admission to hospital may be avoided. If disorientation is allowed to develop or if the patient has not presented soon enough to prevent it referral to hospital will be necessary. Other diagnoses should be considered in the disoriented alcoholic patient, particularly subdural haematoma, pneumonia, and meningitis.

Nursing the patient in a well illuminated uncluttered environment helps to reduce disorientation. If associated physical illnesses permit delirious patients are best managed in psychiatric wards where they may be out of bed. Sometimes it helps to have a relative present. Sedation must be given quickly, with an adequate, sufficient loading dose: diazepam 50 mg or chlordiazepoxide 100 mg might be started, followed by smaller hourly doses until agitation is controlled. Dosage is tailed off to zero over about the next four days. Patients in hospital have died from hypostatic pneumonia when cumulative sedatives are continued for too long; this is particularly likely to occur when sedatives such as chlormethiazole are given by intravenous infusion, a method that may also cause death from respiratory depression.[14] (Ethanol itself is less cumulative and therefore perhaps safer, and has been used in intensive care units in a dose of 30 ml initially followed by 10 ml every hour in 5% dextrose.) For severe agitation haloperidol or droperidol 10 mg intramuscularly may be needed, but the benzodiazepine should be continued for its anticonvulsant effects. A parenteral vitamin preparation containing thiamine should be given daily for about five days. Fluid should be replaced sparingly because alcoholics may have impaired ability to excrete water[15] and a tendency to cerebral oedema.[16]

As the mental state improves the doctor has the opportunity to explain in a non-judgmental manner the link between the illness and the patient's drinking. In the Swedish study five of the 11 who made a good long term recovery from their alcoholism reported that the episode of delirium tremens had been a turning point.[2] Four of those who did well reported at follow up that they were now drinking beer occasionally but never to excess, and their claims were supported by an informant and blood tests. They were all men who had sustained a close relationship. Most importantly, however, the period between moving out of problem drinking and resuming limited drinking was punctuated by some three to five years of abstinence; two had achieved this with disulfiram. The doctor's advice to patients recovering from delirium tremens must be abstinence.

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Assessing clinical competence

Need for improvement

Licensing agencies and the public are much concerned with assessing the competence of doctors.[1] But the methods that are widely used to assess competence are largely outdated. Better methods are available, and bodies responsible for both undergraduate and postgraduate education need to use them.

The essential skills required for a doctor are generally agreed and include establishing a rapport with patients; eliciting accurate information about patients' problems and establishing the patients' reactions to them; conducting an examination of physical and mental state; selecting and interpreting investigations; showing diagnostic ability; undertaking education, reassurance, and counselling of patients; and managing patients in the immediate and long term. The problem is how best to determine the required level of competence in each area and assess it.

The notion of how well a newly qualified doctor should be able to perform constitutes minimum competence. This can be determined by asking experienced and recently qualified doctors to identify the problems they meet commonly and those they meet less often but must manage effectively if disasters are to be avoided. The required skills can then be made explicit.[2] An analysis of critical incidents (in which skills are needed to their fullest extent) and of examples of good and bad practice as judged by both doctors and patients may also help identify skills.[3] With checklists of essential skills assessors would know what they are looking for.

Traditionally assessment has relied on written tests and clinical examinations, but doubts have been cast on their validity and reliability. Performance on multiple choice questions and patient management problems correlates poorly with ratings of ability by clinical instructors. Scores on standard clinical examinations relate poorly to interviewing and observational skills,[4] and measures of psychosocial attitudes and perceived competence are no substitute for proved ability.[5] These methods provide indirect measures of performance and probably tap different skills.

The objective structured clinical examination has been introduced to assess essential clinical skills.[6,7] Typically clinical students must attend a series of stations. At each station they are given an explicit task such as eliciting key information, examining a system of the body, suggesting and interpreting investigations, educating the patient about his or her condition and treatment, and advising on further management.

