liaison with other professional groups, both within the hospital and within the community. Indeed, the enthusiasm to develop such liaison brings an increasing workload.

The counsellor was employed as a clinical nurse specialist (grade H), which was considered to be the minimum for the responsibilities entailed. This, together with the use of a hospital car, clearly has important cost implications for the health authority. Only a quarter of the counsellor's time is spent supporting her clinical colleagues in the department. The cost must be set against the long term expense of supporting relatives in the community who have no initial support and subsequently present with major psychiatric problems and unresolved grief reactions.

A few courses are now available for those wishing to study bereavement counselling, but they are usually designed by and intended for people with a specific interest in the hospice movement. An exception is the six week training session run by CRUSE for voluntary bereavement counsellors.

Conclusion

Sudden death robs the relatives of preparatory grief, is more common in young people, and usually occurs either in the clinical environment of the resuscitation room or in an unfamiliar high dependency or intensive care unit. People who are suddenly bereaved may require more support and counselling than those who have known for some time that their relative is dying, yet they usually receive less. All accident and emergency departments should review their arrangements for providing help for the bereaved and integrate their services with those available in the community. A similar system should be developed in intensive care, coronary care, and neurosurgical units, where many patients die shortly after admission. If such support were widely available it might reduce the number of people presenting with unresolved grief reactions.

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Letter from . . . Chicago

Ten opinions

George Dunea

I woke up that morning with a painful elbow. In the mirror I could see a slightly raised swelling, some 8 cm in diameter, red, and tender on palpation. I asked my wife to help me put on an ice bandage, but it only made things worse, so I took it off again. Then I began to rummage through a drawer that contained various medicine bottles, expired eye drops, disposable razors, a neck collar for long aeroplane trips, a bottle of aftershave lotion, some old Australian coins, and an engraved knife bought in Toledo during the long summer of 1959.

"You should show this to a doctor," she said. "I wasn't planning to do so," I replied, struggling to open a bottle that disappointingly turned out to contain dicyclomine—the blue tablet that cures all distress below the diaphragm—unlike chlorpheniramine, the yellow pill that eliminates most symptoms above, including cough, sinus, congestion, itching, restlessness, and an inability to sleep. There were faint suggestions wafting through the air of doctors treating themselves and fears of losing control. By that time I had found the orange pain pills, so distinct in their action from the blues and yellows.

At the hospital drug and formulary that morning we talked about the rising cost of drugs. Why use the expensive non-steroidal anti-inflammatory drugs when ibuprofen and indomethacin can be bought for 15 to 25 cents? I agreed, fortified by two orange pills, not thinking it relevant to mention that they were free samples of the expensive alternatives. After more discussion we adjourned and I asked the doctors to look at my elbow. The older surgeon advised hot packs, recommending antibiotics only if I saw red streaks running up the arm. A young internist wanted to aspirate the area, but the surgeon said "you won't get any fluid." The infectious disease specialist said he would agree with the surgeon were it not for a small scab on top of the lump. "Should I take ciprofloxacin?" I asked, ready to use the latest universal nostrum. She preferred a new oral cephalosporin that I had not heard of, "better for staph," and I picked up 10 tablets from the pharmacy—"would normally run you $20, doc."

Back at my office, a Letter from Chicago beginning to germinate in my mind, I remembered writing some years ago about the war correspondent thrown into despair because three specialists had each recommended a different treatment for his carcinoma of the prostate. Later, also, a senator had written in a financial newspaper, complaining that there was too much uncertainty in medicine. He was referring to the big dollar items, coronary bypass, carotid endarterectomy, and the like. But what about swellings at the back of the elbow?

At the clinic I asked a physician whose opinion I respected. "Take ciprofloxacin," he said. Another thought I had cellulitis and should take antibiotics. A third, more academic, did not know what was the matter, nor what I should do, but recommended a battery of blood tests. I reflected that his career would have come to an abrupt end at the clinical part of the membership examination.

Is it tennis elbow or gout?

I tried out some of the house officers. "It's a tennis elbow," said one of them. "It's gout," said another, mashing it harder than necessary. I pointed out that the joint was not involved and that my uric acid level had been normal three months earlier. The resident said that he would feel happier if I had it repeated and also offered to tap the joint.

The clinic over, my psychological state restored by orange non-steroidals and expensive cephalosporins, I went to a meeting on tuberculosis. I learnt that there were 16 million sufferers in the world; eight million new cases yearly; two million deaths. One billion (with a B, the lecturer emphasised) have been exposed to Koch's bacillus. In America epidemiologists had

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extrapolated that tuberculosis would be eradicated by the year 2005, but now the disease has made a comeback, especially in young blacks, older hispanics, nursing home inmates, and people with AIDS. Being foreign born confers a 13-fold risk—especially for newcomers from Asia. I learnt about new nucleic acid probes, diagnostic tests that have already become cheaper and less time consuming than cultures. Also how six months' treatment is effective provided both isoniazid and rifampicin are used, nine months' if you include pyrazinamide. I even asked a question at the end—the visitor replied he could not be certain.

