doctors can take to change Soviet policy. It is certainly true that progress is slow and that conditions remain grim for dissidents in prisons or psychiatric hospitals. However, the case of Dr Vladimir Brodsky suggests that Western doctors can have an impact.

Dr Brodsky, a Soviet physician, was imprisoned as a result of his membership of the independent Moscow based Group for Trust, which advocates greater individual contact between East and West. Through the organisation International Physicians for the Prevention of Nuclear War (IPPNW), the British affiliates (the Medical Campaign against Nuclear Weapons and the Medical Association for the Prevention of War) made sustained representations to the Soviet affiliate about Dr Brodsky's case. At the last conference of IPPNW in Cologne earlier this year it was publicly stated that the Soviet government would release another prominent member of the group and that Dr Brodsky's case would be given "favourable consideration." Since that time Dr Brodsky, his wife and child, and several other members of the group have been released to the west.

This example, together with the recent release of Dr Andrei Sakharov from internal exile, is a hopeful sign of change. Both underline the importance, as Ms White concluded, of making contact with Soviet counterparts in the belief that improved professional contacts can lead to an improved dialogue on this and other issues dividing East and West. The forthcoming IPPNW annual conference in Moscow in May will provide one such forum. An outstanding unresolved case in the field of human rights concerns Dr Anatoli Koryagin, who has suffered greatly for his courageous stand against the abuse of psychiatry in the USSR.

Another useful channel of contact is through the UK/USSR agreement on health cooperation. MCANW and MAPW have been pressing for the resumption of this intergovernmental agreement and this has recently occurred. It provides for an exchange of skill and knowledge in certain areas and should result in a modest but worthwhile improvement in communication between the medical professions in the two countries.

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Death in the clouds

SIR,—Mr Richard Wakeford's harrowing experience of the sudden death of a passenger during flight (20-27 December, p 1642) is rare, but the possibility must be addressed by those of us who are responsible for safety in commercial aircraft. Our own approach is different from the traditional one followed by British Airways.

All airlines provide basic first aid training for cabin staff but also rely on the chance presence of a doctor competent to deal with the more serious emergencies. This is often unrealistic because competence—and even credentials—are usually not assured, and circumstances and paucity of equipment limit what might otherwise be achieved. For example, most cabin staff are reasonably skilled in basic cardiopulmonary resuscitation, but this is unlikely to be useful for a victim of a cardiac arrest at 30 000 feet when no definitive treatment can be provided within an hour or more.

We have decided instead to train selected cabin staff to a high standard of skill in dealing with emergencies in flight and to provide equipment that offers a reasonable prospect of effective treatment for conditions that are dangerous or distressing. We believe that well motivated and highly intelligent volunteers among the crew of larger aircraft can be trained to diagnose and treat virtually all the important conditions they are likely to encounter.

An analysis of illness in flight from an experience of many years has shown that the variety of true emergencies is limited. With our system a cardiac arrest in an aircraft would involve the use of a semiautomatic ("advisory") defibrillator by a trained flight attendant and recovery is at least a possibility. We believe we are the first airline in the world to be equipped to deal with this and other important emergencies: though our experience is limited to a matter of months, we do not doubt that our policy of advanced first aid training will soon be shown to be capable of influencing favourably events such as that witnessed by Mr Wakeford.

We are interested to know that British Airways is now considering expanding their medical training for some cabin staff to enable them to function in a "paramedical" role when required. Our experience of training 150 such individuals leads us to encourage Lord King and his colleagues to follow this path. We believe that other airlines will appreciate the value of advanced first aid and will adopt similar schemes in due course.

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Dose dependent response of symptoms, pituitary, and bone to transdermal oestrogen in postmenopausal women

SIR,—Drs P L Selby and M Peacock (22 November, p 1337) claim to have shown "dose related" effects of transdermal oestradiol on climacteric symptoms, plasma follicle stimulating hormone concentrations, and urinary calcium and hydroxyproline excretion. However, it is unclear how the experimental design of the study could show such an effect.

They state that no patient had received any hormone replacement therapy in the month before the study. We are not convinced that this is an adequate "washout" period. Coope observed that the frequency of flushing was reduced to below pretreatment levels for at least two months after a changeover from oestrogen to placebo (which represents oestrogen withdrawal).[1]

The authors provide virtually no information on their assessment of symptoms. Were all assessments performed by one investigator? This is essential in a valid dose response study, particularly since the different oestrogen doses are achieved by patches of varying sizes and shapes which are clearly recognisable. It is not clear what exactly the symptom score comprised and how much weighting was attached to vasomotor symptoms. If this were large the investigators would have needed to study their patients for longer than three weeks. We have previously reported that transdermal oestradiol symptoms reduce the frequency of flushing episodes by 60% after three weeks but by over 90% after three months.[2] Why was therapy therefore administered for a suboptimal period?

In their statistical description the authors merely state that they used paired analyses within dose groups. The meaning of these differences between dose groups, to which a "dose related" effect refers, cannot be inferred purely from these comparisons. They should have tested specifically whether the same variable differed *according* to dose group.

The authors claim that each variable studied could be related to its own dose response curve for plasma oestradiol. The curves thus presented were, however, arbitrary lines drawn through the means of the given variable and of plasma oestradiol for the four dose groups. Surely this is not intended to be taken as further evidence of a dose related effect?

The authors cannot state, without qualification, that the dose response curves for the various variables are all congruent when the term "congruent" is used to apply to an arbitrary measure with little quantitative support. Similarly, this is not evidence to support a direct effect of oestradiol on bone independent of calcium regulatory hormones.

From the data presented, it is therefore impossible to agree that hormone replacement therapy producing an effect equivalent to higher oestradiol concentrations is likely to increase the risk of side effects without conferring any additional benefit. Clearly, further studies, including analyses of measures of lipid, lipoprotein, and carbohydrate metabolism, together with direct measurements of bone mass, are required before any such conclusions can be drawn.

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A new health region for London?

SIR,—Professor J R Butler's leading article on primary care in the inner cities (13 December, p 1519) highlights one of the major problems in providing an acceptable standard of health care in large cities. The difficulties in matching primary care provision to hospital facilities of the right sort in the right place are not, however, considered, and I submit that for London at least this is a major concern. London's problems in regard to balanced health care provision are so large and so many that a radical revision of the administrative arrangements seems to be long overdue. It is doubtful that the division of the city and the home counties into the four Thames regions has worked well either for the capital or for the peripheral districts in each region. At a time when RAWP is reducing facilities in London itself it is less apparent that it is doing much to improve resources in other parts of each of the four regions.

Has the time not come to split off Greater London from the rest and make it into one health region in its own right? This London region could then concentrate on rationalising its own difficulties without looking over its shoulder all the time to worry about resources peripherally. The outer parts of the Thames regions could then be absorbed into the Wessex, Oxford, and East Anglian regions. A new region could be set up (the South Coast Region?) to look after the needs of Kent, parts of Surrey, and the whole of Sussex.

The advantages of such a change would be to enable a more rational and fairer allocation of resources to be made for the home counties generally, and to provide at last a means of organising health resources in London in a more logical and integrated manner, including primary care facilities. The immensely valuable teaching hospitals and their great contribution to teaching and research could then be organised in a more effective manner to the benefit of all.

It is with great reluctance that I suggest a further reorganisation to a part of the health service