suggested in the report that chiropractors would work "with help from physiotherapists" is a serious misconception and we would strenuously resist any attempt to erode our direct referral relationship with consultants.

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St Joseph's Hospice

SIR,—I have recently retired from general practice in Hackney and have considerable experience of the work of St Joseph's Hospice and, like Dr B E R Symonds (19 January, p 184), find the strictures of AS (15 December, p 1579) unjustified.

I have never known a patient with terminal illness to be refused admission and at no time have I been asked the religion of my patient. I was always made welcome when visiting my patients, who usually commented on the kindness of the staff. Naturally, the environment is that of a Roman Catholic institution with nuns in attendance.

The McMillan domiciliary service attached to the hospice is in my experience unique. It provides expert medical and nursing care 24 hours a day for patients wishing to die at home.

I am glad of this opportunity to thank the staff of St Joseph's Hospice for their invaluable help to many of my terminal patients. I should like to add that I am a Jew and an agnostic.

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Cimetidine for pruritus related to systemic disorders

SIR,—I was interested to read the report on the use of cimetidine for pruritus in Hodgkin's Disease (19 January, p 151). However, I feel that some comments are warranted.

It is suggested in the introductory paragraph that cimetidine has been of value in the itching of cholestasis, chronic renal failure, and the myeloproliferative disorders. However, the supporting references do not bear this out. The evidence for its usefulness in the itching of polycythaemia rubra vera is limited to two case reports.[1 2] On the basis of this, a small uncontrolled trial was carried out on 12 patients with itching associated with polycythaemia; there was no improvement in the itching in any of the patients.[2] Similarly, there have been only two case reports of the usefulness of cimetidine in the itching associated with cholestasis. The same authors then carried out a small double-blind controlled trial involving six patients with itching related to cholestasis and showed that cimetidine was helpful in only one patient, while two patients responded to placebo.[3] There has been one uncontrolled trial on the use of cimetidine in the itching related to chronic renal failure in 10 patients, in which there was no improvement in the itching in any of the patients studied.[4]

Evidence therefore of the usefulness of cimetidine in relieving itching related to cholestasis, chronic renal failure, and polycythaemia rubra vera is limited to a few isolated case reports, and its effectiveness has not been substantiated in the few clinical trials carried out. The further reporting of the use of cimetidine in pruritus related to Hodgkin's disease in four patients may be of some interest.

It is, however, essential, if any valid conclusions are to be made, that further investigations into the use of cimetidine in pruritus related to systemic disorders should be based on large, properly controlled trials and not on uncontrolled case reports.

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[1] Easton P, Galbraith PR. *N Engl J Med* 1978;**299**:1134.
[2] Scott GL, Norton RJ. *N Engl J Med* 1979;**300**:434.
[3] Harrison AR, Littenberg G, Goldstein L, Kaplowitz N. *N Engl J Med* 1979;**300**:433-4.
[4] Zappacosta AR, Howss D. *N Engl J Med* 1979;**300**:1280.

Emergency admission arrangements in hospital with inadequate resources

SIR—The recent correspondence in the lay and medical press concerning compensation for alleged negligence by doctors reminds one of the increasing problems whereby doctors, generally in the junior grades, are wrongly accused of negligence (sometimes partly more difficult to defend through inadequate records made by them). The defence organisations and the health authorities, if negligence is proved, often both contribute to the damages. In many of these cases negligence is not present but there are "negligent conditions" present.

(1) "*Musical beds*" *with patients*—Patients are often moved from ward to ward, sometimes late in the night, in order to attempt to obtain a high-dependency bed for an emergency admission. It is quite likely that the patient concerned suffers not only psychologically but physically from being moved to a low-dependency area if his medical condition barely warrants this. The legal responsibility for this move could rest unfairly with the doctor.

(2) "*Bussing*" *of patients*—This occurs when patients arrive in the casualty department and the junior medical staff are "persuaded" by non-medical Health Service workers to move the patients to another hospital. It has happened that patients have died or deteriorated during transit and actions have been brought against junior doctors as a result.

(3) *Long waiting periods in casualty*—Patients can wait a very long period in casualty because the doctors know that a particularly high-dependency bed is needed for a patient but the administration cannot find a suitable available one. Even with consultant support—which, of course, should be requested—the doctor may be left with the alternatives of keeping a very ill patient in casualty, risking transporting him to another hospital, or admitting him to a quite unsuitable bed. If the consultant is not in the hospital he cannot help with regard to immediate clinical decision making. Does a doctor or consultant have any authority to put up an extra bed in these circumstances? Obviously it is unfortunate for extra beds to be put up in any ward but emergency conditions do sometimes arise where this is essential. If the request to put up an extra bed is countermanded by other than medical staff the doctor must write in the notes the name of the person who refused this request.

On any occasion when allegations of negligence in these circumstances are made against medical practitioners they should be firmly resisted by the defence organisations as the suffering caused to the patient is not due to lack of medical skill or care.

Family doctors have recently been worried concerning their medicolegal responsibilities when they are unable to obtain the admission of their patient to a suitable hospital bed. I gather that the BMA General Medical Services Committee is looking into the matter in relation both to the common law angle and to the family doctor's National Health Service terms of service. But I hope that is is unnecessary to say that the suggestions are not only aimed at protecting the medical profession from a legal standpoint. What perhaps is more important is to try to prevent the quite unnecessary strain which junior doctors suffer through having to work in completely inadequate conditions to the detriment of their patients. Administrators and politicians sometimes appear to think that the admission to any hospital bed resolves the situation; unless adequate resources for diagnosis and treatment are available, however, admission itself is of little use and merely gives a false sense of security to the patient and his relatives.

There comes a time when the medical profession has got to raise a voice against the continuing lowering of standards in the Health Service.

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The threshold of urgency

SIR,—The current dispute about out-of-hours work by the medical laboratory scientific officers is regretted and one must hope that a solution will soon be found. It is essential to keep in sight the fact that some 20 years or so ago out-of-hours work was done only for the seriously ill where life or limb could be saved, but over the years the threshold has become very much lowered. The situation now is that the junior medical staff even at preregistration level ask for a host of tests that would be better done during the routine working week. If the clinical consultant would influence the choice of test in relation to serious need a great deal of time and money would be saved. Furthermore, one must accept that work done during the routine day with all the major apparatus in use is the most accurate.

If there is a case for an extended working day that really is a separate issue.

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Patients first

SIR,—Having just spent three frustrating and rewarding years as a district management team consultant representative I have just read the Government's Green Paper *Patients First* with great interest.

It is very clear to me that the district management team in its present form must be the executive body of the new health districts. Its composition is exactly right to reflect the needs of hospital and community. The sensible unification of general practice, community medicine, and hospital practice brought about by the 1974 reorganisation must continue, each