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Hospital Beds for the Mentally Handicapped

SIR,—Following the Ely Hospital Report in 1969¹ the official policy of running down the number of patients in hospitals for the mentally handicapped has improved conditions for inpatients in these hospitals, but the failure concurrently to provide compensatory residential accommodation outside the hospitals is leading to a critical position for mentally handicapped people and their families.

For example, at this hospital, which three years ago had over 840 beds for the mentally handicapped, inpatient numbers have been reduced to 600 as a result firstly of discharging mildly mentally handicapped inpatients to local authority hostels, secondly, of transferring some patients to a new hospital, and thirdly, of removing the beds of inpatients who have died. Even with 600 patients this hospital still has not achieved the minimum standard of 30 beds in adult wards and 20 in children's wards as was recommended in 1965.² Of these 600 long-stay patients, 540 have I.Q.s below 55 and 370 have I.Q.s under 40. Most of the patients in the hospital with I.Q.s over 55 have personality disorders, mental illness, epilepsy, or physical disability which preclude their acceptance by the present local authority hostels. Of the moderately retarded group (I.Q. 40-55), many could live in sheltered hostel accommodation were it available and supervised by staff accustomed to them.

The point is being reached at this hospital where no more relatives are able to take patients home and few patients are now

eligible for existing hostels. When a patient dies or is discharged the question arises whether to remove the bed to reduce overcrowding and make people listed for admission wait longer or to allocate it to a person for whom there has been pressure for admission and so perpetuate overcrowding. This hospital is not able to buy or to staff its own hostel accommodation. With the legacy of long-stay patients occupying all the beds there is not the accommodation to develop the more flexible systems of care possible in a completely new hospital.

If the hospital beds are provided they tend to fill; if they are not there then mentally handicapped people remain at home or occupy beds in mental illness or paediatric wards. Parents, family doctors, other consultants, and social services departments complain because they cannot dispose of their mentally handicapped patients. Perhaps there is method in the apparent madness of the present policy if it causes them to turn their concern and attention to the problem of the mentally handicapped and to demand more adequate provision and services for these people.—I am, etc.,

D. A. SPENCER

Meanwood Park Hospital,
Leeds

¹ Department of Health and Social Security, *Report of the Committee of Inquiry into Allegations of Ill-treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff*, Cmnd. 3975. London, H.M.S.O., 1969.

² National Health Service, *Improving the Effectiveness of the Hospital Service for the Mentally Subnormal*, H.M. (65) 104. London, Ministry of Health, 1965.

Making Hospital Geriatrics Work

SIR,—Your issue of 3 November contained a most encouraging article by Dr. T. D. O'Brien and others (p. 277) and an important warning letter from Dr. R. V. Boyd (p. 298). Success or failure, not merely of geriatrics but of the whole hospital service, depends on proper appreciation of the points these authors raise. "Blocked" beds in acute hospitals, so frequently reported to the Hospital Advisory Service,¹ must be unblocked by making better provision for the elderly. At Oldham success has been achieved by a trend of increased geriatric discharges over the past 18 years in a situation where the bed provision in 1972 was 9.1 per 1,000 population aged 65 and over for the geriatric unit and 20.1 for welfare accommodation. Evidence for England and Wales from the Hospital In-patient Enquiry² shows that in the period 1966-70 the rate of increase of discharges from geriatric departments averaged 6.4% per annum compared with 2.7% per annum from medical departments. Both rates were much faster than the rate of increase of the population aged 65 and over, which was less than 2% per annum, and to that extent the increased level of care expected by the public and accepted by the elderly themselves is being met nationwide.