Examiners use a previously agreed checklist to judge performance. Concurrent written exercises using multiple

choice questions, patient management problems, or modified essay questions can help assess competence. They should cover a broad range of skills and use materials such as radiographs, electrocardiograms, and videotapes. Each item should be audited for its clinical relevance.[8]

Despite these systematic approaches assessors achieve least agreement on interviewing skills and physical examination. More reliable results are obtained from using patient simulators when the students' performance is rated by simulators and non-clinical raters.[9] This method is no costlier than traditional approaches and allows students to be given detailed feedback on their strengths and weaknesses. Student numbers and time constrain, however, the range of clinical problems and skills that can be assessed and the depth of the assessment.

More detailed and direct audit of skills may be achieved by asking students to interview and examine carefully selected real or simulated patients and then recording their performance on audio or videotape. The students may then be assessed with agreed rating scales by raters selected for their consistency and for their ability to discriminate between competent and incompetent students.[7] Observation skills may be tested by videotapes, which have the advantage that they may cover both acute and less common illnesses and may be standardised.[9]

It is worth going to this effort because students' patterns of learning are heavily influenced by the content and method of their examinations.[10] A greater emphasis on essential skills will thus motivate students to ensure that they acquire them. It also encourages teachers to change their teaching so that key skills are adequately covered. Unfortunately current methods encourage students to adopt a "surface" rather than an "understanding" approach to learning and emphasise facts rather than skills. So it is not surprising that experienced doctors lack key interviewing skills.[11]

Assessing undergraduates is difficult, but assessing postgraduates is even more fraught. The royal colleges could, however, do much to emphasise the importance of key skills by insisting on a minimal degree of competence. They could then ensure that this is reached by independent and direct observation and rating of trainees during postgraduate training.

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The importance of hospital domestics

Valued by patients but undervalued by the government

Every patient knows the value of ordinary human contact during a spell in hospital. A joke with the porter or a kind word from the domestic may be far more reassuring than the pronouncements of the professionals. A welcome reminder of everyday life, they provide an opportunity to be yourself instead of a number. Relatives as well as patients often find it easier to ask ancillary workers for information or advice, and junior nurses and doctors also turn to them on the quiet; as a student nurse recently put it, "they have been there for years, they know how sister likes it done."[1] Now the importance of domestics has been confirmed by a study sponsored by the Economic and Social Research Council.[2]

Researcher Dr Elizabeth Hart spent six months as a cleaner in a large teaching hospital and observed that the work of domestics "plays a vital informal part in patient care." Her coworkers derived considerable satisfaction from this caring role. Many of them had far closer contact with patients than the job technically required, and those who worked continuously in the same setting developed a feeling of responsibility for "their wards."

This commitment is, however, rarely acknowledged, like the labours of all those underpaid and mostly invisible staff who service patients and professionals, maintain the wards and other areas, and keep the NHS machine ticking over. Predictably, most cleaners are women, including a disproportionate number from ethnic minorities. They come to public notice only during pay disputes, when they are usually characterised as greedy militants; yet the average cleaner's take home pay recorded by Hart was £68 a week, including weekend work.

This study records the domestics' commitment and pride in their work and their importance in establishing a congenial as well as clean environment for patient care. Disturbingly, however, Hart also finds evidence of mounting discontent, reflected in the fact that many hospitals have great difficulty in recruiting ancillary staff. "The women felt disillusioned and demoralised," she reports. Low morale was compounded by their fears about the future, amid an atmosphere of uncertainty that they thought arose from long term changes in the nature and organisation of their work.

These changes hinge on two main developments. One is the sharpening of the distinction between nursing and household duties over the past two decades; this has tended to deprive domestics of the legitimate patient contact they have hitherto enjoyed. The other threatening development is privatisation. As Hart points out, contracting out domestic services has led to still worse pay and conditions; and by cutting hours and fragmenting the workforce privatisation has helped to destroy the domestic's commitment to "her ward" and her main source of job satisfaction. This in turn deprives patients and professionals of her human touch. It is a classic example of the consequences of putting cost before quality.

Several conclusions may be drawn from the study. Better pay and more flexible conditions are essential to end exploitation and help the recruitment of domestics. The government should also reconsider its insistence on privatisation in the