After the lecture I espied a rheumatologist in the audience. He took one look and said it was an inflamed olecranon bursa, with a "hole" on top, probably infected with staphylococcus. He agreed with the antibiotics and said that the bursa should be aspirated in four days if it was not better by then. There was a chance that there might not be any infection but I should take the antibiotic anyway.

This time the patient was satisfied. But though I was sympathetic to the complaint about too much uncertainty in medicine, I was still disinclined to propose a universal, government funded, nine opinion programme. The rheumatologist had certainly sounded the most convincing. He was probably also right in saying that it did not matter very much what I did. This I confirmed by stopping the expensive cephalosporin the next day. Presumably another "toss up," as decision analysts have referred to what at first sight are perceived as big differences in specialists' recommendations.

That night I reported to my wife that my olecranon bursitis had been examined by nine specialists. "Looks horrible," came the tenth opinion, "Don't you think you should have an *x* ray examination?"

How To Do It

Cope in office

Tom Solomon

"How on earth did you cope with it all?" asked my successor, as I handed over the reins of office. Twelve months previously, when I had started as president of Osler House Club, Oxford's Medical Student Union, I had been similarly daunted. Of course all the relevant files had been passed on to me, but I soon realised that there was so much more to it than that. Even a flick through some articles in this series, helpful though they were, did not teach me some of the basics that seem vital for someone taking on this sort of responsibility for the first time. Much of what I have learnt will, I am sure, prove to be of value to the many medical students and junior doctors who will find themselves in increasingly managerial roles in the future.

Time management

Whatever the particular management role you have taken on it will soon become apparent that your own degree of organisation will make a big difference in determining how well you cope. Crucial to this is how effectively you manage your time. However plush your Filofax, there will still never be enough hours in the day for everything you would like to do. But one way in which you can ease this difficulty is by limiting the constant interruptions which seem to be part of the job. Initially you like to feel that you are always available for people to pop in, "My door is always open," you say. But you will soon realise how much of a time waster this can be: for not only is there the delay while you talk to your visitor but there is the additional inefficiency of having to keep stopping and starting. Far better to set aside a period—perhaps five till six every evening in the bar—when people know that they can catch you. Similarly, though being offered a hospital bleep may be a tremendous boost to the ego of an aspiring medical student, the scope it allows for unnecessary interruptions means that you are far better off without it. You can be too readily available for your own good.

Never ending post, though initially flattering, soon becomes a source of headache. At first I tended to open the day's post in a spare five minutes, just to see if any of it appealed, then I would look at it again later. Over the next few days some letters would be read a third or fourth time as I answered them. Others would lurk at the bottom of my bag for weeks before I would finally get around to answering them or throwing them away. This rereading of the correspondence was obviously highly inefficient. In a mood of ruthless efficiency I developed a "handle it once" policy. The post would remain untouched in my pigeonhole until I had sufficient time to deal with it all in one go. If this meant I had to ignore it for a day or two, then so be it. Once opened, however, it would be answered straight away so that each letter would be handled just once and dealt with there and then.

Replying to letters is also a potential time waster if you are not careful. It amuses me to see how my successor—just as I did at first—diligently types out beautiful replies for all his correspondence, however trivial or unimportant it may be. You soon learn that for most of it a reply scrawled on notepaper or even across the bottom of the received letter will do. Why waste half an hour carefully explaining to Hackmann Stethoscopes that you do not think students will be interested in a "special one pound reduction" offer on the new cardiology scope, when a simple "not interested, thank you" will suffice.

Committee life

To ensure smooth running of committee meetings a great deal of tact and skill is needed. It is worth first considering how the meetings will work. Will someone chair the debate, with the issues being formally voted on, or will there be more free ranging discussion to arrive at mutually agreed solutions? In my experience the discursive approach works far better, and on the few occasions when our committee had to resort to formal voting it was a sign that things were not going well. Surprisingly, even when there was discord, voting could not always be relied on to produce the most sensible conclusion. For example, at one of our first meetings there was great disagreement about bar opening nights. To try to resolve this we finally voted on the various alternatives. The result, however, was an unhappy and nonsensical compromise (the bar to be open every night except Thursday) which pleased nobody. It took a few tactful late night 'phone calls to retrieve us from the mess we had created.

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