 'all snakes and no ladders.' So a proposal comes from a Cogwheel discussion, and then passes successively to the medical executive committee, district medical team, and area health authority—who then refer it back to their area medical advisory committee for local advice. The great ploy then, worthy of Stephen Potter himself, is for the medical executive committee to set up a working party to look into the matter."

Was it all gloom and no hope? Probably yes, for underlying some of the hospital doctors' malaise was a fear that "they" had decided to provide other forms of health care at the expense of the district general hospital. "Our area health authority's recent report said virtually nothing about plans for the district general hospitals," he said. "On the other hand (though it may well be pie in the sky), there was much mention of the importance of building a chain of health centres—at a cost of £½m. each. There's also this report about community hospitals, which certainly have a potentially useful role, but shouldn't be allowed to deprive the D.G.H. of such funds as are allocated for the hospital service. If any central decision about changing the emphasis away from the D.G.H. has been taken, then it should be exposed to public debate, while those who work there ought to have the courtesy of being told, so that they can plan on the basis of even fewer resources. Otherwise, what a few years ago was the most satisfying job in the world—clinical medicine—will totally lose its zest and attraction."

[1] *British Medical Journal*, 1970, **1**, 421.
[2] *British Medical Journal*, 1975, **1**, 675.

Any Questions?

We publish below a selection of questions and answers of general interest

Post-herpetic Hyperaesthesia

Is there any effective radical treatment for post-herpetic hyperaesthesia affecting the 8th intercostal space? Has excision of the scar and skin-grafting of the raw surface ever been attempted?

There is no effective radical treatment for post-herpetic hyperaesthesia. Excision of the total cutaneous area of hyperaesthesia and hyperpathia, cutting all the nerves coming from this area, cutting and undercutting the skin and then replacing the excised area of skin have all been tried unsuccessfully. The inquirer asks about "effective radical treatment." If he could be content with somewhat effective symptomatic treatment, many measures deserve a trial. If there is the kind of sensitivity in which the lightest touches cause pain whereas firm touches or pressure do not do so, it is worth fitting the patient with a "plastozote" jacket, which obviates any chance light contacts. Pain relieving sprays can be tried as well as vibration, repeated injections of local anaesthetics beneath the hyperaesthetic skin, and the most recent symptomatic treatment: prolonged electric stimulation of the skin by means of a portable stimulator that the patient wears.[1]

Nathan, P. W., and Wall, P. D., *British Medical Journal*, 1974, **3**, 645.

"Cattle Truck" Sign

Some years ago much was made of the beading of the blood in the retinal arteries as a certain sign of life being extinct. Has this sign proved of use in determining the precise moment of death?

As blood flow in small vessels slows, the cellular elements tend to clump together leaving clear zones of plasma between the aggregates. In small veins the slow passage of a series of cellular aggregates of this kind is called the "cattle truck" appearance. If the blood flow stops entirely the small blood vessels collapse and become threadlike in zones of plasma where the tissue pressure exceeds the intravenous pressure. The resulting beaded appearance may be seen with the ophthalmoscope just after death and before haziness in the cornea and ocular media obscures the view. Fragmentation of the blood column is not a reliable sign of death since it can also result from complete obstruction of the ophthalmic and central retinal artery though in these cases cessation of blood flow is seldom complete. In patients who have suffered acute brain swelling after trauma or infarction the intracranial pressure may rise to a higher level than the blood pressure causing an arrest of cerebral circulation which may be detected angiographically when contrast material fails to enter the skull. This is often quoted as a reliable index of brain death but can also be confused with distal obstruction of the carotid artery. To avoid this difficulty it is preferable to demonstrate circulatory arrest in all the main cerebral arteries. Continuation of blood flow in cerebral or retinal arteries cannot be taken to show survival of nervous elements.

Medical Certificates for Rehousing

What medical grounds would your expert regard as warranting urgent rehousing since so many applications relate to failure to adjust to society or to accept irritating environmental or social conditions allegedly interfering with health?

Medical priority for rehousing can certainly not be determined by listing medical conditions in some order of precedence. Pressing housing need on medical grounds can only be assessed by matching the existing housing conditions of an applicant with his or her medical condition. To quote an extreme example, a mother of twins aged 18 months with severe aortic stenosis who lives on the fourth floor without a lift merits rehousing urgently; with a working lift the urgency would be nothing like so high, and if she lives on the ground floor, rehousing may not achieve anything. The difficulty of assessing medical housing need from sometimes meaningless medical certificates and the fact that "pointing" medical certificates only has a placebo effect in most cases has led some housing authorities to cease processing these altogether. In cases of overriding medical need doctors would do best to write fully and personally to the medical officer of environmental health (district community physician).

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