an acute admitting hospital is seldom far away. But in the coming years of financial stringency the population must choose between this luxury of convenience and rather opt for a streamlined, rationalized, and efficient service. For example, for every 5 acute hospitals at present open 24 hours a day, in the future one hospital only in that district should be adequately staffed and equipped to deal with all emergencies. At present there is great variation in work load between hospitals of comparable staffing and beds. Such a scheme would give junior staff no less experience but a more concentrated training and indeed would assist in reducing the present very long periods of post-graduate medical training which have long distinguished Britain from comparable nations. If you are on duty in the hospital, at whatever grade, you might as well be busy!

I am not advocating wholesale reduction in the hours worked by junior hospital staff, though some cuts could be achieved, but rather suggesting that nothing but good would stem from bringing planning and order to what in some areas resembles nothing less than chaos. Within the next 5 years it is probable that less rather than more doctors will be available to staff our hospitals, with an increase in the proportion of women trained who then either take part-time appointments or leave medicine for a large part of their life and with the prospect of significant reductions in the numbers of foreign medical graduates entering the country. Consideration of these further reasons for likely diminishing skilled medical manpower adds substantial weight to a plea for enhanced efficiency.

Surely it should be possible for medical staff through their local medical executive committees and district management teams to put such proposals as outlined above to the relevant higher area and/or regional health authorities and refuse to take "no" for an answer. While I am not so naive as to ignore all the vested interests and petty little empires that over the years have grown up within the N.H.S., surely the time has come for those whose eyes are open to let a "wind of change" blast all the muddled and ineffective thinking from all those areas where they can influence affairs. After all, it only needs common sense and resolution—alas, rare qualities indeed, especially in combination, in 1975.—I am, etc.,

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Randomization

SIR,—In the controlled clinical trial reported by Mr. I. L. Rosenberg and others (22 March, p. 649) randomization to the three treatment groups was by month of birth, those born in the first four months of the year being allocated to one treatment, etc. The resulting group sizes were 73, 79, and 121 respectively, with 22 withdrawals. Prior to withdrawal the group sizes were 88, 85, and 122 respectively (Pollock A.V., personal communication) and this poor distribution of group sizes deviates significantly from expectation ($P=0.015$, χ^2 test).

Assuming that one aim of this method of randomization was the reasonable one of achieving roughly equal group sizes (though

this is not necessarily the statistical optimum) it has clearly not proved satisfactory in this respect. One is therefore also led to question whether this method can be trusted to ensure that on average the treatment groups are similar with respect to patient characteristics correlated with the trial end-points, a necessary condition for unbiased comparison. In view of the ready availability of eminently satisfactory randomizing techniques using random numbers,¹ which can be constrained to give equal group sizes if required, it is unnecessary to rely on other techniques of possible dubiety such as ones based on dates of birth.

The unbalanced distribution of group sizes is in itself interesting. After allowing for differing lengths of the months and seasonality of birth rate the significance of the observed deviations increases, so the explanation does not lie here. An explanation in terms of admission procedure or simple bad luck must initially be preferred to the possibility of a real correlation between morbidity and month of birth. I am currently collecting examples of such correlations and should be interested to hear from anyone with relevant data in narrowly defined disease areas rather than in a heterogeneous situation.—I am, etc.,

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¹ Armitage, P., *Statistical Methods in Medical Research*, Oxford, Blackwell, 1971.

Safer Cigarettes

SIR,—In their somewhat heavy condemnation of your leading article (17 May, p. 354), Professor C. M. Fletcher and Dr. K. P. Ball (14 June, p. 613) seem to reflect a sadly one-sided view. They "strongly deplore" the term "safer cigarettes" and favour referring to them as "less lethal cigarettes." Whether we call them less lethal, less harmful, less hazardous, or safer, the fact that such cigarettes already exist and are gradually being improved would seem to merit encouragement and welcome rather than scepticism and disparagement.

Our common aim surely is to reduce smoking-related disease. Traditional methods of health education, antismoking propaganda, and treatment at antismoking clinics have had a long run without conspicuous success. There have been cries for more money and more restrictions, but such intensification is unlikely to meet with much success so long as those involved remain fixated on the goal of abolishing all smoking. In my view far more could be achieved by focusing more of this effort on the more realistic goal of safer smoking.¹ The switch to filter-tipped cigarettes (a form of safer smoking) has done more to reduce smoking-related disease than have two decades of health education and antismoking propaganda.

The more recently developed ventilated filters enable tar, nicotine, and carbon monoxide (CO) yields to be reduced to very low levels. This makes it possible for cigarettes to become even less hazardous. But there is a rub. Most smokers smoke to obtain nicotine and modify their smoking pattern to regulate their nicotine intake. If the nicotine concentration of the mainstream smoke is

reduced the smoker compensates by taking more smoke into his lungs; and if the nicotine yield is lowered so much (<0.3 mg) that an adequate nicotine intake is impossible despite this compensatory increase in smoking the cigarette will simply lose acceptability.^{2,3} Such evidence suggests that the safer cigarette will be the one with a very low tar yield and a very low CO yield but a medium (about 1.0 mg) rather than very low nicotine yield. It is the ratio of the nicotine to tar and CO that matters.

