subheadings, so that all the drugs of similar action were to be found together. The anti-depressives are a case in point. Instead of all antidepressives being listed alphabetically, as in *MIMS*, *Medindex* classified them into monoamine oxidase inhibitors, thymoleptics, and others. Other useful sections were the paragraphs of indications and safety factors at the beginning of each section, and the index of official and other approved names.

I am sure there must be many general practitioners who regret the passing of *Medindex* as much as I do. I have written to the publishers asking them to reinstate it, and if we were all to do the same perhaps they would publish it again.—I am, etc.,

Maudeley,
Shropshire.

J. B. METCALFE.

Families in Flats

SIR,—I apologize for the delay, due to time and distance factors, in writing to comment on your leading article (18 November, p. 376) and Wing Commander Desmond M. Fanning's excellent paper on families in flats (18 November, p. 382).

I was an Army medical officer of health in Germany at that particular time with responsibilities for the health of all military families, other than R.A.F. dependants, in that same area.

You say that Wing Commander Fanning "provided an adequate control group and he was able to eliminate the major variables." On the evidence available this is not quite true, since he compares a total of 672 flat dwellers with a maximum figure of 162 house inhabitants—that is, a ratio of more than 4:1. The "first consultation rate" is affected by factors imposed by the patient, and if flat dwellers were less happy with their lot than house dwellers they would tend to visit the doctor's surgery more frequently for minor ailments.

There are other factors not mentioned which might vary between the two groups unless measures were taken to exclude these variables. Spread of respiratory infections in a house or flat may be affected by central heating. In Germany hot-water radiators are in general use, and this system dries the atmosphere and facilitates spread of respiratory infections. The degree of heating can also vary from one flat or house to another, as does the location of heating units. Variation in place of contact and closeness of contact of members of a family would occur from one living unit to another.

A vitally important factor not mentioned is the degree and quality of maternal care, with particular reference to children in the 0 to 5 age group. Service mothers living outside the United Kingdom are divorced from grandparents and close relations and friends. Also there are many social and other distractions which take parents out of the home frequently. Many mothers in this particular social class need the support of others in managing their families, and while our health visitors can and do excellent work in this respect they can only spend a relatively small amount of time with each family.

There is no proof that variation exists in respect of the above-mentioned factors between flat and house dwellers. However, these and other environmental and personal

health factors should be considered in future prospective cohort studies. We owe a debt to Wing Commander Fanning for starting the ball rolling. It is up to others to further research into this important field of public health.

Here in Hong Kong most of our military families live in multiple flats, six to fifteen storeys high. There is some evidence to support Wing Commander Fanning's views on morbidity, with particular reference to the neuroses. There are of course additional factors which do not occur in Germany—for example, extreme summer heat and humidity, relatively cold winters, lack of open space and recreational facilities in some instances, and noise factors. So few families live in houses that comparative studies are not possible, but sufficient evidence is available to suggest that as a way of life flat-dwelling is very different from house-dwelling, and that many families do not readily adapt to the change.—I am, etc.,

Hong Kong.

J. G. P. POWER.

Human Tissue Act

SIR,—The Automobile Association is to be congratulated on the initiative shown in an issue of *Drive*¹ in encouraging the donation of human tissue for organ transplantation. But unfortunately the law has been misinterpreted in two important respects. Under the Human Tissue Act 1961, which lays down the methods by which parts of a body may be made available for therapeutic purposes or for purposes of medical education or research, the person lawfully in possession of the body may authorize the removal of a part of the body if the deceased, either in writing at any time or orally in the presence of two or more witnesses during his last illness, made (and did not withdraw) a request that his body or a specified part of it should be used for one of the stated purposes. The Medical Defence Union has been advised by leading counsel that, save in the exceptional case, the hospital where a patient died is not lawfully in possession of the body for the purposes of the Act. On the contrary it is the executors or the close family—for example the spouse, if any, or children of the deceased—who must authorize the removal, and they may veto the wishes of the deceased if they choose. The hospital has no power to authorize it. Furthermore, every road-traffic death must be the subject of an inquest, and the Act specifically lays down that in such a case there shall be no removal of any part of the body without the prior consent of the coroner. When the deceased has not expressed the wish that his body should be used the procedure under the Act can be even more difficult to operate.

The Medical Defence Union, although fully aware of the reservations mentioned in Lord Brock's profound review in *The Times*,² believes that the advance in medical knowledge and techniques during the past seven years makes it urgently necessary for the Human Tissue Act to be looked at again.—I am, etc.,

PHILIP H. ADDISON.

Secretary, Medical Defence Union.

London W.C.1.

REFERENCES

- ¹ *Drive*, No. 4, New Year, 1968.
- ² *The Times*, February, 1968.

Ambulance Services

SIR,—I was interested in the excellent study of the ambulance services in the Portsmouth district by Mr. W. N. F. Boughey (10 February, p. 369). May I add a few remarks on two aspects of the subject?

