clinical departments, which facilitates the transfer of the system to other departments. We have also found that the information required by clinicians is greater than that required by management. From this basis an information strategy that takes into account the needs of all users—managers, nurses, clinicians, and administrative staff—is being developed for the trust.

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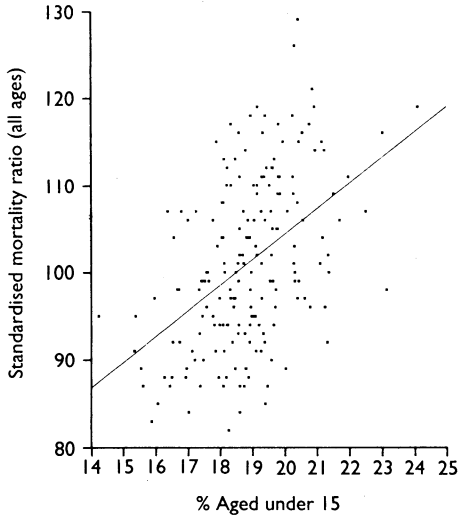
1 Bunch C. Developing a hospital information strategy: a clinician's view. *BMJ* 1992;**304**:1033-6. (18 April.)

NHS distribution of funds unfair

EDITOR,—Stephen Singleton and colleagues raise two objections[1] to our observation of a significant inverse correlation between the percentage of elderly people resident in each English health district and its all cause standardised mortality ratio and our conclusion that the national formula, weighted for the proportion of elderly people, is likely to increase the health differential between affluent and deprived populations.[2]

Firstly, while agreeing that there is a significant negative correlation, Singleton and colleagues argue that because the coefficient of determination (r^2) is 0·11 (or 0·06 when they removed the six districts with the highest percentage of elderly people) the association is not strong, suggesting that other factors contribute to the variation in standardised mortality ratios. This is not in dispute; the essential point is that age structure is related to standardised mortality ratio. Indeed, the younger end of the age range (0-14 years) shows an even stronger association with the ratio, with a correlation coefficient of $r=0·46$ ($p=0·0001$) and a coefficient of determination (r^2) of 0·21 (figure), indicating that 21% of the variation in the standardised mortality ratio can be accounted for by the linear dependence of the ratio on the proportion of the population aged 0-14.

Secondly, Singleton and colleagues argue that "it is the elderly people who are not dead (of course) who need resources." This assertion is simplistic. If we assume that the provision of health care prolongs life, and we do, then surely it is those at greatest risk of dying prematurely who need the resources so that they too can become "survivors." They imply that all elderly populations are equally in need of health care—that is, when people reach 65 differences in health status disappear. We contend that health differences are likely to be exaggerated in the over 65s as healthy people migrate to affluent areas and that districts with high standardised mortality ratios are likely to have greater health needs at both ends of the age range than districts with low standardised mortality ratios.



Simple linear regression of population of district health authorities aged under 15 and standardised mortality ratio. $y=2·94x+45·7$, $r^2=0·21$

There is a danger in using the national formula to allocate resources to districts as this would result in more resources going to affluent retirement areas (with low standardised mortality ratios) and less to deprived inner city populations (with high standardised mortality ratios). If the purpose of weighting capitation payments is to reduce differentials in health status then regional health authorities must develop resource allocation models that distribute more funds to those districts with the greatest health needs.

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1 Singleton S, Tiplady P, Kirkup B. Weightings used in distributing NHS resources. *BMJ* 1992;**304**:1117-8. (25 April.)
2 Williams ES, Scott C, Brazil R. NHS distribution of funds unfair. *BMJ* 1992;**304**:643. (7 March.)

Sympathy for the whistle blower

EDITOR,—I was both saddened and angered by Norman Parker's review of the BBC programme "Dear Mr Pink."[1] I would not disagree that Mr Pink is an individualist, but he also seems to be an intensely humanitarian and dedicated professional who aspires to the highest standards. Parker seems unable to recall the depths that professional morale plumbed in 1989. The representative bodies and statutory councils of the medical and nursing professions seemed unable to resist attacks from a hostile and intransigent government. Some people, like Mr Pink, were not prepared to subside into the state of mute acceptance suggested by Parker and apparently adopted by Mr Pink's colleagues.

