unit, thereby freeing beds.[1] Indeed, the fact that roughly 42% of admissions to Ryan's unit are elective surgical cases might seem to support this view. Furthermore, the small number of patients whose operations were cancelled or who had to be transferred from the unit suggests that Newcastle might be reasonably well supplied with beds in intensive care units.

Unfortunately, Ryan's figures may not be representative of other centres, particularly as the Department of Health's recent audit report highlighted a wide variation in the provision of beds in intensive care units in England.[2] For instance, in 1993 the Wessex region had an average of 1·9 beds per 100 000 population yet the figure for the Northern region was 2·6.[2] Portsmouth Hospitals NHS Trust has only nine intensive care unit beds to serve a local population of about 550 000—a ratio of 1·63—and this fails to recognise the presence of a regional renal unit.

Our data (table) show a different picture from that described by Ryan[1] and others.[3] The monthly occupancy in intensive care units in Portsmouth varies between 70% and 98%, 86% of admissions require treatment on the basis of Wagner *et al*'s criteria,[4] and only 17% of admissions occur after elective surgery. Less than 6·5% of bed days are accounted for by patients who are not ventilated.

Admissions to Portsmouth intensive therapy service, April 1993 to March 1995

	1993-4	1994-5
Admissions	700	663
Total bed days* (maximum 3285)	2 722	2 850
Bed occupancy (%)	83	87
No (%) of patients ventilated	546 (78)	557 (84)
No (%) of patients given haemofiltration	119 (17)	146 (22)
No (%) of patients with pulmonary artery catheter	245 (35)	265 (40)
Total points on therapeutic intervention scoring system	99 005	104 503
Elective surgical cancellations	96	106
Transfers to other districts' intensive care units because of lack of beds	27	31

*One bed day=1 patient resident in intensive care unit for 24 hours.

In the past two years operations (mainly for aortic and oesophageal surgery) were cancelled on at least 205 occasions because of the lack of an intensive care unit bed and 58 patients in the intensive care unit were transferred to other units, sometimes up to 130 km away, simply to permit a sick patient to be admitted as an emergency. An unknown number of emergency patients were also transferred direct from general wards or the accident department, simply because of a lack of intensive care unit facilities.

Clearly, the solution to the shortage of intensive care unit facilities may not be the same for all regions, trusts, or intensive care units. For some the development of a high dependency unit will ease pressure on intensive care unit beds; for others, intensive care unit beds may be replaced by those in high dependency units. For a third group, however, it is essential that both extra intensive care unit beds and a high dependency facility are provided.

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1 Ryan DW. Rationing intensive care. *BMJ* 1995;**310**:1010-1. (15 April.)
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Data from one high dependency unit supports their effectiveness

EDITOR,—D W Ryan[1] and J Bion,[2] in discussing the provision of intensive care beds, suggest that there should be more high dependency beds, although information on their effectiveness seems to be lacking. At the Royal Hallamshire Hospital we opened a two bedded, five day high dependency unit in 1992. The primary reason for this was to counter the recurrent cancellation of elective major surgery when an intensive care bed could not be guaranteed. In addition, it was hoped to reduce the number of urgent transfers out of the intensive therapy unit and generally improve the care of postoperative patients.

Since the unit's development the number of cases of elective surgery that have been cancelled has fallen effectively to zero (table), as has the number of emergency transfers out of intensive care to accommodate new patients. This has been achieved by allowing the booking of a bed in the high dependency unit for elective surgery to take precedence over emergency admissions. Although the unit was developed primarily for elective surgery, emergency or unplanned patients could be admitted if there was a vacant bed.

Since the unit was opened the number of beds has been increased to four for six days, which has increased the workload for both planned and unplanned admissions (table) and reduced the relative cost per patient. Although Ryan's comment that a bed in a high dependency unit is cheaper than one in an intensive therapy unit, this is relative to the size of the unit and hence to the number of beds that are staffed and the number of patients who can be treated. By far the most expensive item on our budget is nursing costs. Our overall cost per patient was reduced considerably when we increased the number of beds to four since we could increase the number of patients with a minimal increase in staffing.

Admissions to high dependency unit at Royal Hallamshire Hospital, April 1992-4

	1992	1993	1994
Admissions to high dependency unit	0	219	315
Planned/unplanned	0	141/78	181/134
Cancellations	15	1	0
Admissions to intensive therapy unit	310	268	346
Transfers out of intensive therapy unit	19	2	0

We are currently reviewing other aspects of the unit's work and costs and hope that this information will support our conviction that all intensive care units should have associated high dependency beds.

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Torture in Israel

EDITOR,—Jon Immanuel may not have intended to be an apologist for torture in Israel, but his review does insufficient justice to the stark material gathered by Human Rights Watch and other bodies.[1] Over 100 000 Palestinians have been arrested since 1987, thousands of whom entered the closed world of Israeli interrogation centres. Amnesty International concurs with Human Rights Watch that torture is institutionalised during interrogation and 90% of convictions in military courts are based on a "confession" alone. The International Committee of the Red Cross, the only organisation with official access to prisoners, normally does not issue statements but made a rare exception in 1992, prompted by continuing serious abuses. Forensic pathologists from Physicians for Human Rights (USA) travelled to Israel on 10 occasions between 1988 and 1992 to participate in necropsies of Palestinian detainees who had died in circumstances implicating their interrogators or other officials.[2] My own professional contact with Gaza showed that it was easy to encounter men, including health workers, with credible personal testimony to torture.[3]

Since 1988 there has been only one case in which interrogators were jailed for serious abuse of a detainee, and Human Rights Watch concludes that official policy has been to permit the security services to operate with impunity. An important aspect of what Human Rights Watch calls the "bureaucratisation" of torture has been the way the medical profession has been drawn in. Human Rights Watch notes that Israeli prison doctors have consistently violated the ethics of their profession by primarily serving the interests of the interrogators, a charge comparable to those levelled at doctors in South Africa after the internationally famous Biko case in 1977. In 1993 the existence of a "medical fitness for interrogation" form was uncovered; doctors who completed such forms could not credibly claim to have no idea that they were certifying detainees to undergo some degree of abuse amounting to torture.

Last November the Israeli cabinet was reported to have eased "restrictions" on the use of physical force during interrogations to improve their efficiency. The international medical community is in a position to add its condemnation to that of bodies like the Israeli-Palestinian Physicians for Human Rights, which is also highlighting the continuing ethical challenge facing army doctors. Torture will continue to be an enemy of Israel's longer term interests and security. And what of the rights of victims, which include the fullest possible acknowledgement of what has been done to them? In South Africa this question is being addressed through a Truth Commission as a contribution to the making of a just peace. Is there a lesson here?

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3 Summerfield D. Health and human rights in Gaza. *BMJ* 1993;**306**:1416.

Correction

APACHE scoring and prediction of survival in intensive care

Owing to an editorial error the names of three of the four authors were omitted from this letter (6 May, p 1197). The other authors were P J McQuillan, consultant in intensive care and anaesthesia; G B Smith, director of intensive therapy services; and B L Taylor, consultant in intensive care and anaesthesia—all of whom have the same address as the cited author of the letter, S N Pilkington.