	Population (thousands)	Expenditure (thousand £s)	% Variation from National Average for Provision of Beds per Capita									
			Total	General Medicine	General Surgery	Trauma/ Orthopaedic	Mental Illness	Mental Handicap	Maternity	Maternity (adjusted)	Geriatric	Geriatric (adjusted)
Lewisham, Southwark, Lambeth, A.H.A.(T.)	768	28 156	−07	102	47	06	−71	−98	06	−05	−17	−29
Bromley	305	7227	−35	30	16	−20	−93	−91	32	28	07	11
Greenwich, Bexley ..	434	11 929	11	40	07	−21	54	−81	37	35	−19	−14
Kent	1462	34 803	03	−17	−14	−13	−03	81	−07	00	02	−03
East Sussex	647	15 683	−19	−19	−06	−37	−41	−36	−47	−29	28	−29

and Mr. Klein this is only exceeded by Liverpool. The disproportion is emphasized in hospital expenditure, where the A.H.A.(T.) has 21% of the region's population but consumes 29% of resources.

A point requiring caution in interpretation of these data, not previously mentioned, is that the population size of each area has a weighting effect. For example, the percentage difference from the national average in provision of mental handicap beds in Kent is +81, and in Greenwich and Bexley it is −81. However, the Kent population is 3·36 times that of Greenwich and Bexley, and in real terms Kent has +1470 beds and Greenwich and Bexley −429.

I would support the suggestion that the D.H.S.S. eventually publish details of the distribution of resources by A.H.A.s, including community and general practitioner services where possible. Until then one would hope for the fullest co-operation from regional information departments in assisting independent researchers.—I am, etc.,

M. J. McCarthy

Preston Hall Hospital,
Maidstone, Kent

Sir,—Mr. M. J. Buxton and Mr. R. E. Klein (8 February, p. 345) correctly point out the difficulties in the precise measurement of the health needs of a population. Since infectious diseases have become less of a problem mortality has ceased to be such a sensitive indicator of the health status of populations. Techniques for measuring need, however, should not be dismissed since increasingly morbidity information is being obtained in surveys direct from representative samples of household respondents.

The General Household Survey[1] is an example in which methods of this type to measure health need are being perfected. Admittedly validation of such information against medical diagnosis will be required. However, it will provide an essential and practical first step in attempting to match resources to health needs in particular populations.—I am, etc.,

D. P. Forster

Department of Community Medicine,
University of Sheffield Medical School,
Sheffield

1 Office of Population Censuses and Surveys: Social Survey Division, *The General Household Survey. Introductory Report.* London, H.M.S.O., 1973.

Surgery in Rhodesia

Sir,—Dr. W. O. O. Sangala (1 March, p. 516) is not quite fair in making a racial issue out of Professor L. F. Levy's Personal View (18 January, p. 147). The latter indicated that selection should be exercised in deciding whether to perform shunting operations on patients with hydrocephalus living far away from Salisbury. The "exotic" operation concerned involves close postoperative supervision. Distance, not indigence, is the main obstacle to successful follow-up.

Professor Levy is not "resigned" to different standards of surgical treatment according to income but aims to provide the maximum benefit for every patient, which depends largely on the geographical situation of the patient's home.—I am, etc.,

S. V. Humphries

Malaga, Spain

Specialists in Community Medicine

Sir,—While I do not entirely accept the specific case made by Mr. A. F. Pentecost (8 February, p. 330, and 15 March, p. 629) I believe that he has drawn attention to an important principle—namely, that doctors should be employed only to do work that requires medical qualifications. I seriously doubt the need to employ community medicine specialists, or for that matter nurses, on capital building and on medical staffing, and I was dismayed to see in a recent advertisement that one area proposed to appoint its seventh specialist in community medicine. For many years the more progressive of the former county health departments demonstrated the success of a policy of reducing the number of doctors employed in administration and using non-medically qualified administrators in their stead, resulting in economies and, dare I say, improved efficiency. This lesson appears to have been overlooked in the course of the present reorganization, and I believe it is vitally important that community physicians are properly supported by high-calibre administrative and clerical staff, thus freeing them for their proper work. There are, for example, suggestions at present that additional community physicians should be appointed at district level, but from my experience of a moderate-sized district I believe that the work load can be contained, always provided that the necessary administrative support is given and community physicians are not, as I believe many are at present, expected to work with the assistance of only a personal secretary.

There has been some confusion concerning nomenclature and may I point out to Mr. Pentecost that the term community physician is generic and applies to all those working in community medicine. Specialists in community medicine, not community health specialists, are the doctors to whom he has referred and are those working at area and regional level in addition to the area and regional medical officers themselves.—I am, etc.,

D. G. H. Patey

Bury St. Edmunds Health District,
Bury St. Edmunds, Suffolk

Geriatric Chairs

Sir,—In February 1829 a young male patient at the Lincoln Asylum was accidentally strangled by a strait jacket. He had been left in the jacket overnight and found dead in the morning. This incident was one which led to the abolition of physicial restraint within the hospital. The non-restraint movement became national, and in the 1840s it was acknowledged that under proper conditions all types of psychiatric patient could be treated without physical restraint.

