her position America must look for potential champions among her humbler citizens of average and less than average height and strengthen the weaknesses in cycling, fencing, gymnastics, and canoeing events.

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[1] Khosla, T, *British Medical Journal*, 1968, **4**, 111.
[2] Khosla, T, *British Journal of Preventive and Social Medicine*, 1971, **25**, 114.

Priorities in the NHS

SIR,—Your leading article (12 June, p 1425) reads as an attempted defence of a poor, persecuted minority—the consultants in acute general hospitals. We all live in difficult times. No doubt they will have the sympathy of those wealthier than themselves with more resources at their disposal. What worries me is what you say in their defence and what you don't say.

For instance, you were challenged (24 April, p 1013) to justify a figure quoted ("every drop of even 0·1% . . .") in a previous leading article (3 April, p 787). Usually such challenges are answered by a reference, an explanation, or an apology. Your technique is a vague quote, from a source not entirely free from bias. In addition you argue about "absolute standards" in medicine. "If a . . . new drug or procedure has been proved to make a substantial difference to mortality or morbidity then the doctors working in the specialty will not be content until they use the new treatment on their patients." For the world as a whole the statement is clearly untrue, but even in Britain I have some doubts—although much depends on how you define "proof" and "substantial," and the choice of referee, when there is conflict between specialties. Even so I would argue that there are other factors involved, such as the degree of effectiveness, the cost, the age and general health of the patient, and his or her wishes. You also mention diagnostic aids. For many years it has been known that if, before giving barbiturate anaesthetics, patients were tested the reduction in specific mortality for porphyria might be substantial. My family would profit from such a routine but I have always understood that it was not done because it was not cost-effective—and I rather agree. Your other point concerns "workhouses." I agree that they are depressing places to work in, and to die in, but do new buildings really affect morbidity, mortality, or morale? I observe in Cardiff and remain sceptical.

The omissions in your defence are even odder. You seem curiously unaware of the rising tide of criticism of these consultants over the past 10 years. It is based in general on their inability to justify the vast increase in their resources by evidence of a comparable increase in "output." In greater detail one could cite the lack of reaction on behalf of these consultants to a considerable mass of observational and experimental evidence about the effectiveness of some treatments, place of treatment, and length of stay in hospital. Possibly the most striking example is the conspiracy of silence with which the cardiologists have welcomed Gordon Mather's comparison of case fatality in coronary care units and at home.[1] I know from my travels that it is much more discussed abroad than here, where it represents our one big chance to save both lives and money at the same time. It is evidence of this nature without adequate reply which has convinced so many people, medical and lay, that the acute sector could well survive a cut in resources without detriment to outcome.

I would in conclusion like to stress areas of agreement. I would agree that there are possibly too many administrators. It is unfortunately at present impossible to measure their ineffectiveness. Similarly, I am suspicious of the rapid growth of the social services without proper evaluation. Finally, I can't agree more about over-prescribing, but what has the BMA done to control it?

A L COCHRANE

Rhoose,
S Glamorgan

[1] Mather, H G, *et al*, *British Medical Journal*, 1976, **1**, 925.

*** Professor Cochrane wants specific examples. We would suggest factor VIII concentrate for haemophilia; total hip replacement for osteoarthritis; the use of fibre endoscopes in the management of upper intestinal haemorrhage; dialysis for end-stage renal failure; intermittent positive pressure respiration for infants with respiratory distress syndrome; pacemakers for old people with hazardous arrhythmias. In all of these cases financial restraints have forced clinicians to operate some rationing system.—ED *BMJ*.

SIR,—It is natural enough that any section of the NHS (or indeed any other service industry) should protest at being selected for a cut in resources. The pros and cons of choosing obstetrics will be hotly debated for a long time to come. However, your leading article (12 June, p 1425) has taken the opportunity of this debate to lash out at the most underprivileged and underfinanced part of the NHS.

In your view "There is . . . no logic in a decision to spend more money on the mentally handicapped and less on the maternity services, which, if improved still further, might well reduce the amount of mental handicap in the community." In my view, this statement is nonsense. What evidence is there that mental handicap, except in a tiny proportion of cases, is caused by deficient maternity services? Is it true to say that as maternity services have improved over the past 50 years or so the numbers of mentally handicapped people have fallen? There is even a case to argue that a few mentally handicapped people would not have survived their birth if maternity care had been worse. More would have died in the first year of life if the neonatal care offered had been of a lower standard. Surely you would not argue the reverse and say that for these reasons maternity and neonatal standards should be reduced?