A battle was being fought for the future of the NHS. In any conflict it is easier to eliminate your enemies if you first isolate them. The programme showed Stephen Dorrell attempting to do this in parliament.[2] Mr Pink was therefore tactically quite correct in gathering support nationally. It is perhaps easier for those of us who do not work alongside him to recognise the truth of his arguments. It was also professionally the correct thing to do. The concerns he raised affected not just the geriatric wards or even Stepping Hill Hospital generally but the health service as a whole. I believe that the "Pink affair" assisted the successful request for additional night staff in one NHS unit where I work. I hope that eventually Parker, the people of Stockport, and the NHS as a whole will feel able to thank Graham Pink for his extraordinary effort of genius and courage.

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1 Parker N. Out of sympathy with the whistle blower. *BMJ* 1992;**304**:1253-4. (9 May.)
2 *House of Commons Official Report (Hansard)* 1990;**183**:cols 146-7.

Obstetrical history of Queen Anne

EDITOR,—In his paper on Queen Anne's illness H E Emson states that gout is very rare in women before the menopause.[1] This is certainly true for primary gout but is not for saturnine gout, which was probably the prevalent form three centuries ago when plumbism was common.[2] A study of patients with saturnine gout living in Queensland in 1968 disclosed almost equal incidence in men and women, and at least half the women were premenopausal.[3]

Chronic lead poisoning has many features in common with porphyria and may coexist with it. Its cumulative nature may lead to a progressive pattern of disease starting with muscular pains, colic, and weakness from peripheral neuropathy and culminating in nephropathy, hypertension, encephalopathy, and convulsions. The observations of the queen's physician, Sir David Hamilton, that the gout "ascended to her brain"[1] and that she died in a state of stupefaction broken by occasional fits of delerium[4] should therefore not be dismissed.

Miscarriage and neonatal deaths were common in women in the time of Queen Anne. Descriptions of such events, often multiple, are mentioned in the case records of Robert Peirce,[5] a physician practising at Bath in the second half of the seventeenth century. It has been suggested that many of these cases were caused by lead poisoning, resulting in both infertility and fetal damage.[6]

There are two possible sources of lead to which Queen Anne might have been unwittingly exposed. Between 1645 and 1715 the quality of German and French wines suffered from the ravages of atrocious weather and the thirty years war, encouraging widespread adulteration of wines with litharge to improve their flavour.[2] Firstly, from her girth, Anne was probably as much a wine swilling gourmand as her husband and possibly preferred sweeter wines which would have been more highly contaminated. Secondly, she covered up her blotchy face with cosmetics which were quite likely to have been compounded from lead salts.

Chronic lead poisoning coupled with a hereditary trait for porphyria seems a more likely explanation for Queen Anne's illness than disseminated lupus erythematosus.

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2 Eisinger J. Lead and wine. *Med Hist* 1982;**26**:279-302.
3 Emmerson BT. Lead gout and primary gout. *Arthritis Rheum* 1968;**2**:623-34.
4 MacAlpine I, Hunter R, Rimington C. Porphyria in the royal houses of Stuart, Hanover and Prussia. In: *Porphyria—a royal malady*. London: BMJ, 1968:39.
5 Peirce R. *The history and memoirs of the Bath*. London, 1713.
6 Heywood A. Lead, gout and Bath Spa therapy. In: Kellaway G, ed. *The hot springs of Bath*. Bath: Bath City Council, 1991:78-9.

Measuring height in children

EDITOR,—The reliability of measurements of the height of young children may be affected by other (extraordinary) factors besides those mentioned by P R Betts and colleagues.[1] A few years ago, when attending a clinic for an annual appointment, my son seemed to have grown more than we could reasonably hope for. Investigation established that a month before our visit the clinic had been refurbished for a royal visit and carpet tiles had been laid over the plastic floor covering. The effect of this was a 1·5 cm improvement in apparent height as the measuring rule was still in its original position, bolted to the wall.

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1 Betts PR, Voss LD, Bailey BJR. Measuring the heights of very young children. *BMJ* 1992;**304**:1351-2. (23 May.)

Advice to authors

Priority will be given to letters that are less than 400 words long and are typed with double spacing. All authors should sign the letter. Please enclose a stamped addressed envelope for acknowledgment.