It seems, however, that the aged may still not partake in the liberal benefits of non-restraint. There are in common use in geriatric and psychiatric hospitals so-called geriatric chairs. These are tubular steel chairs with some degree of padding. There is in front of the patient a tray held firmly in place by two tubular steel extensions which fit into the arms of the chair. The tray is secured in one model by two butterfly screws. In another type it swivels out and is locked by a spring on one of the upright supports of the arm. The chairs are wheeled and are so made as not to fall over. They represent every convenience except freedom for the patient. The elderly patient who may be confused is unable to co-ordinate sufficiently to remove the heavy tray and is as physically restrained as if in handcuffs. Recently in Lancashire an emaciated patient was strangled by slipping down behind the tray and getting her nightdress caught on the clamping screw.

It will be urged that under present conditions of nursing staff shortage and a relative increase in the aged population such measures are essential. On the contrary, such measures may produce disinterested nursing and medical staff and have no part to play in the modern care of geriatric or psychogeriatric patients. Restless patients can often be much more comfortably nursed in an ordinary "recliner" chair. If doctors feel that geriatric chairs are necessary they should be alert to their dangers.—I am, etc.,

Kingsley Jones

St. Nicholas' Hospital,
Great Yarmouth

The Samaritans

Sir,—In his article on "Stress and Distress" Professor R. C. B. Aitken (15 March, p. 611) refers to the assistance given by people in voluntary organizations in improving a patient's welfare. This trend has developed rapidly and has proved of great value in supplementing the help provided by the medical, paramedical, and other professional agencies. The Samaritans are one of these voluntary organizations. Their central role is to give immediate help to those in despair or suicidal, but they also deal with a large variety of human problems, many of

which have an important medical component, the majority of these being in the psychiatric field.

The Samaritans were founded 21 years ago and today have nearly 150 branches in the British Isles, with some 18 000 volunteers. They dealt with more than 192 000 new self-referred clients in 1974. One of their great advantages is that they provide a 24-hour service and all the time that the client needs, either by telephone or face to face, without any delay. They are not experts or attached to any establishment but just ordinary men and women of all ages and social conditions who are accepted as volunteers because they have the special flair for establishing a warm, caring, and empathetic relationship which is basic to the Samaritan role. Selection, however, is strict and they are systematically prepared.

Nearly all the branches have a psychiatric consultant and a general practitioner adviser. In the many cases of depression and other psychiatric conditions their aim is always to get the client in touch with his own doctor as soon as possible and to maintain a close liaison with him—always, however, with the client's consent. Not infrequently doctors suggest to their patients that they should get in touch with the Samaritans for the special help that they can give.

Professor Aitken stresses that the clinical relationship is "the most powerful aid to reducing distress" and says, "it can bring about miracles." It is this relationship, operating in many cases in conjunction with the help of medical and social services, that the Samaritans aim to provide.—I am, etc.,

DORIS ODLUM

Poole, Dorset

Treatment of Protein-losing Gastroenteropathy

SIR,—Though several possible explanations of the mechanism of excessive enteric protein loss in "protein-losing gastroenteropathy" have been made, no definite treatment for the disease has yet been found except for the surgical resection of the affected digestive tract.

We have examined the gastric mucosa obtained by biopsy under fibrescopy from a 25-year-old man with erosive gastritis accompanied by hypoproteinemia and increased faecal ^{131}I-polyvinyl-pyrrolidone faecal excretion and found marked elevation of the activity of "tissue activator of plasminogen" (TA).[1] The evidence suggested the possibility that the increased fibrinolytic activity in the gastric mucosa participates in the enhancement of mucosal permeability to protein. The patient was therefore treated by oral administration of a synthetic inhibitor of plasmin, *trans*-4-aminomethyl-cyclohexane carboxylic acid (tranexamic acid).[2] In a month marked elevation of the serum protein level and a reduction of the mucous membrane disorder were observed. After treatment for three months no hypoproteinemia reappeared when placebo was given.

In a 22-year-old woman with Crohn's disease, though the TA activity of the small intestine could not be examined, tranexamic acid again had a dramatic effect in elevating the serum protein level, with reduction in the severe watery diarrhoea. In a 30-year-old man with Menetrier's disease biopsy of the gastric mucosa revealed high TA activity in parallel with a decrease in serum protein level. He underwent surgical resection of the stomach without a previous trial of tranexamic acid therapy since the presence of a submucosal tumour was suspected; this was not confirmed, however, by subsequent histological examination.