The real irony of your argument is in the statement that "the Department seems not to understand that there are some absolute standards in medicine." As far as mental handicap is concerned it seems to be you who fail to grasp this point. Let us face up to the fact that in many mental handicap hospitals, despite the valiant efforts of staff, those absolute standards are not being achieved simply because the hospitals have been starved of resources. Readers who doubt this should take the opportunity of visiting their local mental handicap hospital and discussing these problems with the staff concerned. All too often wild comments about one sector of the NHS are made by another simply because there is a lack of knowledge of the problems involved.

JOHN GUNN

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SIR,—In your leading article "Priorities and morale in the NHS" (12 June, p 1425) you say: "If there is no prospect of a hospital providing its staff with the means to give their patients optimum medical care then many of them will look for work in a medical setting that can provide those means. That—not greed for higher pay—is the reason that many dedicated young doctors . . . are looking for jobs overseas." This refers particularly to the suggested 2% per annum future cut in the cost of maternity services to match the 5% per annum cut in the birth rate over the past five years.

Where are these doctors to look? Not to Canada, Australia, or the USA, whither go the majority of our emigrants. These are not countries that provide optimum maternity care by British standards as measured by maternal or neonatal mortality, no matter what technical facilities they may offer (see table). To the EEC? Only Denmark and the Netherlands are able to show anything like comparable outcome of pregnancy to that experienced in England and Wales.

Country	Maternal mortality per 100 000 births	Neonatal mortality per 1000 live births
Australia	25·6	13·0
Canada	20·2	13·5
USA	22·4	15·7
France	28·2	12·6
Germany (FDR)	51·8	18·4
Italy	54·5	20·4
Irish Republic	31·1	12·8
Denmark	8·5	11·0
Netherlands	13·4	9·5
England and Wales	18·6	12·3

From *World Health Statistics Annual, 1970*. Geneva, WHO, 1973.

Surely medicine is about curing and caring for the sick to the best of our knowledge with the resources that are available. Politics is about allocating those resources. Science is about the validity of our knowledge. All three are bound to interact with one another, but we must keep the concepts distinct or confusion, and hence lowered morale, will ensue. It is this confusion that has unsettled our profession for so long.

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Glucose is dextrose is glucose

SIR,—A patient who is suspected of having a disease that affects the metabolism of glucose is often subjected to a glucose tolerance test. In the department of chemical pathology 50-100 g may be weighed out from a bottle labelled "glucose" and given orally, and the plasma glucose concentration and urinary glucose are measured at intervals. The patient who develops hypoglycaemia or needs intravenous fluid is usually, however, treated with an infusion labelled "dextrose."

In our experience many doctors and medical students believe that dextrose is a carbohydrate that is different from glucose and do not realise that dextrose is the name given in the *British Pharmacopoeia* (1973) and the *British Pharmaceutical Codex* (1973) for glucose monohydrate. This causes confusion in understanding disease and in treatment. Glucose is the scientifically acceptable trivial name for D(+)-glucose. We make a plea for the universal use in medicine of "glucose" as the only name for this compound and of "glucose monohydrate" when it is necessary to specify that the glucose molecule is not anhydrous (as it carries one molecule of water)—and for the abandonment by pharmacists of the name "dextrose."

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Accidents on holiday

SIR,—With the holiday season beginning, may I make a plea for co-operation between the accident and emergency services throughout the country?

As usual, holiday-makers will injure themselves while away from home and return for their further care to their home areas. May I ask that all casualty and orthopaedic staff consider this as part of the management of the injured patient and allow these people to bring their *x*-rays and a record of their previous management with them when they return home? Already this season I have had experience of hospitals not forwarding the information "because they did not know to which department a patient was going to be referred," and of information retained by the patient's general practitioner on his return home even though local hospital follow-up had been requested by him.

Although the carriage of clinical information by the patient himself is open to abuse, I feel this is more desirable than the frustration and exasperation I feel when a patient walks in with a plaster on and with a note saying "please continue his care" and no other information.

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Dangers of tinted glasses for driving

SIR,—Professor R A Weale's anxieties (15 May, p 1212) on the subject of the danger of wearing photochromic lenses when driving deserves the very widest support. One hopes that he will be supported not only by ophthalmologists but also by the various other optical professions.

It is, however, also appropriate to remind all drivers and the public at large that it is not only photochromic glasses that may present a source of danger but that all forms of tinted or light-absorbing lenses and windscreens may present quite hidden dangers. These can arise when the wearer or user is confronted unawares with an unusual combination of light sources, sudden change of illumination, and/or selective absorption on the part of a visualised object (such as a cyclist at night).

While, like many other unnecessary human activities, the wearing of tinted glasses is to be deprecated but at the same time tolerated, it is high time that all those who are aware of the genuine potential dangers—and this includes certain motoring organisations and journalistic sources which should know better—play their part in an intelligent campaign to underline in commonsense and comprehensible terms the dangers that can be involved.