I do not claim that such cigarettes would be completely safe, for nicotine is unlikely to prove completely safe. But they would substantially reduce the risk of lung cancer, which is caused by the tar, and if Professor Fletcher and Dr. Ball are correct about CO rather than nicotine being the cause of smoking-related cardiovascular disease such cigarettes would reduce the risk of this as well. If people cannot stop smoking and smoke mainly to obtain nicotine there is no reason why cigarettes should not be made which allow them to have their nicotine without having it contaminated by excessive amounts of tar and CO.

Finally, Professor Fletcher and Dr. Ball's letter contains an error. They claim that 160,000 people in Britain stopped smoking after two Thames Television programmes in April and that this represents 2% of the smoking population. This would mean that the smoking population was only 8m. But in the United Kingdom in 1973 there were 19.2m. cigarette smokers.⁴—I am, etc.,

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¹ Russell, M. A. H., *Lancet*, 1971, 1, 254.

² Russell, M. A. H., et al., *British Medical Journal*, 1973, 4, 512.

³ Russell, M. A. H., et al., *British Medical Journal*, 1975, 2, 414.

⁴ Tobacco Research Council. *Statistics of Smoking in the United Kingdom, 1973 Supplement*. London, T.R.C., 1974.

Diagnosis in the Elderly

SIR,—It is surprising that Dr. J. R. Hampton and his colleagues in their thought-provoking paper (31 May, p. 486) on the value of history, examination, and investigation in reaching a diagnosis made no statement on the ages of the patients seen.

It seems likely that old people did not form a large part of their sample. Nevertheless, old people will continue to be seen in general medical clinics elsewhere in large numbers. Clinical experience suggests that the observations made by Dr. Hampton and his colleagues are not applicable to old people. The frequency with which specific illnesses present in non-specific ways in old people is well recognized by those dealing with them. Concentration on the patient's own history without equal attention to the history from other sources, examination, and simple investigation may result in the failure to diagnose such conditions as pulmonary tuberculosis, thyroid disorders, and vitamin B₁₂ and iron deficiency anaemias, to mention just a few of the most easily treatable.

It is already known that the incidence of diseases, their presentations, and the appropriate forms of treatment in old people differ from these aspects in the under-65s. If it

is accepted that the way history, examination, and investigation are applied must also alter, we become aware of yet another difference between general and geriatric medicine, and the failure of many teaching hospitals to provide adequate (or sometimes any) instruction on the management of old people becomes even more absurd.—I am, etc.,

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The Suicide Profile

SIR,—I was interested to read your leading article on suicide (7 June, p. 525). The figures over the past decade may well have fallen, but the coroner today bends over backwards to avoid the verdict of suicide, so that the statistics are an underestimate of the true state of affairs. A woman patient of mine drowned herself in a foot of water. She was a known case of depression with a strong suicidal urge and she had spent a good deal of time in a psychiatric hospital. Because there was no note to indicate her intent, accidental death was recorded. There are many cases like this.

You were right to stress the importance of the doctor-patient relationship. Surely one of the best ways of enhancing the rapport situation is to inquire tactfully about the presence or absence of suicidal ideas. It usually gives the patient great relief to be able to share such a guilt-laden secret with his doctor, and his sagging morale can be boosted by remarks to the effect that such feelings are an indication of how ill he must have felt and how wise he is to seek advice. He is told that today depression is a treatable illness. Surely every doctor should know how to assess the suicidal risk of the depressed patient.—I am, etc.,

C. A. H. WATTS

Ashby de la Zouch, Leics

Secondary Syphilis and Hepatitis

SIR,—May I support the reminders in your leading articles (31 May, p. 460 and 18 January, p. 112) that abnormal liver function tests and pyrexia of unknown origin may be presenting features of "the great mimic" by citing a recent patient with both these features in whom we initially omitted to consider syphilis?

An unmarried 48-year-old artist, admitted under the care of Dr. J. H. Baron, gave a three-week history of recurrent headache and drenching night sweats, having recently returned from three weeks in South Africa, where he had a week's influenzal illness of headache, neck stiffness, and sweating. He was febrile, with large axillary and inguinal nodes, a large tender spleen, and a smoothly enlarged and slightly tender liver, but no rash. Haemoglobin was 12.6 g/dl, white cell count $4.8 \times 10^9/l$ (4800/mm³) (normal differential), E.S.R. 60 mm in 1 hr, alkaline phosphatase 277 IU/l (normal range 20-95), aspartate transaminase 27 IU (normal range 4-17), Paul-Bunnell negative. No malarial parasites were seen on thick and thin films. Four blood cultures were negative.

Because he drank unpasteurized milk brucellosis was suspected, but agglutination tests were non-diagnostic. His Australia antigen test (cross-over electrophoretic method) was negative.