These three cases strongly support the new concept that increased TA activity, probably due to the underlying mucosal disorder, may play an important role in the pathogenesis of protein-losing gastroenteropathy.—We are, etc.,

MOTOHARU KONDO
KEIMEI HOSOKAWA
MASASUKE MASUDA

Department of Medicine,
Kyoto Prefectural University of Medicine,
Japan

1 Astrup, T., and Albrechtson, O. K., *Scandinavian Journal of Clinical and Laboratory Investigation*, 1957, **9**, 233.
2 Okamoto, S., *et al.*, *Keio Journal of Medicine*, 1964, **13**, 177.

Illness in the Clouds

SIR,—Your leading article (8 February, p. 295) gave a succinct review of the problem and also highlighted the predicament of those with pre-existing medical conditions who must be transported by air. It was notable from the B.O.A.C. figures[1] that 47 of the 90 deaths were those of notified invalids. It is our experience that compliance with the conditions stated on the "medical certificate of fitness for air travel" is often taken as a protection against illness in flight.

During the past five years Transcare International has escorted 950 people on flights. Of these, 755 were on scheduled flights and 220 on air ambulance flights; 170 were accompanied by a doctor and 805 by a state registered nurse. There have been no deaths in the air or later attributable to transport of the patients. It would seem that the severely ill can be moved safely by air provided that their condition is stabilized before the flight, that close watch is made on their condition during flight, and that any abnormality arising is immediately corrected.—I am, etc.,

R. J. FAIRHURST
Medical Officer,
Transcare International

Croydon, Surrey

1 Richards, P. R. M.D. thesis, University of London, 1970.

Heberden's Angina and Syncope Anginosa

SIR,—It is a pity that the otherwise excellent report from Drs. J. B. Irving and A. H. Kitchin (8 March, p. 555) was marred by a complete distortion of the historical perspective of ischaemic heart disease. Heberden did not describe angina in relation to syncope but "giddiness, confusion, stupidity, inattention, forgetfulness and irresolution . . . . they either sink under it in a fainting fit, or it is with great efforts and struggling they can keep from it . . . ."[1] under the heading of "hypochondriacus et hystericus affectus." The concept and the term "syncope anginosa" were described in 1799 by C. H. Parry,[2] himself an Edinburgh graduate.

Indeed, the confusion which has existed about angina pectoris vis-à-vis syncope anginosa and the inability of generations of physicians to distinguish between these disorders have contributed to our failure in the present day to understand the pathophysiology of ischaemic heart disease as expressed by these two conditions. Heberden's angina is commonly due to the effects of obstruction to blood flow by coronary arterial atherosclerosis during exercise-induced tachycardia, whereas Parry's syncope anginosa is associated with reduced tissue perfusion during bradycardiac dysrhythmias, as has been documented by Trousseau, Charcot, Allbutt, and others and reviewed in an account which resolves the Heberden-Parry controversy about the nature and pathogenesis of angina pectoris.[3] Heberden's angina develops in active patients, Parry's syncope anginosa presents occasionally as intermittent claudication but more commonly in the less active elderly patient as repeated falls, fractures, sometimes strokes, and even dementia.[4]—I am, etc.,

BRIAN LIVESLEY

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King's College Hospital,
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1 Heberden, W., *Commentaries on the History and Cure of Diseases*, p. 226. London, Payne, 1802.
2 Parry, C. H., *An Enquiry into the Symptoms and Causes of the Syncope Anginosa, Commonly Called Angina Pectoris*. Bath, Cruttwell, 1799.
3 Livesley, B., *Medical History*, 1975, **19**, 158.
4 Livesley, B., and Atkinson, L., *Modern Geriatrics*, 1974, **4**, 458.

Kilo-what?

SIR,—We have moved towards uneasy coexistence with kilojoules—perhaps partly because of the great opportunities for future advertising copy-writers ("a joule of a food" etc.)

We must, however, report that the kilopascal (8 February, p. 333) moved us to two apprehensive kilochaplins (basic units of amusement). Let us hope that the earnest purveyors of instantaneous logic in scientific measurement are neither too high on the kiloquixote scale (impossible dream units) nor likely to cause rising titres of kilokhans (international units of chaos and confusion, named after the amiable 13th century Jenghiz).—We are, etc.,

DERRICK B. JELLIFFE
E. F. PATRICE JELLIFFE

School of Public Health,
University of California,
Los Angeles, California

Consultant Contract

SIR,—It is clear from the most recent correspondence from the British Medical Association that only one issue now lies between the consultants and the Government, that is, as the secretary of the Central Committee for Hospital Medical Services says in his most recent letter to us, "the definition of the contractual commitments of whole-time and maximum part-time consultants, and the distinction between them."

The Government has already made quite considerable efforts to define, in terms of time worked, sessional commitments of consultants, and this leaves us clear to proceed to discussion of on-call and extra duty payments. The issue dividing consultants from