after qualification and it is this inappropriate training and unfulfilled expectations which lead to a rapid decline of morale at all levels.

I would disagree that paramedical and auxiliary workers are unwilling to work in the rural areas—unless they have been trained in the capital. It is essential that these cadres be selected and trained in the provincial areas where they will work. Auxiliaries are invariably drawn between students who have failed in professional level and in a provincial hospital instead of a capital-based national teaching hospital. For all cadres the vital essential is a job description with training founded on that job description.

I fully agree that an isolated worker, doctor or "lesser-trained worker," develops extraordinary habits, both professional and social. It has long been known that without regular supervision, consultation, and encouragement peripheral workers at all levels will fail. The onus lies on those who should supervise them. I take serious exception to the attitude of the medical worker. They are not appropriately trained for their job requirements after a careful analysis of the job requirements. The degree of training for one cadre cannot be judged in the context of another cadre's job description.

Curriculum adjustment may lower standards but only if the curriculum is not in accordance with the requirements of the job. For this reason many African and Eastern countries are now holding their own postgraduate examinations—the U.K. training failed them in the work they require their own nationals to undertake. For this reason this school's M.Comm.H. course includes a three-month problem-solving exercise in a developing country and the teaching is orientated towards the developing countries and minorities. We are now unable to keep up with the increasing demand for this course.

The first commandment is to formulate a full job description, the second to formulate a presentation to meet that job description, and the third is to supervise and assess in the field.—I am, etc.,

F. M. Shattock
Department of Tropical Community Health, Liverpool School of Tropical Medicine, Liverpool

The Suicide Profile

Sir,—I take issue with you on two points raised in your timely leading article (7 June, p. 5250).

You state that "depressed illness accounts for at least two-thirds of cases" of suicide. I assume the source of this statement to be the recent study of Barracough et al. Suicide has been dealt with by many eminent writers of fiction. Invariably a meaningful connexion is drawn between an intolerable life situation and the suicide bid. Are we now to conclude that those who have attempted suicide are wrong? How reliably can a psychiatrist retrospectively diagnose depressive illness on the evidence of distraught relatives? Since there are no objective criteria for such a diagnosis and since it merges quite arbitrarily into ordinary unhappiness it is a matter of chance where he draws the line. It is noteworthy that in Sainsbury's study,2 which you quote, the incidence of depressive illness was only 27%. It is unlikely that many people have killed themselves in anything but a state of unhappiness, but this is not to say that the unhappiness accounted for the suicide. One might equally say that since a high proportion of brides were happy during the month before marriage the wedding was accounted for by the happiness.

You further state that "any depressed patient may and must do" commit suicide and that "depression can be and frequently is a fatal complaint." "May" and "can," yes, but "many do" and "frequently," hardly. The proposition that depressed patients who kill themselves must be very small indeed. Barracough et al. reported that only 6% of a series of depressives had even attempted suicide. According to their study, the patient would feel able to confess his suicidal thoughts, Barracough et al. reported that a staggering two-thirds of suicides had visited their general practitioners during the month before death. At this time most were probably harbouring suicidal thoughts. It is also wrong to say that suicide requires the use of psychotropic drugs. Couple this with the recent finding of Morgan that 80% of suicide attempters had been prescribed the drugs they took by a doctor. Where we see suicide not as the possible fatal outcome of an illness but as the temporary loss of hope of a fellow mortal we might save more lives.—I am, etc.,

John Birethell
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1 Barracough, B. M., British Journal of Psychiatry, 1976, 131, 18.
3 Morgan, H. G. Personal communication.

A Question of Diagnosis

Sir,—I was interested in Dr. D. C. Anderson's presentation of "A Unique Case of Iatrogenic Cushing's Syndrome" (5 July, p. 37). Is the diagnosis correct? Could this not be just a case of Wilson's disease?—I am, etc.,

B. H. Bass
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Cost-Benefit Analysis of Long-term Haemodialysis for Chronic Renal Failure

Sir,—To rely on the average wage as an indicator of economic benefit to society of the use of dialysis (Mr. J. Buxton and Dr. R. R. West, 17 May, p. 376) is highly misleading. For instance, dialysis includes the benefit of life to patients who do not work and also evaluates the lives of those women who work as half that of men. Policy conclusions which might be derived from this are therefore absurd.

Cost-benefit analysis is about measurements of social costs and benefits of activities. The measurement of benefits of health care presents great problems because the society and individuals stand to gain far more from health care than their ability to contribute to the productive capacity of the nation, and indeed wages are a poor measure even of the latter.—I am, etc.,

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Slow-K Ulceration of Oesophagus with Aneurysmal Littre

Sir,—Dr. A. D. Howie and R. W. Strachan (26 April, p. 176) draw attention to the danger of oesophageal ulceration when Slow-K tablets are administered to patients with left atrial enlargement. In their own case the dysphagia and ulceration followed insertion of a metrial prosthesis, as in the examples they quote from the literature. The following case shows that this complication may occur in the absence of surgical intervention.

A woman was found at the age of 33 to have aneurysmal dilatation of the left atrium with mitral regurgitation and atrial fibrillation. She was in atrial fibrillation but was well compensated on digoxin. At the age of 44 she was admitted in heart failure and frusemide 80 mg per day together with Slow-K two tablets twice daily was prescribed. After 51 days of this regimen she died from a massive haematemesis. No dysphagia was recorded, but an episode of retrosternal pain occurred early during the treatment and this lasted for some days. A barium swallow showed moderate mitral stenosis and atrial fibrillation with incompetence. The left atrium measured about 15 cm across, with a characteristic normal-sized appendage. There was no ulceration of the oesophagus below the carina. The ulcerated area involved about 5 cm of the oesophagus leaving 4 cm of apparently normal oesophagus