scabies—a highly contagious and little-known disease—should be considered in the presence of a hyperkeratotic desquamation, and possibly non-itchy rash occurring in a patient suffering from carcinoma and on biopsy will provide sufficient evidence for timely prophylactic treatment of contacts—a measure of great importance both in the hospital ward and the home.—I am, etc.,

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**α-Thalassaemia in Britain**

Sir,—The results of surveys for abnormal haemoglobins such as the one reported by Dr. J. Stuart and his colleagues from Birmingham (3 November, p. 284) illustrate the point that if one does not include in any series of screening tests a test for Hb H bodies, the diagnosis of α-thalassaemia trait will be missed.6,7 Tests used in the Birmingham survey included haemoglobin electrophoresis and Hb A2 and Hb F estimations. Of the 6,835 children studied, 26 were found to have the β-thalassaemia trait and no α-thalassaemia trait. This contrasts with the experience at this hospital, where a service containing many Negro and Asian immigrants and where in the past three months there have been 26 new cases of β-thalassaemia trait and 15 of α-thalassaemia trait. The α-thalassaemia patients included 1 Turk, 1 Chinese, 1 Greek, 1 Lebanese, 1 Pakistani, 1 African, 2 Indians, 5 West Indians, and 2 Europeans (1 Pole and 1 Briton with German ancestry). Two of the West Indians were from the same family. The patients with α-thalassaemia trait had similar blood films to those with β-thalassaemia trait and the same abnormal red cell indices (low mean corpuscular haemoglobin and mean cell volume). Their haemoglobin electrophoretic patterns were normal and their Hb A2 levels were in the normal, usually the low normal, range. In each patient Hb H bodies were present in a small proportion of the red cells and the patients had not been tested for Hb H bodies for the diagnosis of α-thalassaemia trait would not have been made.

The conventional search for Hb H bodies can be tedious and it has been found possible to make the Hb H body test more sensitive. Blood from just below the buffy coat of a column of blood centrifuged in a Wintrobe tube is mixed with brilliant cresyl blue stain and incubated at 37°C for three hours. It is usually then possible to find several Hb H-containing cells in each high-power microscope field. It is only to be expected that if one is searching for an unstable haemoglobin such as Hb H, the best yield would be in the fraction of blood rich in reticulocytes and young red cells. It is not being suggested that every person being screened for abnormal haemoglobins should have an Hb H body test. However, if one studies those patients with thalassaemic blood films, abnormal red cell indices, and a normal Hb A2 level, there should be a good yield of α-thalassaemia trait in this group. Experience at this hospital suggests that for every two cases of β-thalassaemia trait there will be one of α-thalassaemia trait in a community containing Negro, Asian, and Mediterranean immigrants.

—We are, etc.,

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**Clinical Diagnostic Process: An Analysis**

Sir,—May I comment on the interesting paper by Dr. D. J. Leaper and others (15 September, p. 569). These authors purport to show that the diagnostic process as a monolithic structure does not exist. They show clear patterns of diagnostic behaviour which differ between senior and junior medical personnel, suggesting that the mental processes used by them should not show basic similarities. Certainly this has been shown by Elstein et al.,2 though their findings were based on simulated consultations which, I, Leaper and his colleagues point out, have to be interpreted with caution.

The diagnostic processes of general practitioners do show common patterns of mental approach,1,4,5 which strongly suggest the possibility of adapting an computer technique based on Bayesian probability.6,7 This not only may have application to future computer technique but, more importantly, helps to define general practice diagnostic pathways so that they may be taught more effectively, that they may be scrutinized,1 and that they may also allow general practitioners to uncover areas of diagnosis which may be safely and profitably delegated to non-medical members of their team.—I am, etc.,

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**Health as a Quantifiable Property**

Sir,—In spite of efforts to prevent disease, medicine has tended to become a huge industry, gravely neglecting the potentialities of the individual to cause or cure disease and the social milieu that affects that potentiality. More attention to the quality of the individual would suggest, enormously reduce the expensive problems of medicine. Efforts to measure one’s quality and health can lead to a false sense of security, and a false belief in one’s immunity from disease.3,4 They risk overcomplexity even though practical measures have been proposed6 for estimating rates of cure. These efforts will fail so long as we lack a positive and usable definition of health.

I have elsewhere defined health ecologically as “a continuing property that can potentially be measured in terms of one’s ability to rally from challenges to adapt (‘insults’).”6 Raliying is measured by speed and success (the level of health reached afterwards). Established tolerance, function, and other rallying tests measure parts of health in absolute units. Present health may reflect amole reserves; or it may be lowered to some threshold as with a child malnourished and therefore vulnerable to a relatively small deficit; or health may be due to compensation, or accompany some genetic or ontogenetic predisposition.

If a property is changeable, it is potentially measurable. Even speculative charting can be realistic (fig. 1a, U). General health will rise with maturation and sink with senescence. Superimposed on the curve will be circadian and other physiological rhythms, and frequent fluctuations during coping episodes, some of which will be labelled as