

- ³ Royall BW. International aspects of drug monitoring: role of the World Health Organisation. *WHO Chron* 1971;**25**:445-51.
- ⁴ Slone D, Jick H, Borda I, *et al*. Drug surveillance utilising nurse monitors: an epidemiological approach. *Lancet* 1966;ii:901-3.
- ⁵ Moir DC, Alexander ER, Barnett JW, Christopher LJ. A hospital based drug information system. *Health Bull (Edinb)* 1975;**33**:82-8.
- ⁶ Inman WHW. *Recorded release*. In: Gross FH, Inman WHW, eds. *Drug monitoring*. London: Academic Press, 1977:65-75.
- ⁷ Rawlins MD, Dollery CT. Post-marketing surveillance by registered release. In: *Post-marketing surveillance of adverse reactions to new medicines*. London: Medico-pharmaceutical Forum, 1978:40-4. Publication No 7.
- ⁸ Lawson DH. Post-marketing surveillance: an alternative approach. In: *Post-marketing surveillance of adverse reactions to new medicines*. London: Medico-pharmaceutical Forum, 1978:50-5. Publication No 7.
- ⁹ Anonymous. Life cycle of an FP10. *Br Med J* 1977;ii:670.
- ¹⁰ Acheson ED. *Medical record linkage*. London: Oxford University Press, 1967.
- ¹¹ Skegg DCG, Doll R. Frequency of eye complaints and rashes among patients receiving practolol and propranolol. *Lancet* 1977;ii:475-8.
- ¹² Dollery CT, Rawlins MD. Monitoring adverse reactions to drugs. *Br Med J* 1977;ii:96-7.
- ¹³ Harron DWG, Griffiths K, Shanks RG. Debendox and congenital malformations in Northern Ireland. *Br Med J* 1980;**281**:1379-81.

Letter from . . . Chicago

Out of the darkness

GEORGE DUNEA

"Tell me, what things do you hate most" the hypnotist asked the woman who for years had been trying to lose weight. "Dead mice and hair in drinks," she replied. Within a few minutes she was in a trance, feeling herself go deeper and deeper, yet not so deep as to lose control completely, and still able to hear the sirens of passing ambulances. "You must look at this spot on the tapestry and watch it change as you relax and feel comfortable—and now you roll your eyeballs up—and now you roll them down—and now the spot is still changing—and now it has disappeared." So the hypnotist droned on soothingly, telling her that the next time she tries to eat a piece of candy she will notice, curiously enough, how much it resembles a dead mouse; and that if she should ever again contemplate the illicit pleasures of a milkshake she will find the glass full of thick black hair. "But you will also observe that when you drink Perrier water it will now taste like champagne"—at which stage the woman swears that her hand reached out to pick up an imaginary glass by its stem. As a final treat she was allowed a brief phantasy, a walk through a rose garden with lovely paths and sparkling fountains before returning to face a life of lettuce and mineral water.

Nobody quite knows how hypnotism works to turn delicious candy into hateful mice, except that it requires a willing subject, that it can be accomplished in some 80% of people, and that it does vaguely said to "bypass the central nervous system." Yet it does seem effective, in that patients have stopped bleeding, women have undergone caesarean section without pain, and many people have stopped smoking or lost weight after one or two sessions for a mere \$50-100—which is certainly less expensive than having one's stomach stapled, a popular procedure now that surgeons have become disenchanted with wiring jaws and bypassing bowels. Hypnotism, furthermore, never lacerates spleens, such as happened recently when a 350-pound (157 kg) man had his stomach stapled by courtesy of Medicaid at a university hospital. While the surgeons were busy stopping the bleeding, others wondered if this was an appropriate way of spending public moneys—perhaps an extension ad absurdum of the "right to medical care." But on the second postoperative day

the patient asserted his most fundamental rights by insisting that the intravenous therapy be discontinued and that he be allowed fluids by mouth. And it must have been the premature or excessive exertion of these inviolable rights that blew out his staples, thus initiating the familiar sequence of sepsis, shock, Swan-Ganz catheter, gentamicin, renal failure, and hyperalimination. At which time a young dietitian naively betrayed her ignorance by asking if it should be necessary to hyperaliminate a 350-pound man. Her mind was quickly set at rest by the surgical resident, who explained that, like hypnotism, hyperalimination was not fully understood, but without it the leucocytes would not function and the wound not heal in this obviously starving patient.