Histological examination of multiple sections of a liver biopsy specimen revealed an intact overall liver architecture, slightly oedematous portal tracts

infiltrated by chronic inflammatory cells, and a few polymorphs, scattered microfoci of inflammatory cells in the parenchyma, scanty doubtful areas of focal reticulon collapse, and an area showing prominent Kupffer cells. Subsequent special staining failed to reveal spirochaetes. These findings are similar to those described by Lee *et al.*¹

His intermittent pyrexia persisted throughout his four weeks in hospital. When we reported our lack of a diagnosis to his general practitioner he mentioned that he obtained a V.D.R.L. test on this patient regularly and that this had been negative when last done, three months previously. On being repeated, the V.D.R.L. test was now positive, as were the cardiolipin W.R. and the fluorescent treponemal antibody test. He became well, free from symptoms and signs, following penicillin therapy.

Several recent reviews of differential diagnosis in pyrexia of unknown origin do not mention testing for syphilis,^{2,4} which, if done initially, would have saved our patient unnecessary investigation in hospital.—We are, etc.,

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1 Lee, R. V., Thornton, G. F., and Coun, H. O., *New England Journal of Medicine*, 1971, **284**, 1423.

2 *British Medical Journal*, 1969, **3**, 128.

3 Molavi, A., and Weinstein, L., *Medical Clinics of North America*, 1969, **54**, 379.

4 Bennett, I. L., and Petersdorf, R. G., in *Harrison's Principles of Internal Medicine*, ed. R. D. Adams, *et al.*, 6th edn., p. 84. New York, McGraw-Hill, 1970.

Abortion (Amendment) Bill

SIR,—We, the undersigned, are general practitioners who wish to record our general support for the Abortion (Amendment) Bill 1975.

The change proposed in clause 1 is valuable because it would discourage the interpretation of the law for sanctioning abortion on demand. We welcome the provisions of clause 7, which further restrict the period of gestation during which termination is permissible—in the interests of both mother and child. We feel that the way clause 11 has been drafted has given rise to misinterpretation. We would suggest that the wording be changed to clarify the intentions of the sponsors.

We regard the whole Bill as an important measure for eliminating abuses of the present Act without restricting the grounds for abortion originally agreed by Parliament in 1967. We believe that the Bill thus clarified will reflect the true desires of the great mass of British opinion rather than those stirred up temporarily by a vociferous lobby who showed unnecessary anxiety at the appearance of the Bill.—We are, etc.,

J. BEATSON HIRD
R. TODMAN
D. L. KIRK

Birmingham

Picking a Diuretic

SIR,—Your leading article on diuretics (7 June, p. 521) concludes that there is "a

substantial degree of inappropriate prescribing." This is stating things rather gently.

Some of my work has me visiting elderly handicapped patients, many on treatment for cardiac failure and oedema. The proportion on frusemide is surprisingly high. Surprising and distressing when one considers the efficacy of thiazides and the extraordinarily high cost of frusemide. Distressing to the handicapped elderly patient who has difficulty hobbling to the lavatory or commode fast and often enough to respond to frusemide's precipitant action. For such patients the drug is an unintentionally unkind and embarrassing prescription.

Frusemide is splendid when urgent diuresis is needed. It is acceptable also if the patient has abnormal facilities to obey abnormal bladder messages. This perhaps is why it is so much used in hospitals. But once the patient is discharged he could be treated as befits home circumstances. The general practitioner could replace frusemide by a thiazide. He would help his patient a great deal (and as a nice side effect contribute a small something to the relief of the taxpayer).—I am, etc.,

A. S. PLAYFAIR

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Defence of the French Language

SIR,—I should like to express my admiration for the sensitive and distinguished article by Professor Philippe Meyer on the problems which the use of English as an "international" medium can cause the French and on the effects which this use may have on the French language itself (7 June, p. 553).

Having in mind that the oral use of new words may influence the development of a language, Professor Meyer fears that the use of foreign scientific terms by French people may in time have a paralysing and corrosive effect on French itself. I think that the main danger here comes from scientific terms as such, and the fact that they may be foreign, though no doubt making their effect marginally worse, is entirely secondary. Scientific terms by their very nature are superficial and "quantitative," and it seems to me to be "vulgar" to use them, even if they are in one's own language, outside a strictly defined scientific context. The beauty of a language resides in its poetic and "qualitative" overtones, and it is precisely these which are lost when scientific jargon usurps normal speech.

I agree most strongly with Professor Meyer's final point—namely, that in spite of all utilitarian arguments in favour of developing English in France an energetic defence of the French language is what is really called for. The "gift" of French or English, as the case may be, to a variety of "colonial" peoples was unquestionably a "cadeau empoisonné." Such a gift amounts to cultural genocide. (This is why, incidentally, the "indirect rule" of British colonialism was so infinitely preferable to the "assimilationism" of French colonialism.) English words in French are likewise a poisoned gift, but the biggest poison of all is the infiltration into a language of scientific jargon and the mode of thought that goes with it.—I am, etc.,

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