stacked against this. The distribution of private sector hospitals is uneven, with two-thirds in the two Thames regions. Thus, what is proposed in Dr Harris's unit cannot be generalized unless there is a more even distribution of private hospitals within the serving catchment area. Moreover, self-funding patients and those funded by medical insurance are usually unable to access community care from the private sector.

If a local private sector unit can provide a service similar to that of the local NHS provider for less money, and the NHS purchasers purchase this, then *de facto* it becomes the NHS provider. Many private psychiatric clinics are isolated, whereas NHS inpatient units tend to be part of district general hospitals. Thus, clinic patients may have difficulty in accessing general hospital facilities. In some private psychiatric hospitals, NHS funded patients cannot receive certain investigations without prior clearance with the NHS purchasers.

The issue is not of prejudice but of reality. The government could ensure that any NHS purchaser using private acute psychiatric beds also integrates community care with the private sector provider. This can only realistically happen if the private sector provider is located in the catchment area.

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Sailors, scurvy, science and authority

Dr Thomas (January 1997, *JRSM*, pp 50–54) acclaims Lind's controlled clinical trial of the treatment of scurvy but does not address the reasons for the Admiralty's delay in implementing the findings.

Lind's study was a prospective, unrandomized, placebo controlled, clinical trial. Although he demonstrated that scurvy could be cured by use of citrus fruits, his figures were not impressive. He took as his population twelve sailors whom he divided into six groups and gave them the treatments of the day[1]. The placebo was sea-water. He had previously given two patients half a pint of sea-water to drink each day for 2 weeks, and found no benefit[2]. His controlled trial was to have lasted a fortnight but after 6 days he ran out of oranges. It was a pity that he was unable to replicate his study at Haslar, where he had 300–400 patients with scurvy under his care at any one time, as his results might have been received differently. However, he could not count on the cooperation of the staff or the patients, many of whom were unreliable, illiterate and incapable of complying with instructions.

The main problem was that the cause of scurvy was unknown and theories abounded. During the eighteenth century Boerhaave had revived the humoral theory of disease and Sir John Pringle was greatly influenced by his teacher's thinking. In addition, pneumatic and organic chemistry was developing in the wake of Newtonian ideas. Pringle strongly supported the received view that scurvy was due to putrefaction[3]. In addition he said it could be prevented and reversed by use of alkaline salts, because they are antiseptic[4]. Lind recognized the need for both acid and alkali to stop putrefaction and recommended the use of oranges and lemons for their acids[2]. Sir Gilbert Blane came closest to understanding the real cause by saying it resulted from a 'scanty diet'[5]. These people and others propounded a range of treatments, from malt to citrus fruits, whose efficacy they supported to some extent through experiment, but largely by their authority.

That it was 42 years before Lind's findings were implemented says more for that authority than for science. The reason for the delay was not so much ineptitude or bureaucracy as the authority of the formidable opponents of Lind's views.[6] They were influential people with forceful personalities, in contrast to Lind who was 'eminently a man of peace'[7]. It was Sir Gilbert Blane who facilitated the introduction of lemon juice to the Fleet in 1795, a year after Lind's death.

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Stress and cancer

I appreciated Professor Wessely's description of my chapter in *Handbook of Stress, Medicine and Health* as a *tour de force* (December 1996 *JRSM*, pp 721–722). However, it would appear he feels that this was accomplished by use of smoke and mirrors. He rejects, or at least objects to, my statement that there are 'anecdotal but irrefutable reports of cancer cures from shrines, faith healers, laetrile, coffee enemas, acupuncture, macrobiotic diets', etc., on the grounds that these two adjectives are mutually exclusive.

The term anecdote simply refers to the recounting of some interesting or striking incident or event. In that regard, there are numerous well documented, incontrovertible, and indisputable examples of remission or complete disappearance of far advanced or seemingly fatal malignancies, with all of the above non-traditional therapies. There was no claim or insinuation that these were preferred forms of treatment, or that they would likely be effective in any substantial number of patients. The point that I wished to make was that the common denominator may well have been a strong faith. Professor Wessely's scepticism might be assuaged by scrutiny of a recent 700 page annotated bibliography containing thousands of cases that are well-documented and equally inexplicable[1].

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