phagocytic cells ingest any bacteria and other particles that reach the terminal respiratory units. Because of its probable importance in preventing many pulmonary infections the alveolar macrophage is the subject of intensive research.

* * *

Thus the lungs have a complex structure that is well suited to their role of gas exchange, and many important non-

respiratory functions are now being identified. Recent work on the structure of the normal lung is helping us to understand the way in which diseases produce their effects, and this should point to improved methods of prevention and treatment.

Reference

¹ Murray, J, *The Normal Lung*. London, Saunders, 1977.

Letter from . . . Dublin

Doctors to tradesmen

EOIN O'BRIEN

British Medical Journal, 1978, **1**, 633-634

After the electorate's unequivocal dismissal of the Coalition Government in June 1977, Mr Charles Haughey has succeeded Mr Brendan Corish as Minister for Health and Social Welfare. Mr Haughey, an experienced politician with a reputation for efficiency and achievement, is a striking contrast to his predecessor, whose preference for indecision rather than the wrong decision characterised his term of office. After quietly watching health from the opposition benches Mr Haughey has seized his portfolio with characteristic enthusiasm, and has made it clear to the medical profession, his civil servants, and the public that he intends to get things done. Let us direct our attention to two issues occupying much of the Minister's time at present—the long overdue contract for consultants and the building of a new hospital for Dublin city.

Consultant contract

Most consultants in Ireland are not subject to a formal contract, deriving their income from a salary calculated according to bed occupancy (the "pool" system), sessional payments, and private practice; these consultants have to make their own provision for sickness, holidays, study leave, and pension. A smaller number of consultants, employed in area health board hospitals, are salaried, with superannuation and sick leave provision, and most of these also derive some income from private practice.¹ During the past few years there has been much discussion between the Department of Health and the profession's representatives. The consultants have expressed a preference for a sessional basis of payment, with remuneration for extra duties, and the right to private practice. The negotiations now taking place in Eire and in Britain are complex and crucial for the future of medicine in both countries. As doctors vie with the politicians for what is essentially money in one guise or another, the interests of the unrepresented party—the patient—can easily be overlooked. Of particular concern is the principle of

continuity of patient care, which has been almost completely abolished within our hospitals, and could now be in jeopardy at consultant level.

By continuity of patient care I mean the right of a patient to be looked after by a doctor thoroughly familiar with his illness, and not merely a doctor from another firm who has not had the good sense to follow the example of his nursing colleagues—that is, the transfer of verbal and written reports on all patients at the change of shift. Doctors and administrators may argue against the concept of continuity of care, but will the patient? Since the substitution of cross-cover for continuity of care, the patient, whether acutely or chronically ill, may be cared for by his own doctors during normal working hours, but when 5 o'clock, the weekend, or a bank-holiday comes God knows who will be called to him in his greatest need.

Looking back a decade or so, one can remember—often vividly, but not in too much anger—the system whereby for an annual salary the intern, often the SHO and at times the registrar, by alternating duties with his partners provided continuity of care for his own patients. These were the days before the introduction of what was euphemistically called *extra-duty payment* in Britain but quite bluntly *overtime* in Ireland. Undoubtedly in those days the doctor was underpaid and overworked. At times, overwork probably resulted in bad decisions (I cannot remember whether the comparison was with airline pilots or lorry drivers), but long hours on duty did not always mean long hours of work—these were the days of the thriving hospital mess, and many were the entertaining hours spent in this establishment while "on duty."

More important, however, was the experience gained under this old system. Experience can be acquired only by exposure to ill patients, and illness cannot be organised to comply with the dictates of shift-work. If a junior hospital doctor in 1963 worked twice as long as his 1973 confrère must it not follow that the latter is less experienced? The question is one of degree in deciding at what stage reducing the hours on duty becomes crucial to the training of the junior hospital doctor. For the doctor overtime payment means fewer hours on duty and more leisure and study time (but the treatment of diabetic keto-acidosis cannot be gleaned from journals, or the surgery of perforation from the textbook)—and, of course, more money, at the sacrifice of experience. For the patient overtime has resulted in the virtual disappearance of continuity of care. The sacrifice has been considerable, and both the junior hospital doctors and their consultant colleagues have paid little heed to the conse-

The Charitable Infirmary, Dublin

EOIN O'BRIEN, FRCP, MRCP, consultant physician

quences, the former through ignorance, and the latter through apathy, acquiescence, or frustration at an administration too intent on solving its own short-term problems. It is now left to the consultants not only to organise rotas based on the cross-cover principle (ensuring that this satisfies the financial dictates of administration), but also to sanction the overtime work done by junior staff, becoming in effect a cheap (and inefficient) time clock.

Continuity of patient care has almost disappeared in urban general practice (not without some protest by the public) and at junior hospital doctor level (without a whimper of protest, presumably because the public are unaware of what is happening), and now with the introduction of a consultant contract there is the danger that it may disappear altogether. If this were to happen the consultant would in effect be abrogating his clinical responsibilities for the patient, and medicine as traditionally practised in Eire would have been changed irrevocably. The times have changed, and perhaps medicine must change also, but surely not without protest at the disappearance of old standards. If the Government or the profession will not study the consequences of overtime payment on the practice of medicine, then perhaps it is high time for patients to do so, carefully and responsibly, but quickly.

