followed by succinylcholine. The duration of the operation was one-and-a-half hours and it was performed on a hot, humid day with an operating room temperature of 32°C. (90°F.). The patient's temperature, as measured by a thermistor probe in the oesophagus, 20 minutes after the commencement of the operation was 40°C. (104°F.) and despite cooling with ice and fans it remained between 39° and 40°C. throughout the procedure. No abnormal bleeding was encountered during the operation. Her temperature remained elevated in the immediate postoperative period and four hours later, despite the presence of suction drains in the deep tissues of the neck, she developed extensive swelling and ecchymoses in the neck extending from the ears to the clavicles. Although the haematoma was mostly in the superficial tissues it was sufficient to give a minor degree of respiratory obstruction.

Her neck was reopened under general anaesthesia and a considerable quantity of semi-liquid blood clot was evacuated from the tissue plane between the platysma and the strap muscles. There was a general ooze from all the surfaces within the wound and many bleeding points were coagulated with diathermy. Two suction drains were inserted and the wound closed. There was a steady stream of blood along these drains, and at this time a defect in the clotting mechanisms was strongly suspected.

At the time of this emergency 5 ml. of venous blood was allowed to stand in a clean, dry, glass test-tube. Within three minutes it had clotted firmly. However, after a further 10 minutes the clot had completely liquefied and subsequently remained in this state. In this way a diagnosis of fibrinolysis was made. On the assumption that she had circulating fibrinolysins, the patient was given 500 mg. of Dicyclic (cyclonamine) intravenously. Four hours later there was serum only in the drainage tubes and no further bleeding occurred. The drains were removed the following day and she made an uneventful recovery with a cure of her hyperparathyroidism.

In this case a presumptive diagnosis of fibrinolysis was made on the appearance of whole-clot lysis. It is appreciated that this simple test did not distinguish between primary and secondary fibrinolysis but the subsequent beneficial effects of Dicyclic make the former more likely. We suggest that the high temperature in the operating theatre resulting from lack of air conditioning may well have caused or contributed to this patient's hyperthermia.

We wish to thank Professor C. E. Dent and Mr. D. R. Davies for allowing us to report on this patient who was under their care, and to Dr. Enid Bennett for her helpful advice.

—We are, etc.,

R. H. WHITAKER.
A. G. A. COWIE.
I. W. AITKEN.

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Psychiatric Drugs Left at Home

SIR,—Lately (17 August, 1968, p. 424) we drew attention to a potential danger

awaiting psychiatric patients in their homes after discharge from hospital—namely, drugs acquired in the course of previous treatment and not destroyed.

The study suggested an association between age, affective disorder, recent physical illness, and drug leaving. It was also noted that a simple written appeal did not diminish the number of patients leaving drugs at home. Following the completion of the study therefore at the general hospital psychiatric unit concerned, a systematic attempt was made to collect the drugs of patients on admission, and the nursing staff continued inquiries until either a positive statement was obtained from the relatives that there were no drugs at home, or the drugs themselves were collected.

Last year 14% of relatives with medicines at home admitted to 2 bottles, 4.5% 3 bottles, and 3.5% to more than three. In the current analysis of the initial 71 patients 25% had 2 bottles, 21% 3 bottles, and 11.5% more than 3 bottles, suggesting that larger quantities were kept than admitted on a single inquiry. Altogether over the period examined 565 bottles containing 16,762 items were collected. A similar operation on a national scale would therefore remove from circulation something like 8 million items. Roughly 4% of the bottles examined contained mixtures of tablets, thus making a nonsense of the instructions on the bottle label. Of the tablets collected were 3,730 phenothiazines, 3,432 tricyclic anti-depressant tablets, and 3,307 azepide tablets. Surprisingly only 899 were barbiturate

tablets, and 1,107 tablets of all types usually prescribed as night sedation. It may be that a ratio of 10 psychotropic drugs to one of night sedation is as prescribed. On the other hand, it seems possible that night sedation is more often actually used as prescribed. The ratio is certainly consistent with the shift which has been observed in recent years in the type of medication used in self-poisoning.

In our operational study previously mentioned of 330 patients first admitted to hospital 147 were found to have drugs at home one week after admission, the source of prescribing being the general practitioner five times more frequently than the hospital service. Six months later 148 patients were found to have drugs at home, the ratio of general practitioner prescriptions to hospital prescriptions now being exactly one to one. Having now prescribed them, in view of the frequency of readmission in psychiatric illness, the hospital psychiatrist clearly has an extra responsibility to ensure that unused drugs are not overlooked and left in the patient's home in the course of later treatment.

