the fate of all those in Leicester who defer their admission is not precisely known, though some waiting list forms contain evidence of several deferments.

The practical point arising from the startling proportion of patients who decide not to be admitted is that the clerical staff are put under great pressure to try to arrange substitute admissions to maximise the use of theatre time and beds, and this extra work is not generally recognised. The simple manoeuvre of overbooking admissions by 25% each week is likely to fail since the failure rate varies for any individual surgeon from week to week. Evidently the admission of patients from a waiting list is an active process and if 25% of the patients on the list are eventually not admitted much effort is required to ensure that the average of 25% of patients who do not attend week on week do not delay the admission of those who would.

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Hospital and community health service costs: England and Scotland compared

SIR,—One of the difficulties when seeking a fair comparison of health costs between England and Scotland is to ensure that English economists and managers understand the very different situations and arrangements that exist in Scotland. It was this difficulty which led Dr Stephen Birch and Mr Allan Maynard in their original contribution[1] to equate Scotland's 15 health boards and associated centralised services with a single regional health authority in England. They appeared to be unaware that the English centralised services do not operate in Scotland. Thus since their English "budget" consisted of the sum of the budgets of the regional health authorities, and did not include centralised services, the Scottish budget appeared to be artificially inflated.

There is a further illustration of this problem in their letter of 24 October (p 1067). With regard to local authority rates they suggest that managers should respond to cost variations by adopting the most efficient input mix. While local rates may vary across England and Scotland, the baselines about which they vary are threefold higher in Scotland. Managers may respond to variations in cost only within geographic limits. The paper by Drs Akehurst and Blackburn,[2] to which Dr Birch and Mr Maynard refer, deals with such variations within a single regional health authority and is not relevant to a comparison between Scotland and England. The wide disparity in the level of rates between England and Scotland is important to Scotland in many economic spheres and not just in medicine.

The claim that private provision has little effect on unmet need, extrapolated from Dr Birch's study of hip replacements, is hard to sustain in the face of the more general findings of Dr Nicholl and colleagues from Sheffield.[3] The summary of this paper states, "When assessing the need for, and provision of, acute health care in England and Wales, the contribution of the private sector cannot be ignored."

Our observation about the use of standardised mortality ratio as a correction for morbidity differences, and therefore resource need, is one of scientific principle. If a correction factor is required, and if the accuracy of that correction is in doubt, the greater the magnitude of the correction the greater the liability of error. Because Scottish costs affected by the standardised mortality ratio require very considerable correction the adequacy of that correction can be challenged.

At a time when the Resource Allocation Working Party formula is being thoroughly reassessed in England we are surprised and concerned that it should continue to be considered proper to use it, without refinement, to compare health finance in England and Scotland.

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1 Birch S, Maynard A. *The RAWP review: RAWPing primary care: RAWPing the United Kingdom*. York: University of York Centre for Health Economics, 1986. (Discussion paper 19.)
2 Akehurst RL, Blackburn K. Geographic cost variation in the North West Regional Health Authority. *Hospital and Health Services Review* 1979;75:400-5.
3 Nicholl JP, Williams BT, Thomas KJ, Knowelden J. Contribution of the private sector to elective surgery in England and Wales. *Lancet* 1984;ii:82-92.

Spending more on turning patients into people

SIR,—The leading article by Sir John Walton (24 October, p 1012) draws attention to the lack of specialist facilities and interest in the rehabilitation of disabled patients. He points to the lack of accredited posts in rehabilitation medicine and suggests that this indicates a lack of interest in rehabilitation among the medical profession. He did not, however, comment on the extensive rehabilitation service provided for elderly patients by geriatricians. Most district health authorities have a geriatric service which in addition to acute and continuing care facilities has both inpatient and outpatient rehabilitation facilities. Even more importantly, geriatric departments will already have developed an appropriate rehabilitation staff, including physiotherapists and occupational and speech therapists, together with a close liaison with the community social and nursing services.

Sir John points out that many of the most severely disabling disorders are caused by neurological disease and cites several examples including stroke, epilepsy, Parkinson's disease, and motor neurone disease. These disorders together with most of the common rheumatic disorders show an appreciable association with age and are commonly treated in departments of geriatric medicine.

There is a need for specialist rehabilitation services particularly for the younger patient and for conditions such as spinal cord lesions and rare disorders such as muscular dystrophy. For most patients, however, rehabilitation within their own district general hopsital is likely to be more attractive than travelling long distances by ambulance to regional centres and for health authorities it is likely to be a more cost effective use of limited resources. More integration of younger patients into the well established geriatric rehabilitation service would provide the basis for a comprehensive rehabilitation service,

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Physiotherapists and rehabilitation

SIR,—Although surprised that Sir John Walton omitted any mention of the role of the physiotherapist in his leading article on rehabilitation (24 October, p 1012), I am delighted that he argued such a persuasive case for an increase in effort in this area. I endorse his comments on regional disability centres and the need to ensure that all are well resourced and properly staffed. Physiotherapists are in the forefront of rehabilitation throughout the health service and, increasingly, in private practice. Like neurologists and occupational therapists, however, they are in short supply. Perhaps we should all be working more closely together in defining an appropriate mix of professionals to undertake this work and campaigning for more resources in the interests of our patients.