The ambulance itself is often unsatisfactory, as Mr. Boughey himself suggests. If any of your readers have had acute peritonitis and have then been tightly strapped on to a 2 ft. (60 cm.) wide wooden shelf in an ambulance body inadequately bolted on to an old Bedford chassis (as I have), they will need little convincing that the ensuing journey may contribute to the death of the patient. It is true that many modern ambulances have good points, but most are unnecessarily large and costly. Mr. Boughey makes the point that the ambulance crew cannot deal efficiently with more than one seriously ill or injured patient at a time. There is therefore little object in having space for two or more stretchers. Standard models such as the Citroën "Safari" estate car require little modification to accommodate one stretcher and attendant and one relative, while their suspension system is superb.

The other point is the training of the ambulance driver. The idea of "rushing the patient to hospital" still survives and is much more likely to be lethal than life-saving except in the rare cases of uncontrollable bleeding. While fluid flywheels and torque converters help in avoiding jerky starts, much can be done with skilled use of an ordinary clutch, and gentle braking should be inculcated. I believe that smoothness is far more important than speed. There is a legend that Sir Henry Royce kept a store of empty hunter watch cases at his works at Derby. A tester had to snap an open watch case shut by driving a front wheel on to it without bending the metal before the chassis could be delivered to the coachbuilders. What wonderful ambulance drivers those testers would have made!—I am, etc.,

London N.6

C. LANGTON HEWER.

Stature and Personality

SIR,—It is traditional to refer to Napoleon as a little man seeking to prove to the world that he was a big one, as Professor Martin Roth does (3 February, p. 309). But the belief rests on a misconception, or rather on a mistranslation. Capable observers of men, the sailors Captain Meynell and Captain Maitland, of the *Bellerophon*, and a soldier, Major-General Sir Henry Bunbury, estimated his height when he was alive at from 5 ft. 5 in. (1.65 m.) to 5 ft. 7 in. (1.70 m.); and after his death Antommarchi by actual measurement made it 5 pieds, 2 pouces, 4 lignes, which is 5 ft. 6 in. (1.68 m.). The unit measurement in France at the time, the *pied de roi*, was divided into 12 pouces, each of 12 lignes, and it added up to 0.324 of a metre, compared with the 0.305 of the *pied anglais*, the English foot. This difference accounts for the low estimates of his height in English translations of the writings of his valet, Constant, his secretary, Baron Fain, and others. Mulhall's *Dictionary of Statistics* (1891) gives the average height of a French adult male in the nineteenth century as 5 ft. 5 in. (1.65 m.), and that of an Englishman as 5 ft. 7½ in. (1.71 m.).

Napoleon therefore seems to have been above the average height for a Frenchman, but, whatever may have been his true height, it is clear that he never in the least resembled the familiar figure of the little "cock-sparrow" who compensates for his small stature by blustering self-assurance and an aggressive bullying manner, from whom many of us must have suffered. From his first emergence into European history Napoleon effortlessly dominated the scene, whether on the parade ground, the battlefield, or in a court—his own or that of a real hereditary monarch. We must look deeper for the influences which may have contributed to his aggressive egocentric personality, but this letter would be too long if I attempted to summarize some of those which I think could have been responsible.—I am, etc.,

Edinburgh.

FRANK RICHARDSON.

Pay-beds in N.H.S. Hospitals

SIR,—I have every sympathy with Mr. Reginald Murley's protest (17 February, p. 449) about the reduction in pay-beds at the Royal Northern Hospital. Both the Joint Consultants Committee and the B.M.A. have protested with the utmost vigour, both in writing and orally, to the Ministry of Health about this particular reduction, which we think is unjustifiably harsh and ought to be reconsidered. Every possible argument has been put forward, including two memoranda prepared by the medical staff committee of the hospital, and the fight is still on.

But why does Mr. Murley turn his wrath against the B.M.A.? The negotiations about pay-beds have been conducted by the Joint Consultants Committee, on which the Royal Colleges have more seats than the B.M.A.; and if Mr. Murley wants to express his feelings by resigning from something he ought to resign his Fellowship of the Royal College of Surgeons rather than his membership of the B.M.A. Neither gesture would have the slightest effect upon the Ministry of Health, and both would be equally futile. The Joint Consultants Committee has protested strongly to the Ministry of Health about the scale of the recent pay-bed reductions in the case of every region, including of course the North-west Metropolitan Region. It must not be overlooked that many members of the present party in power at Westminster would like to see pay-beds abolished altogether, and some people might think that the preservation of three-quarters of the pay-beds from closure is, in present circumstances, no small feat by the Joint Consultants Committee.

I am sorry to hear that Mr. Murley and his colleagues were consulted only perfunctorily by the hospital authorities. It is perhaps worth mentioning that the regional committees for hospital medical services were given full details by the B.M.A. (on 9 February 1966) of the Minister's proposals, and were urged to take a close interest in the regional reviews of pay-bed occupancy—advice which was repeated on 23 June 1966. In addition, the chairman of the Joint Consultants Committee wrote to all consultants in January 1967 and told them what was going on.—I am, etc.,

H. H. LANGSTON,
Chairman, Central Committee for
Hospital Medical Services.

London W.C.1.