We are indebted to Miss R. M. Tinker, F.P.S., and her staff for their analysis of the substances collected during a period of just over a year.—We are, etc.,

ASHLEY ROBIN.
D. L. FREEMAN-BROWNE.

Runwell Hospital,
near Wickford,
Essex.

Hospital Staffing Structure

SIR,—You kindly published a letter from the consultant staff of the Kettering and District General Hospital (26 July, p. 236) in which we rejected the report *The Responsibilities of the Consultant Grade*.¹ Since then many other doctors, as individuals, grades, and whole staff committees, have expressed similar views and rejected the document.

We were therefore most relieved to observe in the *Supplement* (27 December, p. 79) that the Central Committee for Hospital Medical Services on 12 December carried a motion by a large majority completely rejecting the report *The Responsibilities of the Consultant Grade* as a basis for discussion.

We are, however, extremely concerned to note that despite general opposition voiced in your columns, and despite the motion in the Central Committee for Hospital Medical Services, the identical proposals feature in the progress report on discussions between representatives of the Health Department and Joint Consultants Committee (*Supplement*, 6 December, p. 53). It is clear to us that the basic propositions are directly descended from *The Responsibilities of the Consultant Grade*. Worse still, they form the template for the manpower projection by the Department of Health and Social Security (*Supplement*, 6 December, p. 55).

After consideration of the progress report we remain equally concerned and equally opposed to the basic propositions. The figures of the manpower projection by the Department merely confirm our worst fears and suspicions. The proposals of the progress report, if implemented, would certainly alter drastically the nature of the consultant's job as we know it today. Further, the progress report does not seek to correct the imbalance between the members in training grades in various specialties; it does not realize that surgical

divisions will shortly become ineffective through lack of anaesthetists, and medical departments made ineffective from lack of radiologists and geriatricians. These major problems of staffing deficiencies in less-popular specialties and also in less-prosperous areas of the country remain unrecognized and unsolved.

We realize that a reorganization of hospital staffing is urgently required, but feel that the progress report is based on the same unacceptable principles as its immediate predecessor, and that it too should be completely rejected as a basis for discussion. We suggest that a fresh working party drawn from the Central Committee for Hospital Medical Services should be set up having a more representative and more informed membership to develop a realistic and generally acceptable staffing structure.—We are, etc.,

GEOFFREY MEDHURST,
Chairman,
Medical Advisory Committee.
PETER ANDREWS,
Chairman,
Medical Staff Committee.

Kettering and District
General Hospital, Northants.

REFERENCES

- The Responsibilities of the Consultant Grade*. Department of Health and Social Security, Department of Health for Scotland. London, H.M.S.O. 1969.

SIR,—Though the document entitled *Responsibilities of the Consultant Grade*¹ has been rejected as a basis for further discussion, the Health Departments are recommending its terms in relation to the staffing of new hospitals. The progress report (*Supplement*, 6 December, p. 53), which has been discussed in the regions was to be de-

bated by the Central Committee for Hospital Medical Services this week, with particular reference to the manpower projection figures which were originally supplied by the Department as a companion to its original document (*Supplement*, 6 December, pp. 55 and 56). If the recommendations of the progress report and the manpower projection are accepted there will be 2,000 consultants forced on the Health Service and 2,000 junior doctors will be phased out of it by 1978.

The problem of the "registrar bulge" requires special consideration by consultants and staff in the regional hospitals, where staffing is presently at the minimum required to maintain essential work. Staffing requirements vary with the specialty. General principles of staff changes cannot be applied to all specialties in precisely the same way.

Before the profession accepts any new proposals these must be seen to be sensible and rational, and sufficient times must be given to discuss them before making decisions. Junior staff should be reduced where their numbers are excessive, but not necessarily as an overall countrywide measure. More consultants should be appointed where they are needed, and where facilities and junior staff exist, and the grade not diluted in a "blunderbuss" manner.

We will not be rushed into accepting a series of senseless generalizations so typical of an expanding bureaucracy.—I am, etc.,

JOHN J. SHIPMAN.
Member, Negotiating
Subcommittee of the
C.C.H.M.S.

Letchworth,
Herts.

REFERENCE

- ¹ *Responsibilities of the Consultant Grade*. Department of Health and Social Security, Department of Health for Scotland. London, H.M.S.O., 1969.

General Practitioners and the District Hospitals

SIR,—The construction of your leading article on "General Practitioners and the District Hospitals" (3 January, p. 2) was fascinating. The opening paragraph of the article started with an apparent understanding of the problem, and clearly stated two very good reasons for the provision of general-practitioner hospital beds. I quote: "The fact that the general practitioners in Great Britain, unlike many colleagues overseas, do not normally enjoy direct access to beds in major hospitals has often been cited as an important cause of emigration. Not surprisingly they have fought long and bitterly for this right, for most were trained exclusively in a hospital environment where the possession of beds was equated with higher status."