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Obstetrics on the labour ward

SIR,—Ms V A Coupland and others (24 October, p 1077) implied that a two tier system demanded more of consultants in terms of work on the labour ward. This is no doubt correct, but we were surprised to learn that the consultants in the two tier hospitals went in on average only 3·5 times a month. We feel that an analysis of the "out of hours" work on the labour ward and the nature of the work carried out is important when determining future staffing levels. We carried out such an analysis for the year 1986, in a three tier district general hospital in Birmingham, which has the lowest perinatal mortality rate in the West Midlands (table). The department had four consultants, four registrars, and four senior house officers. Of the 3766 deliveries in 1986, 392 (10·4%) were by caesarean section and 834 (22·1%) were carried out by doctors.

Timing of emergency workload in 1986

	Time		
	9 am-5 pm	5 pm-10 pm	10 pm-9 am
No of caesarean sections:			
Emergency	94	74	128
Elective	99		
No of instrumental deliveries	158	113	163
Overall % of workload	42	22·5	35·5
% Of emergency work	34·3	25·4	40·3

In this hospital the intervention rate would generally be regarded as low, but almost 66% of the emergency work on the labour ward was carried out in the "out of office hours" period of 5 pm to 9 am.

As the amount of litigation is growing faster in obstetrics[1-3] than in any other branch of medicine and to provide the level of care (prompt care) that every pregnant woman deserves, a detailed analysis of the out of hours emergency work that needs to be carried out on the labour wards should be taken into consideration before the three tier system in district general hospitals is dismantled in favour of a consultant based system, as recommended by the Short report.[4] Consultants, even if they value their skilled practitioner role, get old, and once they are in their 50s they may not appreciate routinely disturbed sleep yet will be expected to offer an excellent "hands on" service the next day. Would a company director put up with such a service commitment until the day he or she retires?

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1 Elstein M. Containment of litigation in obstetrics and gynaecology: prevention. *Journal of the Medical Defence Union* 1987;3:19-20.
2 Doherty R. Childbirth: a natural process? *Journal of the Medical Defence Union* 1987;2(2):10.
3 Barnes J. Litigation in obstetrics and gynaecology. *Journal of the Medical Defence Union* 1987;2(1):10.
4 Social Services Committee. *Medical education with special reference to the number of doctors and the career structure in hospitals.* London: HMSO, 1981. (Short report.)

Soviet health care at first hand

SIR,—I can corroborate Dorothy Trott's account of Soviet health care (14 November, p 1282). After acute shivering, malaise, and vomiting the hotel doctor sent me to Samarkand Hospital for a day of treatment. The outpatients room was dull, dirty, and cold. I felt ill while my admission details were being taken and was immediately given sal volatile and smelling salts. I was not examined, I had a knife like pain in my side which I assumed to be muscular from vomiting, but I could not speak Russian and they did not speak English. The outpatient department, accustomed to foreigners with diarrhoea and vomiting, proceeded to treat me very firmly in a similar fashion to the experiences of Mrs Trott. After an intravenous drip I was thankful to get back to bed in my hotel.

The discomfort, malaise, and weakness continued, and two days later the flight from Tashkent to Alma Ata was the last straw. I was most unwilling to go to hospital after the Samarkand experience but I was taken by Russian ambulance to Hospital 12, Alma Ata. After a thorough examination and radiography I was taken to a small, old but beautifully warm two bedded room and an interpreter was brought in. Groups of people dressed as chefs appeared, then I realised that this is the official dress of senior medical officers: the more important the higher the starched chef's hat. The interpreter asked my permission for any treatment to be given. I gladly gave it—by now I was slightly delirious, and breathing very shallowly with an irregular pulse. I said "No blood please because of AIDS" and was told that nobody in Russia has AIDS except for a few foreigners in Moscow and they are all sent home at once.

The full machinery went to work systematically. Tests were given to exclude allergy to penicillin, etc. Then there were intravenous injections, electrocardiograms, blood tests, and intramuscular injections (69 over the next 12 days), and blood pressure and temperature (with a very large solid thermometer in my axilla) were taken regularly. I was badly dehydrated so was given two intravenous drips, but nobody offered me a drink of water.

There is apparently no bedside nursing in Russian hospitals: my bed was not made, linen was not changed, and patients are not washed or bathed, or even helped to undress. Next day when my daughter came to visit me she was offered the second bed and nursed me, returning to the hotel daily for a bath and to visit the local market for fruit, salad, and edible food. Though plentiful the hospital food was usually cool and fatty and not suitable for invalids, so most patients had food brought in daily.

We were told that it was difficult to get cleaners; occasionally the linoleum floor was washed, with a cloth on a stick, by an aspiring medical student (a girl aged 16) and an engineering student (a girl aged 18) as their voluntary service. This seemed a good idea: both were cheerful, healthy, and learning English, which they were keen to practise. The sink was cleaned (with ? ashes) once and the room damp dusted. At night the floors and walls teemed with cockroaches.