There are, however, some large pockets within this national trend where a totally different situation obtains. In Birmingham where, though geriatricians succeeded in discharging more patients from 1966 to 1970, the rate of increase was small (less than 1% per annum) and the discharge rate per 1,000

elderly population fell. As I reported in 1972,³ the geriatric turnover rate in the city had plunged to a low level. Counteracting this trend to some extent, the discharge rate of persons aged 65 and over from medical departments rose dramatically at a rate of 6.9% per annum from 1966 to 1971 compared with only 2.8% per annum for patients under the age of 65. In spite of this rise, the rate will have to accelerate to match the increasing demand for emergency admissions. The trend must eventually be self-limiting because older patients stay longer in hospital and their increasing numbers will lower the rate of turnover in medical departments. We are approaching, and have already in some districts of Birmingham reached, the critical mark where, as Dr. Boyd points out, low-turnover/long-waiting-list geriatric services become the rule and public need can no longer be met either in full or even up to present standards. In short, the hospital service in these areas is failing the old progressively. Dr. Boyd records passing the critical point at Greenwich when his bed ratio fell below 11.1 beds per 1,000 population aged 65 and over. One must accept that local variations in the critical level are bound to occur, but it is important to remember that even where the number of geriatric beds remains unaltered the increased numbers of elderly are steadily reducing the number of beds per head of the population—that is, bed coverage for the elderly is falling.

To reverse the present trend in which medical emergencies, especially in the elderly, overflow into and flood other hospital departments it is necessary to increase the geriatric side and restore the balance to a position nearer the national "norm." The price of failure to do this will be breakdown of hospital emergency services in those areas which neglect the old. It is to be expected that physicians working under great pressure should demand more beds and staff and use their built-in majority in a Cog-wheel administration to press their claims. But if we compare the saving to the hospital service of a physician doubling his turnover with the effect of a geriatrician achieving the same thing, we find that a physician would save less than 10,000 bed days each year, whereas a geriatrician would save more than 100,000 bed days annually. Inpatient care is the most expensive resource dispensed by the hospital service and it is evident that greater potential saving lies in more concentrated effort to reduce the hospital stay of geriatric patients. The scale of provision required is known from census figures for years to come—most of us alive today are in the queue for geriatric care.—I am, etc.,

R. W. PARNELL

Highcroft Hospital,
Edlington, Birmingham

1 National Health Service Hospital Advisory Service, *Annual Report for 1972*. London, H.M.S.O., 1973.

2 Department of Health and Social Security, *Report on Hospital In-patient Enquiry for the Year 1971*. London, H.M.S.O., 1973.

3 Parnell, R. W., *British Medical Journal*, 1972, 3, 760.

Experiments on Children

SIR,—A view accepting as ethical the use of children in experiments not directly bene-

ficial to them, provided that these investigations are of negligible risk and potential medical value and that informed parental consent is obtained, has been put forward in two recent publications.^{1,2}

The editorial in the October edition of *Archives of Disease in Childhood*¹ is of particular interest because it is immediately followed by a paper³ describing an investigation on children with measles in Nigeria in which non-therapeutic procedures were carried out both on diseased children and on their unaffected sibs. Each patient appears to have undergone two blood tests and two sets of three intradermal skin tests, and also the application of sensitization and challenge doses of dinitrochlorobenzene, in addition to a normal treatment regimen. Their sibs underwent a similar series of tests.

The editorial referred to above suggests as a *reductio ad absurdum* the slight risk and comparative benefit of extra weighings of children as a mode of investigating different feeding methods. It is possible to question whether this situation is quite as absurd as it seems, though one would not go so far as to condemn it as unethical. Here is a case of an individual being subjected without his or her knowledge or consent to an investigation which, like venepuncture, undoubtedly causes discomfort. This is not a question of "risk of harm"—harm of an uncertain degree is caused by the act of venepuncture or by the act of weighing, since many young children and babies are manifestly upset while these tests are performed.

Is it the function of the doctor to cause suffering to an individual patient, considering the patient in an epidemiological context rather than in an interpersonal relationship? Should a child lose his right as an individual simply because he is immature and because his suffering cannot be measured; and should he become susceptible to the doubtful judgement of others as to what constitutes potential medical progress in a world where so much progress is illusory?