As one progressed through the article, hope faded and reality appeared. Various reasons are put forward why such a facility cannot be provided. In the concluding paragraph the voice of the established consultant breaks through with the bald statement that "it may be unrealistic to believe that general practitioners can or will always want to make more than a marginal contribution to staffing the hospital service. Perhaps a better form of participation may come in a way least discussed at the moment—namely, in situations

where the family doctor can offer the hospital team a skill based on his special knowledge and experience."

Surely this misses the whole point, or does it? The point is that general practitioners must be allowed to care for their patients themselves to the limits of their capabilities. If these limits are never allowed to be extended, then these limits will automatically contract. The literature abounds with statements and reasons why the family doctor should be given the privilege of his own hospital beds. Some of these statements were made by those who saw the writing on the wall and emigrated. For those of us that remain and care about standards of medicine we wish to offer our patients it would seem that reasoned argument and statement of needs alone is not enough. Now that the structure of the staffing of the National Health Service, the responsibility of the consultant grade, and medical education in general are all in the melting-pot we must make such a noise that our voice is heard. And if the voice is not listened to the noise must get louder.

I feel that your article started off by stating what we want, but finished up by telling us what we are likely to get. Indeed, I hope that this will not be so.—I am, etc.,

SIMON JENKINS.

Bury, Lancs.

Private Medical Insurance

SIR,—I am surprised that so little comment has arisen in the *B.M.J.* as a result of Mr. Crossman's remarks on the effects of private medical insurance. A misconceived statement on a subject pertaining to medicine one would expect to arouse spirited protest. That it was bristling with dogma culled from years of his party's traditional hostility to "privilege" arising from obsolete class attitudes and the apparent wish to reduce everyone to an amorphous uniformity is to be expected. This may explain the profession's comparative indifference. However, unless we as a profession make it known that we disagree with statements such as this, a Minister like Mr. Crossman might quite reasonably assume we agree with them.

There is of course no evidence that private treatment in private beds or consulting-rooms produces longer N.H.S. waiting lists. Possibly it fractionally reduces them; but this is not provable either. It could be argued that abolition of private insurance would result in fewer consultants taking part-time posts because of the reduction in private work which might follow. This would be to assume that N.H.S. departments could cope with extra sessions and so increase the turnover of N.H.S. patients and usefully employ the extra time available from the consultants. It seems unlikely that operating theatres and x-ray departments in most hospitals could be stretched beyond the present limitations imposed by ancillary staff shortages, to use two examples only. In any case, what part-time consultants do in their sessions which are not devoted to the N.H.S. is really none of Mr. Crossman's business.

Mr. Crossman's remarks, although directed at the medical insurance firms, are

also an indirect attack on part-time consultants. Strong objections should be lodged if medicine is not to be meekly further shackled by the State.—I am, etc.,

J. A. HERSEY.

Letchworth, Herts.

SIR,—It would be interesting to know, and try to understand, Mr. Richard Crossman's motives for threatening to ban private insurance for medical treatment. To do so would at once increase the size of the large queues already waiting for National Health Services. Ordinary people would think that the way to reduce waiting-lists would be to provide more services—beds, operating facilities, equipment, technicians, and most of all, nurses.

If Mr. Crossman really practises what he preaches—never, for example, travelling by car on account of getting to his destination more quickly and more comfortably than people who wait in bus queues—one must admire him, even while disagreeing with him.—I am, etc.,

E. V. BEVAN.

Cambridge.

Vocational Training for General Practice

SIR,—Thirty-five years ago I did two years in hospital and a year as an assistant before entering general practice. At that time, because of economic pressures, some had to go straight into practice after passing their finals. Preregistration posts have been made practicable by salaries for house jobs more adequate than in my day.

Improvements in surgery accommodation during the past 20 years have not resulted from compulsion, but by virtue of competition and because for some there has been encouragement with grants and loans. The more general use of ancillaries has not resulted from compulsion but because grants have been made available.

Men and women who qualify in medicine have a sense of responsibility or they would not trouble. A "vocation" is an inner light which may be present or may be acquired, but which cannot be taught. The good jobs will always go to the suitable men and women who have fitted themselves for them.

What is wrong about the present proposals is the element of compulsion. A doctor is essentially an individualist, who will be the better for going his own way. It is a mistake not to give the maximum freedom and encouragement. Competition, a special interest, the desire for self-improvement, the inner light—these are the keys, not compulsion. Wisdom is better than mere learning, kindness than high ability, willingness to serve than organization. Only the years can bring the maturity of judgement and character which make a whole man.—I am, etc.,

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