sense." Having seen something of the miserable existence led by some of these poor little people and their families from operation to operation, in and out of hospital like shuttlecocks, with little hope of anything better in the future, we are shocked at the apparent lack of imagination on the part of the committee which can think that this constitutes "the child's best interests."

If there are important matters of fact, such as the probable duration of life if untreated, which have not been disclosed, affecting the decision reached in this case, there must be many like ourselves who would be only too relieved to know them. If not, then this is a terrifying example of the idea that if a thing can be done, this is a good enough reason for doing it.

The medical profession has surely lost its way when wisdom and compassion are replaced by cleverness and technology.—We are, etc.,

GORDON SHARPE
UNA M. KROLL
TOM WILLIAMSON
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London S.W.19

SIR,—The Hull case discussed in your leading article (9 December, p. 567) substantiates one's fears that society (as represented in this case by consultants, court, and social services committee) is determined to enforce the theory that medical interference is always preferable to laissez faire. And this in disregard of the persons most intimately involved—the patients.

Is this not another instance of an unthinking adulation of the therapeutic principle, exemplified in hundreds of cases daily, especially among geriatric patients? This principle could be summarized as—"If you can, you must." It is time it was pointed out that the ability to do so does not automatically give the right to interfere with the processes of nature.—I am, etc.,

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Barbiturates and Methyldopa Metabolism

SIR,—In 1971 Káldor *et al.*¹ reported a study which showed that a false increase in serum catecholamine induced by the administration of methyldopa could be reduced by the simultaneous administration of phenobarbitone. Taking the catecholamine level as an indicator of the methyldopa level, they suggested that methyldopa metabolism may be accelerated by barbiturates through enzyme induction.

We have therefore studied the levels of methyldopa in the blood of five hypertensive patients before and during treatment with phenobarbitone. The patients were treated with methyldopa for at least 14 days before the investigation started. The concentrations of α -methyldopa and its metabolite α -methyldopa-O-sulphate were estimated by a modification of the methods described by Sjoerdsma *et al.*² and Schlossmann *et al.*³ The blood specimens were taken two hours after an oral dose of methyldopa given after an overnight fast. Three specimens were taken on three different days before and

during phenobarbitone intake. During the whole study the patients received their usual dosage of methyldopa ranging from 750 to 1,500 mg daily divided in three doses; 100 mg of phenobarbitone was given by mouth each afternoon for an average of seven days.

The results are shown in the figure. In four of the patients no reduction of the

Effect of Phenobarbitone on Serum Methyldopa Concentrations.

■ = concentration of α -methyldopa.
□ = concentration of α -methyldopa-O-sulphate.
— indicates concentration of α -methyldopa-O-sulphate as percentage of total $\div 10$.
The arrow indicates the day of starting phenobarbitone administration.

total concentration of methyldopa was seen after phenobarbitone treatment was started. In one patient (case 1) a slight reduction occurred, but in all the patients the ratio of conjugated methyldopa to methyldopa was constant during the whole period. This preliminary investigation thus does not support the view of Káldor *et al.*¹ that phenobarbitone induces the enzyme system which conjugates methyldopa in the liver, and we feel that the levels of catecholamines in the blood are not a good indicator of the methyldopa concentration.—We are, etc.,

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- 1 Káldor, A., Juvancz, P., Demeczky, M., Sebestyén, K., and Palotas, J., *British Medical Journal*, 1971, 3, 518.
- 2 Sjoerdsma, A., Vendsalu, A., and Engelman, K., *Circulation*, 1963, 28, 492.
- 3 Schlossmann, K., Bock, K. D., and Kronenberg, G., *Klinische Wochenschrift*, 1964, 42, 440.

How Many Acute Beds Do We Really Need?

SIR,—In his paper Mr. M. Wheeler (28 October, p. 220) warns us that "any conclusion from such incomplete evidence must be tentative." He is wise to do so, but he

then goes too far when he says the results of his survey are "auspicious" not only for West Suffolk but for "the hospital service as a whole." In these days, when it is fashionable for bureaucrats to translate the tentative conclusions of reports into dogma before the ink is dry, it is essential to have all the evidence before decisions of great consequence are taken across the country.

While the article may be expected to receive an official accolade, other unhappy East Anglians who find their present 2.7 acute beds per 1,000 population so inadequate as to constitute a recurring misery for patients and staff alike, and who have been directed, despite protest, to work to a future norm of 2.0 per 1,000, should warn others about to be similarly coerced not to accept the claim by Mr. Wheeler for these paragons in West Suffolk. Why did he not quote the population for the Bury catchment area, and why did he base much of his case on Hospital In-Patient Inquiry sources known to be unreliable?

The startling realization that some mental patients may continue to need some form of custodial care if they are not to break their families or get into prison has at last begun to dawn in the sepulchres of bureaucracy. But the damage done to the reputation of those who have for years peddled the opposite view is, we fear, irreparable. It seems that we are about to witness a comparable error in the sanctification of that current *religio*, "community care," which we have been told to swallow like good children because it will save costly acute beds. We are assured fervently that patients will be happier and much more humanely treated in their own homes and that such care will be cheaper without reduction in quality. We wonder.

For some years we have been asking to be shown the results of the costing of a paper exercise of such a scheme, and then a properly conducted pilot scheme, not only in places like Bury St. Edmunds, where some consultants have appointments at other hospitals and where some patients are referred to neighbouring hospital groups, but in areas more representative of the country as a whole. Until properly conducted costing exercises are carried out we suggest that the provision of preconvalescent care to patients in their homes will require at least 33% more in money and personnel than at present in hospital and convalescent homes, and that the quality of care will be inferior. And the reason is that the provision of meals, unskilled attendance in the absence of relatives, medical and nursing care, and physiotherapy and occupational therapy in the individual home will involve a vast amount of time on the road between each unit of attendance, to which must be added the packing and unpacking of equipment in inconvenient and unfamiliar surroundings.

And lastly, if some fairy godmother did provide the extra money, what is the likelihood of the required numbers of adequately trained personnel becoming available? This latest example of feckless planning is to be imposed on us without the elementary safeguards of costing, which any other enterprise than a state monopoly would regard as imperative.—We are, etc.,

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J. P. HUGHES

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