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Correspondence

Letters to the Editor should not exceed 500 words.

Recognition of Hypothermia

SIR,—Death is a condition which is seldom difficult to recognize. However, the widely publicized report (*Daily Telegraph*, 1 November, p. 1) of a patient who "came to life" in a mortuary illustrates perfectly a situation in which the immediate diagnosis of death is not necessarily possible.

It is well known that hypothermic patients have a very slow, soft pulse and quiet heart sounds, which are easy to miss, and a respiratory rate so slow that examination of the patient's chest for half a minute may not reveal any movement; furthermore, the pupils are usually dilated. Apart from this it is theoretically possible for a profoundly hypothermic patient to survive a twenty-minute period of untreated ventricular fibrillation, during which both pulse and breathing are absent.

A suicidal patient who takes an overdose of drugs at night has a long period of uninterrupted unconsciousness in which to become hypothermic. It is not surprising, therefore, that all six hypothermic patients in whose treatment I have been involved had taken overdoses on the previous night. All but one were found in "exposed" places by people who started the day's work early.

I should like to suggest that any practitioner disturbed from his breakfast to attend an unconscious patient should have the diagnosis of hypothermia in the back of his mind. Perhaps he should also be reluctant to pronounce death immediately in such patients, but consider the possibility of cardiac resuscitation, transfer to hospital, electrocardiography, and an attempt at defibrillation. The prospect of permanent brain damage in these patients need not be a deterrent; the protection of tissues against hypoxia at low body temperatures is remarkable.[1,2]—I am, etc.,

R. H. FELL.

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REFERENCES

1 Linton, A. L., and Ledingham, I. McA., *Lancet*, 1966, **1**, 24.
2 Fell, R. H., Gunning, A. J., Bardhan, K. D., and Triger, D. R., *Lancet*, 1968, **1**, 392.

Exploitation of Nurses

SIR,—Two responses will have been aroused in most of us by your timely leading article (8 November, p. 320)—gratitude for having the basic facts of nurses' pay so clearly set out, and shame that we as doctors, who daily rely on our nurses' skills, should have done so little by way of supporting their just demands.

Has not the time come, Sir, when those of us who are established, whether consultants or general practitioners, should make it clear that from now on we wish to forgo any question of increase in our pay until urgent and major upgrading of nurses' pay has been achieved?—I am, etc.,

DOUGLAS GAIRDNER.

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SIR,—During the course of my pre-registration year I have constantly been made aware how severely the present nursing shortages are affecting both the daily and, more particularly, nightly welfare of patients and the efficient running of the hospital service.

Your timely leading article "Exploitation of Nurses" (8 November, p. 320) highlights poor basic pay, poor conditions of service, and poor rewards for advancement as possible causes of the present discontent. At present, shortage of nursing staff must surely be one of the most urgent problems facing the hospital administrators. If the present fall in recruitment continues (as seems likely with a smaller proportion of 18-year-olds in the population), it can scarcely be long before there is a very real crisis in nursing.

The popular press has recently given the nurses' demands much welcome publicity, and there is no doubt that a large mass of the public (particularly among ex-patients) are sympathetic to their cause. Most doctors, too, I feel sure, would wish "economic justice" to their nursing colleagues.

However, I feel sure that the medical profession, particularly those working within the hospitals, should be able to offer some more tangible backing. It will require our strongest possible support if the Government is to realize the severity of the present situation. Only then is it likely that the appropriate measures will be taken to avert this potential crisis within the hospital service.—I am, etc.,

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SIR,—In the last paragraph of your excellent leading article (8 November, p. 320) you mention that a ward sister who does not wish to leave bedside nursing cannot earn more than £1,315 per annum. She is not only the key, as you say, to maintaining high standards of care; most matrons will agree that without experienced ward sisters the hospital service will break. The Salmon attempt to introduce a proper career structure for nurses undervalues the need for experienced ward sisters.[1] To this extent it places a higher priority on administrative structure than on patients' needs.

A qualified medical man has some choice as to whether he enters general practice, teaching, research, hospital medicine, or medical administration. Why should an experienced ward sister be compelled to enter administration, or be penalized for following what may be her true and indispensable vocation? Is it too late to lift the barrier, reward experience, and remedy this serious defect in the Salmon structure?—I am, etc.,

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REFERENCE

1 *Report of the Committee on Senior Nursing Staff Procedure*, 1966. London, H.M.S.O.