

With either treatment oral potassium supplements should be given daily. After intravenous therapy, when the patient is improving, prednisone will need to be given by mouth, the dose being reduced slowly.

Because of the delay in the appearance of the maximal effect of parenteral corticosteroids it is prudent for the doctor to give 200 mg of hydrocortisone intravenously to the patient who is being sent to hospital from an outlying district. Corticotrophin is not usually recommended for the treatment of acute asthma in patients on regular treatment with corticosteroids because the adrenal response in terms of cortisol output is likely to be inadequate. But patients with severe asthma who were not dependent on steroids have done well when given tetracosactrin depot (1 mg intramuscularly on admission followed by repeated injections of the same dose at 24-hour intervals for three to five days). Though the plasma cortisol levels rose significantly on this regimen they did not reach 100 µg/dl.<sup>17</sup> Again, oral potassium supplements must be given.

- <sup>1</sup> Speizer, F E, *et al*, *British Medical Journal*, 1968, 1, 339.
- <sup>2</sup> Rees, H A, Millar, J S, and Donald, K W, *Quarterly Journal of Medicine*, 1968, 37, 541.
- <sup>3</sup> Rebuck, A S, and Read, J, *American Journal of Medicine*, 1971, 51, 788.
- <sup>4</sup> McFadden, E R, and Lyons, H A, *New England Journal of Medicine*, 1968, 278, 1027.
- <sup>5</sup> Palmer, K N V, and Kelman, G R, *American Review of Respiratory Disease*, 1973, 107, 940.
- <sup>6</sup> Choo-Kang, Y F J, Simpson, W P, and Grant, I W B, *British Medical Journal*, 1969, 2, 287.
- <sup>7</sup> Fitchett, D H, McNicol, M W, and Riordan, J F, *British Medical Journal*, 1975, 1, 53.
- <sup>8</sup> Goldberg, R, *et al*, *Postgraduate Medical Journal*, 1975, 51, 53.
- <sup>9</sup> Oliver, M F, *Circulation*, 1972, 45, 491.
- <sup>10</sup> Nicholson, D P, and Chick, T W, *American Review of Respiratory Disease*, 1973, 108, 241.
- <sup>11</sup> Robinson, G A, Butcher, R W, and Sutherland, E W, *Annual Review of Biochemistry*, 1968, 37, 149.
- <sup>12</sup> Parker, C W, Huber, M G, and Baumann, M L, *Journal of Clinical Investigation*, 1973, 52, 1342.
- <sup>13</sup> Shenfield, G M, *et al*, *Thorax*, 1975, 30, 430.
- <sup>14</sup> Ellul-Micallef, R, and Fenech, F F, *Thorax*, 1975, 30, 312.
- <sup>15</sup> Ellul-Micallef, R, Borthwick, R C, and McHardy, G J R, *Clinical Science and Molecular Medicine*, 1974, 47, 105.
- <sup>16</sup> Collins, J V, *et al*, *Lancet*, 1970, 2, 1047.
- <sup>17</sup> Collins, J V, *et al*, *Quarterly Journal of Medicine*, 1975, 44, 259.

## Transplant sensationalism

Anyone who wonders why British transplant surgeons have difficulty in getting cadaver organs need look no further than the front page of the *News of the World* for 28 September.<sup>1</sup> A banner headline "The Body Snatchers" introduced an article suggesting that the Department of Health's recent circular<sup>2</sup> on the interpretation of the Human Tissue Act 1961 "opened the way for no-consent transplants." In fact, the circular did no more than confirm the advice given by our legal correspondent<sup>3</sup> as long ago as 1973: that when patients die in hospital the "person lawfully in possession of the body" is the hospital authority, and that in those circumstances the kidneys may be removed without the relatives' specific consent provided that reasonable inquiries have failed to show any evidence of objection by the patient or his family.

Sadly, the Medical Defence Union persists<sup>4</sup> in taking an opposite view and in advising its members that they may risk civil action if they follow the Government's guidance. Yet the circumstances in which the legal uncertainty is relevant are relatively few; for there would be no shortage of kidneys

if full use was made of the opportunities presented by patients dying in intensive care and neurosurgical units. Almost always in such cases the relatives are available for consultation; but only too often the clinicians concerned prefer to ignore the possibility and make no approach for consent.

Part of this reluctance is, no doubt, due to pressure of work and a natural unwillingness to intrude into the relatives' grief, but a second important factor is the antagonism to transplantation still to be found in some members of the public and whipped up by newspaper sensationalism.

The disappointing response by the public to the Department of Health's donor card scheme may well be attributable—at least in part—to the antagonism shown by some sections of the press to transplantation. Antitransplant propaganda—like other vociferous protest campaigns—commonly combines emotion and ignorance and often misrepresents the facts.

<sup>1</sup> *News of the World*, 28 September 1975.

<sup>2</sup> *Health Service Circular*, HSC (1S) 156.

<sup>3</sup> *British Medical Journal*, 1973, 3, 360.

<sup>4</sup> *Daily Mail*, 29 September 1975.

## Painful redistribution

There are two major issues about the allocation of resources to the National Health Service. The first is what proportion of the nation's income should go to the NHS. The second is how best to share out the available resources within the Service. Uncertainty about the former gives added urgency to the latter: the less money there is around the more important it is to ensure that it will be distributed in an equitable way. Given our present economic plight, it is therefore not surprising that the Department of Health should have set up a working party in May this year to look into the distribution of resources within the NHS and that the working party in turn has put on an unusual turn of speed to produce its first interim report.<sup>1</sup> If its recommendations are accepted and implemented the report's effects will be both unprecedented and considerable: there will be a cut in the total revenue funds allocated to some of the regional health authorities in the next financial year.

The NHS inherited unequal distribution of resources among the different regions of the country, seemingly unrelated to available indicators of need.<sup>2</sup> The persistence of these inequalities persuaded the DHSS in 1970 to introduce a new formula for allocating revenue funds to the regions. This was designed to iron out some of the more glaring discrepancies over 10 years by allowing the budgets of the worst-off regions to increase at a faster rate than those of the best-off ones. Nevertheless, the success of this approach—which was in any case criticised for its leisurely timetable—depended crucially on the overall growth in the resources of the NHS as a whole: the scope for bringing about equity by a differential growth rate obviously diminishes if the growth rate itself falls (or if there is no growth).

This, then, is the problem to which the working party—composed predominantly of NHS administrators and DHSS officials—addressed itself. The 1970 formula was based on three rough and ready indicators of need: population structure, occupied beds, and case load. This clearly favoured the status quo: by including bed numbers as indicators of present need (as distinct from past policies) it loaded the