Future of the B.M.A.

SIR,—I am deeply disturbed by the Council's published intention (*Supplement*, 20 January, p. 9) to raise the subscription to 20 guineas in the near future, and I would like to warn the Council of the harm that this will do to the Association membership. Resignations would be submitted in large numbers.

Surely common sense must call for an agonizing reappraisal of the expenditure of the Association. The plethora of committees—and the outflow of travelling, subsistence, and entertainment moneys thereby—must be pruned. In my view the time has come for the Association to drop all academic and pseudo-academic exercises: these are now superfluous owing to the growth of the colleges, institutes, and the rapid spread of postgraduate centres over the whole country. The Association must concentrate upon the welfare and future requirements of the profession and the Health Service if the Association is to survive the second half of the twentieth century.—I am, etc.,

Welwyn Garden City, GORDON F. CASSIE.
Herts.

Common Weal

SIR,—Our profession was much—perhaps too much—in the public eye in the past few years in its successful attempt to secure a more equitable method of remuneration. We are now in the midst of another financial crisis—the worst and, one hopes, the last of the series—and it seems to me and to thousands of doctors who feel as I do that our profession has a part to play in supporting the nation's welfare. This surely is a time for professional bodies to forget their narrow self-interest, and, in the old classic term, to work for the common weal.

I strongly suggest, therefore, that the Council of the B.M.A. and all the medical bodies who contribute to the membership of the Negotiating Body should instruct them without further ado to request the Review Body that the present three-year period be extended to four, and that this extra year be considered a non-year regarding any increment of salary. In other words, there would be a salary standstill for one year. I feel sure that the great majority of our profession would agree to this as a matter in the national interest and one where we could show an example to other sectional interests.

This should be done immediately on the authority of these executive bodies, who would seek approval for their actions at the B.M.A. Annual General Meeting and the Annual Meeting of the Local Medical Committees. A reference back to the whole profession and a further public wrangle about this matter would be very unseemly and unnecessary.—I am, etc.,

ALASTAIR U. MACKINNON.

Leeds, Yorkshire.

Prescription Charges

SIR,—It would seem that, however implemented, the new prescription charges will cause a lot of extra work. This is work which should be done by administrators rather than by doctors, and this could be arranged in the majority of cases by requiring

that all persons who believe that they will be eligible for exemption from the charge should send their medical cards to the executive council (or Ministry of Social Security), where it may be endorsed to signify exemption. All that would be necessary then would be for the patient to show this card at the chemist when collecting medicines—or at the doctor's, when a different E.C.10 could be used—to claim exemption from charge. This method might have the added effect of making patients find their medical cards and do something active towards claiming their rights. I admit that in the case of "chronic sick" a doctor's note might be required by the administrators before endorsing the medical card.

A coincident measure with the reintroduction of charges should be the ruling that no prescription for more than one month's supply at the stated dosage can be issued, but that N.H.S. prescriptions on E.C.10 can be repeated a stated number of times (to be chargeable each time). This would avoid the inevitable request from the non-chronic "chronic," who will surely demand "a really big bottle of my linctus" or "a year's supply of my slimming pills" to keep their costs down.—I am, etc.,

Droitwich Spa,
Worcs.

R. M. PEBERDY.

Hospital Polypharmacy

SIR,—The following is the final paragraph of a discharge report from a hospital, recently received:

"She has now been returned to your care on a 120-g. carbohydrate diet; lente insulin 24 units daily; nicotinic acid, 25 mg. b.d.; Lipoflavonoid 2 capsules t.d.s.; ferrous sulphate, 200 mg. t.d.s.; Doloxene [propoxyphene], 1 cap. q.d.s.; vitamin C 100 mg. t.d.s."

I don't know what proportion of her husband's income the 2s. 6d. per item will amount to, but in the fringe-group incomes such an array of items may well mean shortages of essentials to other members of the family. If this sort of thing goes on it is going to bring hospital medicine into disrepute with those who practise "domestic medicine" and ultimately with the general population. Alternatively perhaps one could let up on the propaganda against using preparations containing more than one active pharmaceutical substance.

Oh for the old-fashioned bottle of medicine, which, if it didn't cure everything, at least kept many patients contented and allowed most of them to cure themselves!—I am, etc.,

Morpeth,
Northumberland.

G. B. STENHOUSE.

Skills Needed in General Practice

SIR,—Dr. C. D. Falconer has found (*Supplement*, 27 January, p. 21) that the general practitioners' commonest complaint is that they are not in fact practising the skills for which they were trained. Would it not be more to the point if they complained that they were not trained for the skills which they needed in their present work?—I am, etc.,

Newick, Sussex.

F. GRAY.