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Management of motor neurone disease

SIR,—Your leading article (12 June, p 1422) rightly emphasises the problems of these patients but says little of means to overcome some of the problems.

As the arms gradually become weaker an electric wheelchair must be prescribed, but only after accurate assessment in a rehabilitation department; too often one sees patients to whom the wrong chair has been supplied; it then has to be changed and this wastes more of the little time that these patients have. Mobile arm supports may be fitted to the chair to counterbalance the weight of the arms and eliminate the force of gravity. The patient may then use his arms to type, eat, and drink or for other activities.

An environmental control system such as Possum is invaluable to control an electric front door lock, lights, radio, TV, etc and to make telephone calls, in- or out-going; this last facility also enables the fit spouse who is at work to communicate with the patient. All that these systems need to actuate them is any muscle movement or suck-blow breath control; modern engineering and electronics can do much to help these patients.

The speechless patient may be able to communicate through a Possum typewriter, the input to the machine being actuated by any remaining muscle function or by suck-blow breath control. Speech is not always the last function to go; I have one patient at present who is speechless but still mobile enough to go out. He has been supplied with a "talking brooch" in which a small typewriter keyboard controls a display of five letters at any one time in a "brooch" worn on the clothes. The display moves along as in some advertising signs and he is able to communicate. It may be slow, but it is an advance; the keyboard is small and easy to carry about. The same patient is able to use an ordinary electric typewriter when at home, having sufficient residual power although speech is unintelligible.

In a letter one cannot cover all the other problems that can be helped, like access and modifications to the home and car or the financial benefits claimable by a disabled person.

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Multiple sclerosis among immigrants

SIR,—Dr J F Kurtzke (19 June, p 1527), referring to the paper on this subject by my colleagues and myself (10 April, p 861), points out that there has been a big increase in new Commonwealth immigrants between 1961 and 1971 and that our study was based on the 1966 census. The populations were given in the paper and it is very simple to work out the number of immigrant years of exposure for their risk of a first admission to hospital for multiple sclerosis.

It may also please Dr Kurtzke to know that there will be a follow-up study based on the West Midlands and using the 1971 census and also that a report will follow on admission to hospital for motor neurone disease in Greater London and the West Midlands. This disease was used as a control.

The very low rate of admission to hospital for multiple sclerosis among new Commonwealth immigrants is confirmed by the low mortality rate from this disease among these immigrants. This is very strong confirmatory evidence that multiple sclerosis is indeed uncommon among non-White immigrants from Asia, new Commonwealth Africa, and new Commonwealth America.

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Folate-responsive neuropathy

SIR,—I was interested in the report of Drs M Manzoor and J Runcie (15 May, p 1176), whose conclusions accord with mine and those of my colleagues on the basis of studies in epileptic, neurological, psychiatric, and geriatric populations over the past 10 years.[1-4]

The response of their 10 patients to folic acid therapy rightly suggested to Drs Manzoor and Runcie a need to review orthodox concepts of folate in relation to nervous system function, and I have recently attempted to do just this in a review of the relevant literature.[4] The issues raised by this review are too complex and numerous to cover in a brief letter, but it should perhaps be emphasised that the association of neuropsychiatric illness and folate deficiency (or, indeed, vitamin B_{12} deficiency) does not always imply a causal relationship and will, therefore, not always result in the type of therapeutic response reported by Drs Manzoor and Runcie, myself, and other authors. In geriatric, psychiatric, and epileptic patients folate deficiency is commonly the result of neuropsychiatric illness for dietary, drug, and other reasons. However, even in these circumstances folate deficiency may well aggravate the underlying disorder, especially if severe and prolonged, and such deficiency should be corrected, except perhaps in the uncomplicated epileptic patient in whom fits may sometimes be exacerbated. Furthermore, pure folate deficiency is relatively uncommon and there may be associated deficiencies which are also exerting an adverse effect on nervous function. Finally, I have suggested that, contrary to orthodox concepts, the neurological manifestations of vitamin B_{12} deficiency are the result of a secondary disturbance of folate metabolism, which is also widely believed to be the explanation for the megaloblastic manifestations of vitamin B_{12} deficiency.[4]

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[1] Reynolds, E H, *et al*, *Epilepsia*, 1966, **7**, 261.
[2] Reynolds, E H, Rothfeld, P, and Pincus, J, *British Medical Journal*, 1973, **2**, 398.
[3] Reynolds, E H, *Epilepsia*, 1975, **16**, 319.
[4] Reynolds, E H, in *Clinics in Haematology*, vol 5, No 3, ed V Hoffbrand, p 661. London, Saunders, 1976.