Though, as Curran and Beecher² have pointed out, it is possible to ridicule a "strict" ethical approach by invoking other aspects of normal life in childhood, I think that there may be a case for saying that neither a doctor nor an ethical committee should be in a position to participate in an assault on a child. Perhaps the function of the doctor should remain to act only in the direct interest of his patient, so that the individual doctor-patient relationship remains sacrosanct until the child is of an age to make up its own mind.

I very much doubt whether the lack of medical knowledge and increase in suffering resulting from this attitude could not be made good by a more positive approach to that relatively neglected realm of the doctor's job, the art of reconciling the patient to those factors in his life, whether or not involving a recognized illness, which make him suffer—the more overtly "physicianly" aspects of medical care. Looking at medical research in a historical context, it should take its place as a luxury, albeit a very important and stimulating one, beside the direct relief of suffering; it should be expendable when necessary.—I am, etc.,

A. E. TULLOCH

St. Thomas's Hospital,
London S.E.1

- ¹ *Archives of Disease in Childhood*, 1973, 48, 751.
- ² Curran, W. J., and Beecher, H. K., *Journal of the American Medical Association*, 1969, 210, 77.
- ³ Whittle, H. C., Bradley-Moore, A., Fleming, A., and Gredwood, B. M., *Archives of Disease in Childhood*, 1973, 48, 753.

Norwegian Scabies during Immunosuppressive Therapy

SIR,—Dr. W. D. Paterson and his colleagues (27 October, p. 211) have added therapy with immunosuppressive drugs to other known predisposing factors in Norwegian scabies, and this is not surprising. Dostrovsky *et al.*¹ cited by these authors, as well as Tanaka and Usuba² and Logan *et al.*³ have reported this infestation in connexion with the leukaemias, and these are diseases of suppressed immunity.

What I found unusual in their case report was the prompt and complete response to 1% gamma-benzene hexachloride, for I have found that repeated applications of benzyl benzoate are inadequate, these cases responding only to a prolonged course of continuous inunction with 10% sulphur ointment. Reversion to this discarded form of therapy has also been found necessary in dealing with epidemics of ordinary scabies affecting geriatric or mentally subnormal patients in institutions, whether or not arising from the crusted form of the disease. This would suggest either resistance developing on the part of the acarus to medicaments in current use or difficulty in applying these remedies in this type of patient.—I am, etc.,

JAMES C. P. LOGAN

Department of Dermatology,
Stobhill General Hospital,
Glasgow

¹ Dostrovsky, A., Raubitschek, F., and Sagher, F., *Dermatologica*, 1956, 113, 26.

² Tanaka, T., and Usuba, M., *Tohoku Journal of Experimental Medicine*, 1960, 72, 35.

³ Logan, J. C. P., Grant, P. W., and Keczek, K., *British Journal of Dermatology*, 1967, 79, 303.

SIR,—I was interested to read the article by Dr. W. D. Paterson and others (27 October, p. 211).

In 1970 I was supervising the terminal illness of a woman suffering from carcinoma who had received radiotherapy and who was on continual steroid therapy (dexamethasone 2 mg thrice daily), when the skin of her body—save for that of her scalp, face, and neck—became covered remorselessly by a series of crusts and scales, with hyperkeratosis especially evident around the nailfolds. A striking feature was the absence of itching.

Such was the degree of desquamation that her bed linen and the immediate surroundings of her bed were covered with scales, many of which came into contact with her husband, daughter, nurse, and myself. Further contact with the rash was inevitable in the course of nursing care and examination. About 3-4 weeks later all of us developed scabies. Only the expertise of a consultant dermatologist unravelled the mystery. Having seen the patient and heard the complaint of her attendants he unhesitatingly diagnosed Norwegian scabies, which was confirmed by microscopical evidence of abundant acari and eggs in a skin biopsy.

There seems no doubt that steroids can alter the reaction of the skin to parasitic invasion, and at a time when scabies is on the increase the possibility of Norwegian