Yet even the most self-assured surgical resident may be wrong, if not in his views on lymphocyte function then at least in estimating prognosis, for after the patient developed jaundice and more bleeding and probable intravascular coagulation even the most optimistic surgeon had given up hope. But the patient defied all odds, rallied, and eventually went home, albeit with an unstapled stomach, thus confirming the old adage that prognosis is difficult if not impossible.

Out of the darkness

Also confirming this truth were last November's elections, where the polls had predicted a close outcome, perhaps with the people voting for the devil they knew, and where few had expected a Republican landslide of such magnitude. Yet with the Republicans in firm control of the Senate, this year may mark the end of the liberal establishment that had dominated the legislature since the days of the Kennedy administration. Most people seemed to agree that the vote was a mandate for change, for less government and less bureaucracy, for a stronger economy and a more decisive foreign policy. As soon as the results were announced the sceptics declared that everything will remain the same, that nothing could be done, that there will be no magical transformations, and the same old problems will persist under the new presidency. But others were cautiously optimistic, watching early appointments with interest, and hoping that the new administration will act decisively and that Mr Reagan will lead the nation out of the darkness.

Yet as the weeks went by there was much talk about the

enormous difficulties of cutting expenditures from a Federal budget made up largely of uncontrollable items (social security, pensions, unemployment and medical benefits, and defence) and there were also fear that Mr Reagan could be in danger of becoming "Thatcherised," meaning that he would not be able to act decisively because of too much diversity of opinion among his followers. For medicine, Mr Reagan's election means the end of plans for comprehensive national health insurance, and perhaps also some easing of Federal controls. Most doctors were pleased with the Republican victory, hoping for a more cooperative attitude from the new administration, though realising that change would come slowly. One suggested approach was to overhaul the Medicare programme by giving the elderly vouchers to buy private insurance, thus eliminating much Federal bureaucracy. But there were also fears that some of the progressive programmes of the past decade would be scrapped: "Is it true that Mr Reagan is the head of the Ku-Klux-Klan and that he will do away with social security," asked a wide-eyed 18-year-old black girl who had been on dialysis for three years. She was clearly misinformed, but only time will tell how the new administration will reconcile cutting costs with caring for the poor and underprivileged.

For science, however, few expect changes as drastic as those advocated by Nobel laureate Milton Friedman, an adviser to Mr Reagan, who would slash all government support for research and higher education, because he thinks they are a waste of money, represent a "flagrant example of the poor being taxed for the benefit of the rich," and probably stifle excellence in research with bureaucratic red-tape; and he was quoted in *Science* as recommending the abolition of the National Science Foundation, the National Institutes of Health, and of most Government funds for research. Yet such an action would seriously stress an academic community already reeling under a progressive tightening of funds—as well as shaken by a series of scandals, also covered in some of the last year's issues of this journal. Thus at Harvard Medical School a 36-year-old immunologist working at the Massachusetts General Hospital had to resign after conceding that he had falsified data in experiments on immune complexes in cancer. At New York University the chairman of anthropology was sentenced to jail for making hallucinogenic and stimulant drugs in his laboratory and planning to sell them on the black market. Another controversial episode was the resignation of the newly appointed chief of medicine at Columbia University for exercising poor judgment in dealing with a junior colleague who had falsified and plagiarised data on insulin receptors. Even more remarkable was the case of the young Jordanian Elias Alsabti, who had pirated or plagiarised so many papers on cancer immunology, and has resurfaced in so many different places, that his brief scientific career comes close to being a good detective thriller.

