the wires or splints to break the regimen. Thus they do not achieve the desired weight reduction and are failures.

The technique of dental splintage, though by no means inexpensive, is cheaper than therapeutic starvation, as inpatient care is avoided and minimum time is lost from work.

GASTRIC BYPASS

Polya partial gastrectomy can cause substantial weight loss by drastically reducing the gastric reservoir and by causing "dumping." These complications have been used to treat massively obese patients by 90% gastric exclusion using either transection with gastrojejunostomy or gastroplasty. The results in two series have been satisfactory but it is technically more difficult in these huge patients than small-bowel bypass and thus is less popular with surgeons.

SMALL-BOWEL BYPASS

Massive small-bowel resection after mesenteric vascular catastrophe is compatible with survival, albeit with a variable amount of nutritional support. A modification of this surgical emergency has been applied to the management of gross refractory obesity in the form of small-bowel bypass without resection. The duodenum and upper jejunum are retained "in circuit" for the absorption of iron, folate, and carbohydrate, and the terminal ileum for vitamin B_{12} and bile salt absorption. The absorption of fat and, to a less extent protein, is reduced by excluding much of the jejunum and most of the ileum.

Weight reduction after bypass amounts, on average, to about 36% of the original body weight. Some have lost as much as half their weight and a few very little. The latter may be caused by early resumption of voracious eating habits, slow small-bowel transit time, or insufficient bypass. Patients under 30 lose more weight than those over 50, and men lose more than women.

As this is a major operation in patients who are by definition bad risks, it might be expected that there would be a high operative or late mortality. The operative death rate is, however, surprisingly low—in the region of 1-1·5%. The late mortality, attributable largely to the metabolic effects of malabsorption, is 3-4%. There are additional risks, which all obese patients carry, of myocardial infarction and thromboembolic disease, which would occur whether or not any operation was performed.

About half the patients have some form of long-term morbidity. Diarrhoea initially is troublesome but may be adequately controlled with codeine phosphate after a few weeks or months. During this period haemorrhoids may be a nuisance. Foul flatus affects some and may be embarrassing; it is usually readily controlled with metronidazole or tetracycline in short courses repeated as necessary. Abdominal distension after meals is also not uncommon and is due to gaseous pseudo-obstruction of the colon. It too can usually be controlled with the same antibiotics.

During the first months, nausea and vomiting may be a problem requiring antiemetics. It usually settles spontaneously, but when accompanied by excessive diarrhoea may require admission to hospital for two or three days of intravenous fluid and electrolyte repletion.

A puzzling complication in a few cases has been polyarthralgia, often affecting the small joints, and polymyalgia. In our experience these problems often settle with co-trimoxazole treatment but in two patients it has been necessary to reverse the operation because they proved resistant to all treatment. The restoration of normal bowel circuitary instantly eliminated the symptoms.

The main complication, and the only serious one, is fatty liver. Ninety per cent of these patients have fatty infiltration of the liver preoperatively, but in almost half this may increase during the first year or two before regressing. During this period a few develop symptoms and signs of fatty liver (anorexia, nausea, and profound lethargy together with enlargement of the liver). Such patients require admission to hospital for parenteral nutrition and elemental diet. Failure to respond may necessitate reversal of the bypass, for this complication is the main cause of death. There is also a low incidence of cirrhosis.

The morbidity of small-bowel bypass has been stressed to emphasise that this procedure should not be considered lightly as the easy way out or as "the answer to the fatties' prayer." Equally, it must be recognised that most patients do extremely well, benefiting physically, psychiatrically, socially, and economically. The hazards mentioned may be reduced by better case selection, eliminating all patients with known heart disease, low intelligence, severe psychiatric disturbance, and alcoholism. But as the operation still remains to be evaluated in the long term it should be performed only on those who are in danger of succumbing to the complications of obesity.

Copies of diet sheets are available on request from Dr Bennett.

Letter from . . . Denmark

After the dispute

FLEMMING FRØLUND

British Medical Journal, 1976, **2**, 1055-1056

Six months ago[1] I wrote about how general practitioners in Denmark took the unusual step of resigning from our health service. Traditionally, renewal of the contract between the GPs and the service has been considered more or less routine, but, to general consternation, things went wrong during the negotiations last autumn—remuneration and the doctor:patient ratio being the most contentious issues.