Before we left the hospital my daughter and I were asked to give an interview for the local radio. We had nothing but praise for the medical attention. When asked to comment on English hospital care I could only tell them that our nurses wash patients, brush their hair, and pay special care to their diet. I felt it would be churlish to elaborate for, although I was a foreign visitor, treatment was free and could not have been more thorough. All had done their best in their own jobs and were working under difficulties in an old, rather roughly furnished building with a lack of equipment (no disposables, old fashioned syringes wrapped in clean paper to carry to the patient when giving injections, no lavatory paper or soap), but there was a real wish to cure their patients. We were told that the present Russian Minister of Health is determined to improve hospital conditions.

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Confidentiality and AIDS

SIR,—Sir Douglas Black rightly queries the increasing practice in some sections of the media to regard death as the point at which medical confidentiality ceases (21 November, p 1345). There is no need for the general public to have "the right to know" what I or any of my patients die from—be it the acquired immune deficiency syndrome (AIDS), cancer, or a coronary.

Unfortunately such titillation sells papers, and this will continue as long as any investigative journalist can pay the registrar £2 for a copy of any death certificate. In fact the *News of The World* has recently published a death certificate from a young nurse who died from AIDS.[1]

A disturbing consequence is that doctors will hesitate in giving the true cause(s) on a death certificate, especially in the case of AIDS or alcoholism. The solution appears to be found in The Netherlands, where the exact medical details are notified separately and so remain confidential.

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1 *News of the World* 1987 Sept 6;11:(cols 5-8).

Medical research and training

SIR,—The juxtaposition of Dr Richard Smith's provocative article on medical research (14 November, p 1248) and Dr Alex Paton's admirable review of Robin Downie's account of the system of postgraduate medical education and training in England (14 November, p 1270) prompts me to write.

The view is widely held that education and research should march together and it is this philosophy that has led the Medical Research Council to propose that its Clinical Research Centre should be merged with the educational activities of the Royal Postgraduate Medical School. Within the National Health Service, however, research and postgraduate teaching are seen as distinct entities which are managed by different organisations. Regional postgraduate deans, for example, have responsibilities for supervising postgraduate training but they are rarely concerned in research. At the same time regional health authorities control research budgets which are specifically concerned with locally organised clinical research within the National Health Service. The time has surely come to bring research and postgraduate teaching together within the National Health Service. Research and teaching at regional level should be coordinated within a single management structure under the chairmanship of regional postgraduate deans of academic distinction who would ensure that research is as important an aspect of postgraduate education as training.

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Death of Oscar Wilde

SIR,—The saddest event of the present literary year was the death from motor neurone disease of Richard Ellman some months before the publication of his latest triumph, the splendid biography of Oscar Wilde (17 October, p 975).

If I venture to suggest that the cause of Wilde's death is at least debatable, I do so in case unquestioned acceptance in an authoritative medical journal of the cause given by the biographer (neurosyphilis) might appear to indicate assent from professionals to his interpretation.

When the available evidence is examined objectively is not the probable cause of Wilde's mortal illness intracranial suppuration (pyogenic rather than luetic) resulting from otitis media? As an Oxford undergraduate the playwright may well, as Ellman avers, have contracted syphilis from a female prostitute, but examinations of Wilde by prison doctors years later disclosed no evidence of tertiary lesions.

The late Professor Ellmann's belief[1] that death resulted from "meningitis, the legacy... of an attack of tertiary syphilis" is really based on the evidence of a literary man, Robert Ross, unversed in the natural history of syphilis. Even before penicillin a diffuse syphilitic meningeal reaction sufficiently acute to cause clinical meningitis was rare—less than 2% of all cases of syphilis. When syphilitic meningitis did occur—usually in the first year of infection—it was rarely fatal, tending to run a benign course and remitting in a few weeks even before treatment was available.[2]

The matter, admittedly, is tangential to the biographer's main concerns; my purpose is not to detract in any way from Dick Ellmann's magnificent achievement. Naturally it would have been ironic had Wilde himself supplied confirmation that "the wages of sin is death." Instead he seems to have proved the truth of Sir William Wilde's observation (quoted by Ellman, p 545) in his *Aural Surgery*: "So long as otorrhoea is present, we never can tell, how, when or where it will end, or what it may lead to."

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1 Ellmann R. *Oscar Wilde*. London: Hamish Hamilton, 1987:546.
2 Merritt HH. *Textbook of neurology*. London: Kimpton, 1963:124.

Points

Butter and government food policy

Dr ALASTAIR MCINNES (Wellingborough, Northants) writes: The British Hyperlipidaemia Association has stated its approach to reducing raised blood lipid concentrations in the general population and in the individual by advocating that no more than 30% of our energy needs should come from fats and no more than 10% from saturated fats (14 November, p 1245). The pursuit of this desirable aim is hindered by government food policy, which in practice is formulated not in Westminster but by the agriculture ministers of the European Community, who are currently meeting in Brussels. Dairy products, before and after we joined the community, have always been heavily subsidised so that we can all buy butter at half the cost of