ordinary life are genuine attempts to move out of the dark ages.

Dr Newcombe argues that mentally handicapped people should not be discharged from hospital into the community because they will thereby become "victims of well intentioned but ill conceived social experiments." Is it logically the case that all attempts at providing a community life for the mentally handicapped are doomed to cause these people to become victims and therefore to suffer? It may well be that Dr Newcombe's experience of community physicians discharging the mentally handicapped into the community has been gained from a number of botched efforts. But it does not follow that because the experiences of Rawcliffe Hall Hospital and Whixley Hospital have been bad that all attempts to enable the mentally handicapped to live in the community will result in them becoming victims. Over the past three years, I have participated in discharging long term and fairly dependent mentally handicapped people into ordinary houses in groups of three or four. This experiment is going well, and all those discharged have greatly improved in their social, intellectual, behavioural, and in some cases their psychiatric functioning. Our experience in the Bath Health District is that our experiment is not only well intentioned but also well conceived. So far 20 adults have been discharged and are successfully being looked after in the community by health service personnel.

Dr Newcombe says that "the driving force behind this mass exodus is not clinical but financial." The enormous improvements in the people who have been discharged to me means that the driving force for further discharge is clinical. Because those discharged become eligible for supplementary benefit and attendance allowance the money not spent by the district in hotel costs when a ward is closed is used for developing other parts of the mental handicap service. The financial motive is not to save money for the health service but to improve our facilities for the mentally handicapped and their families without having to wait for an increase in our mental handicap budget.

Dr Newcombe refers to the consultant in mental handicap being the person who admits and discharges patients from hospital. If the consultant is prepared to discharge the mentally handicapped into the community then I am sure that he will be able to continue his traditional role of admitting and discharging. If, however, he continues to resist any move (mass exodus is pejorative, I think) of the mentally handicapped from hospital to community then I fear he will be constantly under challenge regarding his right and perhaps his competence in deciding who should be admitted or discharged from hospital.

Please let us move out of the current dark ages where hundreds of low intelligence people (hitherto called mentally handicapped or mentally impaired) are confined to hospitals. Let us continue our experiments and discover which community facilities are successful and which are not.

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SIR,—Dr J Newcombe (7 April, p 1083) courageously questions the overenthusiastic placing of people with mental handicap into community care, which is so variable in its quality that it is a time bomb ticking away eventually to explode into scandal.

Soon some untoward incident, perhaps something trivial or even bizarre, will come to light in the community care of such people. This will stir up a nationwide scandal with expressions of indignation, disgust, and recriminations by public, press, politicians, and professionals. Journalists and television reporters will unearth horror stories of disgracefully squalid facilities with too few

trained staff. Anger will make scapegoats of those who have unloaded patients on to an ill prepared community.

Community care will be brought into disrepute, with a possible swing back to more institutionalised care. Thinking will have gone a full circle and idealism will have been discredited by overidealism.

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Are spinal injuries more common in rugby union than in rugby league football?

SIR,—The debate over the dangers of rugby continues (21 April, p 1229), and one interesting comment has been made by Dr R D Walker (4 February, p 400), who has suggested that rugby league is inherently more safe than rugby union. This has not been our experience, and we have looked at all the cases of rugby injuries admitted to our regional spinal injuries unit between 1956 and 1983.

Thirteen patients were admitted with spinal cord injury from playing rugby league football. Two were professional, and two were schoolboys. Ages ranged from 16 to 35 years (average 24). The commonest site of injury was the lower cervical spine (11 out of 13 were injured between C4 and C7), and the commonest mechanism was neck hyperflexion with or without rotation. Two players had lower injuries: one of the third lumbar root due to hyperextension with rotation; and the other a fracture dislocation between dorsal spine 11 and 12. The moment when this player (wearing number 13) was injured is shown in the photograph. In seven cases the ball carrier was injured, and in four the tackler, and two of the injuries occurred as a result of scrum collapse.

One quadriplegic man died from a pulmonary embolus. Six are permanently quadriplegic, two have a quadriparesis, and four made a complete recovery.

During the same period there were seven spinal cord injuries as a result of rugby union. All except one were cervical injuries. Three patients remain quadriplegic, three have no deficit, and one has a quadriparesis.

Rugby league appears to carry a similar risk of cord injury to rugby union. Eight out of the 13 rugby league injuries were admitted in the last three years. Has rugby league become more dangerous or are there more playing the game? Dr J R Silver (7 January, p 37) and Scher¹ have also found a recent increase in spinal cord injuries in rugby.

The moment at which the player number 13 suffered a fracture dislocation of the dorsal spine.

We found that the ball carrier is at most risk. Three of them were injured because of foul play (two "dumping" and one high tackle), and one because of multiple tackling, a technique which appears to be more common since the tours by the Australian and Queensland rugby league teams in recent years. Two injuries were due to the scrum collapsing; one player was a hooker, and the other unexpectedly a scrum half. Rightly this is widely regarded as dangerous play.

We found no correlation either with the number of games played before injury or with the time of the season. We have no evidence that lack of fitness or training contributed.

We conclude that spinal cord injuries are as common in rugby league as rugby union. This is surprising since ruck and mauls do not develop in rugby league, and these accounted for almost a third of Dr Silver's rugby union cases.

We recommend the following: (1) Tighter control by referees and coaches to reduce foul play. (2) Multiple tackling should be discouraged. (3) A register of rugby injuries—with direct feedback to referees, legislators, coaches, and players—similar to the National Football Head and Neck Injury Register which seems to have been effective in the USA.²

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¹ Scher AT. Rugby injuries to the cervical spinal cord. *S Afr Med J* 1980;57:37.

² Mueller FO, Blyth CS. The physician and sports. *Medicine* 1979;7:71.

Failure of general practitioners to prevent

SIR,—It is curious that people often seek to discredit rather than praise the work of others, and the response of Dr I S Johnson (7 April, p 1085) to the two papers on detection and management of hypertension in general practice (24 March, p 903 and 906) is typical of this human failing.

Dr Karim H Kurji and Dr Andrew P Haines (p 903) and Dr Gerald Michael (p 906) did not show failure, they honestly and openly showed deficiencies in one finite area of preventive medicine (hypertension detection and management). This is the way of progress, is it not? Without review and feedback we cannot improve.

Perhaps Dr Kurji and Dr Haines would have evaded criticism if they had rephrased their conclusions thus.

"... 53% of patients consulting had blood pressures recorded in the previous ten years, and it is encouraging that many more readings were made between 1977 and 1982 than in the previous five years. Another remarkable finding was that some practices had blood pressure readings on as many as 82% of their patients. The exceptional potential in primary care consultations for simple blood pressure screening is clearly shown, but practices with less impressive results (as low as 24%) need to look again at their policies and ask why they are not achieving more."

We find it worrying that general practitioner research workers are failing to recognise that only ten years ago the evidence for blood pressure screening or case finding in the general population was far from good. Now that the evidence is beginning to point to the value of earlier treatment for hypertension we must