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FLEMMING FRØLUND, MD, general practitioner

The dispute became official from 1 December, but, though this could be described as "industrial action" on the part of the doctors, it had nothing in common with a strike. Patients and doctors continued their time-honoured symbiosis much the same as before. Patients paid fees, but were later fully reimbursed by the health service. Many of the older patients stayed away, probably because they were uncertain about the new (and temporary) conditions and preferred to wait and see. It seems, as always, that it is the weak and innocent who suffer when major disagreements arise between groups in society.

The dispute lasted for four months: on 1 April a new contract came into effect and work in the surgery returned to normal. Disputes such as these are not only irritating but also seem unreasonable and pointless among civilised people. All the same, these slightly uncivilised conditions for a time may have been useful shock treatment for all concerned. We have all learnt that

those things that for a long time have been taken for granted may quite easily and quickly fall to pieces. Too often people appreciate what they have only when they lose it.

New contract

The new contract resembles the old one in most respects. One difference is that the health service now has some influence on the size of a doctor's practice, and on where he is allowed to practise. There has been a high output of medical graduates in recent years, which has led to a considerable increase in the number of general practitioners. So it has been necessary to regulate the distribution of doctors so that desirable areas do not become overpopulated while unattractive parts of the country have too few doctors.

Another difference is the introduction of separate payment by the health service for family planning advice. In the past patients have had to pay for such advice themselves, unless they chose to visit a public family planning clinic—most patients preferred to see their own doctors for advice, even if they had to pay. In return, many doctors chose to give the advice as part of ordinary medical care, and without charging anything. When advice was sought about the pill it was especially difficult to overlook the fact that the advice (and the follow-up) was nothing less than large-scale long-term drug treatment given to essentially healthy women. Family planning, however, has now been officially accepted as a normal part of medical care to which people have a right. One reason for this change in attitude has undoubtedly been the somewhat alarming rise in legal abortions since the introduction of a liberal abortion Act a few years ago. We hope that the new arrangement will result in fewer induced abortions.

Who, in the end, won the dispute between the GPs and the Health Service? Perhaps good old-fashioned common sense.

New Act

On 1 April a new Act was promulgated which provides for improved public assistance to everybody with social or medico-social difficulties. The Danish Health Service now resembles the British system with a synthesis of medical care and social services brought together under one roof, but administered locally. For the individual doctor the new arrangement means a much greater degree of formalised co-operation with the social services. For the patient it may well be an important step forward: it will no longer be necessary to rush round from one office to another to sort out the different aspects of what the welfare services have to offer.

But there are still some doubts abroad. As always, good intentions may not work in practice, and some doctors feel that it may simply give them more work, for it is hard to see how their usual work load could diminish. Some patients, too, may feel overwhelmed by this new superstructure and the apparently greater State control over the individual. Ultimately it is the patients' verdict of the new system that matters most. They are the consumers for whose benefit a system exists.

Reference

[1] Frølund, F, *British Medical Journal*, 1976 **1**, 387.

Contemporary Themes

Experiment in managing sociopathic behaviour disorders

MOYA WOODSIDE, ALAN HARROW, JOHN V BASSON, JAMES W AFFLECK

British Medical Journal, 1976, **2**, 1056-1059

Summary

A ward catering for both sexes admitted patients with aggressive, suicidal, or otherwise disturbed behaviour for observation and treatment until decisions could be made about their long-term needs. Patients were referred from the police, special hospitals, and the courts and some were transferred from other wards in the hospital. A third of the first 100 patients were admitted for forensic reasons. Twelve inmates were discharged to long-term accommodation for disturbed patients. The ward was intended to provide fairly short-term accommodation, though no time limits were set, and it was run as a medium secure unit. The ward was run by 16-18 nurses with support from medical teams, occupational therapists, and clinical psychologists. It has secured its status as a special unit within the hospital and will continue with the active support of the hospital staff.

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Introduction

The confusion that has arisen in the mental health services has resulted in a reduction of facilities for patients with sociopathic behaviour disorders to below the basic requirements. This has led to increasing overcrowding in the special hospitals, inappropriate prison committals, vagrancy, and lack of treatment. It has been suggested[1] that psychiatric hospitals are losing the skills needed to look after really difficult patients. Bowden[2] pointed out that the complete absence of suitable facilities in 40% of the mental hospitals within one region, coupled with the planned inability of district general hospital units to deal with disturbed patients, has resulted in the concentration of the