A new hospital for Dublin

Most of Dublin's many hospitals function in small, antiquated, albeit architecturally appealing, Georgian or Victorian buildings. For many years the Department of Health has wasted much time in discussing the reorganisation of the city's hospitals, but Mr Haughey was scarcely in office when he announced that by using the plans of the nearly completed Wilton Hospital in Cork he would erect within five years a £15m hospital to replace two of Dublin's oldest institutes—the Charitable Infirmary, Jervis Street (the oldest voluntary hospital in these islands, founded in 1718), and St Laurence's Hospital, which comprises the Hardwicke (founded in 1803), the Richmond (1811), and the Whitworth (1817) Hospitals, originally and collectively named the House of Industry Hospitals, but known affectionately by Dubliners as "The Richmond."

The medical profession generally welcomed Mr Haughey's flair for getting things done without wasting too much time in discussion (a facet of his behaviour that could cause problems), but there were those who questioned the wisdom of siting the new hospital at Beaumont, thereby depriving the city centre (so badly in need of revitalisation) of two of its oldest hospitals. Be that as it may, building will start shortly, and two formerly petulant rivals are now preoccupied with the problem of how best to share the same bed—so preoccupied, in fact, that little attention has been given to the name of the new hospital, which predictably is already being referred to as the Beaumont Hospital, a soulless and unimaginative appellation that could, unfortunately, become a reality. Dublin being Dublin, we can anticipate beatific and political aspirants for the honour of commemoration; but there is no record to my knowledge of a saint being associated with either institute, and politicians have done little to enhance their reputations in their relatively short associations with these hospitals. There were, however, two important medical personalities on the staffs of both the Charitable Infirmary and the Richmond—Robert Adams and Dominic Corrigan.

ROBERT ADAMS

Robert Adams was born in Dublin in 1791 and graduated from the Royal College of Surgeons in Ireland in 1815. While a member of the staff of the Charitable Infirmary he published in 1827 a long article in the *Dublin Hospital Reports* entitled "Cases of Diseases of the Heart Accompanied with Pathological Observations," in which, describing a patient with syncope and

bradycardia, he made the unique suggestion that the "apoplexy must be considered less a disease in itself than symptomatic of one, the organic seat of which is in the heart." William Stokes in 1846 in his now famous paper on "Observations of Some Cases of Permanently Slow Pulse" notes Adams's earlier contribution and both are commemorated in the eponym Stokes-Adams disease.

DOMINIC CORRIGAN

Dominic John Corrigan, born in 1802 to a Catholic family, graduated from Edinburgh in 1835 with his famous contemporary William Stokes. In 1831 he was appointed physician to the Charitable Infirmary and a year later published in the *Edinburgh Medical and Surgical Journal* his famous paper "On Permanent Patency of the Mouth of the Aorta, or Inadequacy of the Aortic Valves."

Corrigan and Adams did for the Charitable Infirmary and the Richmond Hospital what Graves and Stokes did for the Meath Hospital, and between them these masters of clinical expression gave to Dublin its "golden age" in medical history. Both deserve commemoration in Dublin, but Corrigan must in terms of general achievement take precedence over Adams; and it would seem fitting that the traditions of the two institutes that he served so well should be preserved by naming the new hospital after him. Indeed, if Mr Haughey gets on with things the building might even be completed for the centenary of Dominic Corrigan's death in 1980.

Reference

- 1 O'Brien, E T, *British Medical Journal*, 1975, 3, 291.

A 40-year-old man has several abnormalities, the most important of which appears to be Klinefelter's syndrome. This was confirmed by lymphocyte culture and found to be of the 47 XXY variety. He had congenital absence of the left kidney with absent left ureter, and the left testicle was not in the scrotum. Both agenesis of one kidney and Klinefelter's syndrome are relatively common, so is there any relationship between the two?

Undescended testes are common in Klinefelter's syndrome, but I know of no special association with unilateral renal agenesis.

I understand that 90% of alcohol ingested is metabolised by the liver at a fixed rate, 10% being lost in sweat and urine. I have heard sporadic and regular drinkers claim that they have considerably less chance of being intoxicated, other circumstances being equal, if they indulge in vigorous exercise or have a cold bath (which would induce shivering). Is there any rational basis for this claim?

I do not know of any evidence that exercise or cold exposure can accelerate the metabolism of ethanol in the body. Lactate accumulation in exercise might be expected to impede ethanol dehydrogenation. The ability of exercise and cold to combat the effects of ethanol on behaviour is probably due to their immediate reflex effect in increasing alertness and reducing drowsiness. It is not generally known, however, that quite small amounts of ethanol can be highly dangerous to people who have exercised for an hour or two, if taken without food. By reducing tissue pyruvate, ethanol reduces gluconeogenesis.¹ When the carbohydrate stores have been depleted by exercise this leads to hypoglycaemia, often severe enough to cause both confusion and rapid body cooling due to an almost total loss of metabolic and vasoconstrictor response to cold.² Several deaths on hills seem to be caused by this. Alcohol should not be taken after exercise unless a substantial meal is eaten at the same time.

¹ Krebs, H A, *et al*, *Biochemical Journal*, 1969, 112, 117.

² Haight, J S J, and Keatinge, W R, *Journal of Physiology*, 1973, 229, 87.