Flight of Ms Nightingale

Meanwhile, I was wrong in reporting some time ago (29 July 1978) that Miss Nightingale was alive and well and fluttering back to the bedside. In fact the Ms Nightingales have flown away in large numbers, staying at home or working at other jobs, so that almost one-half of them are not nursing and many more are needed. In Chicago the deficit is estimated at 1500-2000 clinical nurses, and although the problem is most severe in the inner city, it is in fact universal. Some hospitals have closed entire wards, others are grossly understaffed, and everywhere the turnover is high as nurses point out that their salaries have not kept up with inflation, that even bus-drivers make more money, and that for most families the extra income is eaten away by the "marriage tax" and by expensive babysitters. At a time when women have many other options, some offering a better image and an easier life, clinical nursing remains physically exhausting and psychologically demanding, the hours are long and inflexible, and the nurse frequently perceives that her efforts are not being appreciated.

Increasingly, in an age of women's liberation, nurses have also begun to question the traditional relationship between nurse and doctor, pointing to the disparity in income and prestige, and no longer satisfied with "playing a subservient role" and being the "doctor's handmaiden." Instead, they want to play a pivotal role in the "health care team," preferring to work independently as nurse practitioners, "primary care nurses," visiting nurses, or public health nurses. In the hospital they are irked by the rigidity of the nursing and administrative hierarchies, by too many bosses, too many memos, too much paperwork, too much tokenism: "They want feedback, but only through appropriate channels." "They tell me I'm a professional but treat me as a labourer, so that I am docked if I am five minutes late but unrewarded if I stay late." Nurses also complain of having to put up with equipment deficiencies, administrative ineptitude, and staffing shortages, and they resent being forced to work extra hours or to share the work with inexperienced aides. Increasingly, they prefer to register with private employment agencies on a day-to-day basis, which allows more flexible working hours for them but is more expensive for the hospital and tends to interfere with the continuity of care. Yet because of the high turnover rate many hospitals have had to resort to gimmicks such as job fairs and recruitment parties, some giving prizes to employees who recruit a new nurse, others offering flexible working conditions and furthering higher education by paying for advanced courses and extra degrees.

Compounding these difficulties, last year, were some highly publicised cases of nurses being accused of killing their patients. In Chicago a nurse was dismissed after reports that two patients had died from insulin overdose in a possible mercy killing. In Massachusetts three nurses were indicted for murder for giving large doses of morphine to patients with metastatic carcinoma of the lung. And in the celebrated "Death's Angel" case a Las Vegas nurse was tried but acquitted on charges of disconnecting patients' oxygen tubes and organising bets on the time the patients would die.

But more basic to the future of nursing has been the insistence of nursing educating bodies on stringent qualifications and stiff educational requirements. While this makes it more difficult for foreign nurses to work in the United States (in many inner city hospitals most nurses come from the Philippines), it also affects practice conditions for native Americans; and not only has nursing become a college course, so that most of the hospital nursing schools have been closed, but in the hospital advancement and increased pay come mainly to those who have higher degrees and opt for supervisory or administrative rather than bedside duties. Older women, whose children have grown up, are likewise reluctant to return to a system where they receive no credit for experience and are placed in subordinate positions to young nurses with special diplomas but no clinical background. Yet not every function in the hospital requires a university degree, and only time will tell how much of the nurse's work will have to be taken over by aides, technicians, practical nurses, or perhaps even the patients' relatives.

Corrections

Brain death in three neurosurgical cases

We regret that an error occurred in this paper by professor Bryan Jennett and others (14 February, p 533). In table II the last row (Swansea) under "Head injury" should have read: "54/64 84%."

Vertigo

We regret that an error occurred in this article by Mr Harold Ludman (7 February, p 454). In the penultimate paragraph of the article the fourth sentence should have read: "Other conservative measures include ultrasonic destruction of the vestibular part of the labyrinth and division of the vestibular part of the vestibulocochlear nerve."