predisposes to diverticular disease, but the basis of this association is, according to the information available, unlikely to be diet. This discrepancy which our findings establish between diet and disease calls for more comprehensive appraisal of the agents underlying the changing patterns of disease. Other factors besides diet, or in association with diet, need more close consideration. For example, the influence of allergies, nervous tension, and acute colonic infections—factors which in varying degree appear to correlate with adoption of Western habits—have not received due attention. We have been impressed by an increasing number of patients with bowel symptoms and palpable thickening of the sigmoid colon suggestive of the spastic colon syndrome. Could this also have a bearing on the causation of diverticular disease? The aetiology of this disease may be multifactorial.

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¹ Archampong, E Q, Christian, F, and Badoe, E A, *Annals of the Royal College of Surgeons of England*, 1978, **60**, 464.

Disinfection with glutaraldehyde

SIR,—Dr R M G Boucher's letter (18 August, p 444) on glutaraldehyde makes interesting reading.

His statement that alkaline glutaraldehyde has a maximum use life of 14 days is untrue. Although alkaline glutaraldehyde (Cidex Solution) has traditionally had a use life of 14 days, a stabilised formula has been available for some time. Known as Cidex Formula 7 Solution in the USA and Cidex Long-life Solution in the UK, this formulation was clearly demonstrated by Miner *et al*¹ to possess a stability similar to that of acid glutaraldehyde over 28 days. In addition, this stabilised alkaline glutaraldehyde was shown to retain its full antimicrobial effectiveness throughout the whole of its 28-day use life.

One wonders if the customers for glutaraldehydes are as unconcerned as Dr Boucher would appear to be regarding corrosion. It is our experience that freedom from corrosion is a major requirement for almost all users, and in this respect all the evidence points to alkaline glutaraldehyde as superior to the acid form.

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¹ Miner, N A, *et al*, *American Journal of Hospital Pharmacy*, 1977, **34**, 376.

The "Radcliffe" hospitals, Oxford

SIR,—Although I agree with much of Dr H Harris's letter (25 August, p 499) about the Radcliffe Hospitals, I would like to dispute two points.

As junior doctors, most of us welcomed the move to a hospital with bright open wards, a spacious casualty area, and comfortable staff accommodation; but it has not been with the "immense sense of relief" he mentions. Shortages of nursing staff, long delays with the switchboard, litter left lying outside the building, and battles to get telephones in doctors' rooms made our jobs more difficult, not easier.

Secondly, although conditions were far from ideal, the Radcliffe Infirmary was *not* uncaring for its patients. As students we were taught the importance of remembering patients are people, and patients themselves often volunteered how much they valued the attention they received from nursing and medical staff alike.

I am sure the initial difficulties at the new John Radcliffe will be overcome, and it will carry on the traditions of excellence and caring in medicine started in the old infirmary. But surely a good hospital is more than just modern buildings?

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SIR,—It was interesting to read Dr A Harris's (25 August, p 499) expressions of relief at leaving the old Radcliffe Infirmary, with its "appalling facilities for staff and patients." He appears to be ignoring the plans for its occupation by other medical patients and their caring staff—mainly geriatric, of course. His letter and the article of Mr Malcolm H Gough (7 July, p 33) are beautiful examples of that unwitting double standard still so widely prevalent.

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The younger disabled unit at Fazakerley Hospital

SIR,—In such a brief article (11 August, p 369), Drs T B Benson and E Williams could obviously do little more than outline the pattern, problems, and philosophy of younger disabled units and only imply through the figures they quote the varying interpretation of the term "younger disabled unit."

They do not make entirely clear the difference between a younger disabled unit and a young chronic sick unit. Difficult though it is to differentiate between these two, it is important that one should, for on this difference will depend, firstly, the quality and quantity of the medical, paramedical, and nursing staff required and, perhaps more important, the ethos of the unit itself. However, strict differentiation between the two immediately implies exclusion of large numbers of the physically disabled under the age of 65. For example, the age distribution of the patients in Fazakerley younger disabled unit is said to be 16–55 years. What happens to patients in the age group 55 to 65? We at the Pinderfields younger disabled unit find great difficulty emotionally, socially, and practically in helping patients to cross the divide defined by their 65th birthday.

Like most younger disabled units, Fazakerley's "does not provide a service for those with a disabling degree of psychiatric illness." This is easily stated but it is interpreted with much more difficulty. When do behavioural problems become "psychiatric illness"? At what stage in the mental deterioration of a physically handicapped patient does the problem become primarily psychiatric—and then what? Such decisions often create a dilemma between the best interests of the individual patient and the interests of the other patients in the unit.

We notice that Fazakerley younger disabled unit has not admitted any patients suffering long-term effects of severe head injuries and it would be interesting to know what happens to them in that area. The numbers of such patients admitted to the unit at Pinderfields Hospital is comparatively small (16% of all admissions), but such patients and their families make immense demands on our

resources (physical, medical, and emotional)—far greater than their numbers would suggest.

The medical staffing of the Fazakerley unit was not made clear. The basic medical cover of the younger disabled unit at Pinderfields is provided by a general practitioner, who attends officially for three afternoon sessions per week. There is a consultant neurologist in charge of the unit and other consultants in other specialties are available if required. Residential junior staff of the neurology unit provide emergency cover. However, the day-to-day running of the unit is primarily in the hands of the general practitioner. The "doctor" is in a much less dominating position than in other areas of hospital and community medicine and is no more important (some would say considerably less) than other members of the unit team. It seems to us that this is in the best interests of the patient and fundamental to rehabilitation. "Take away the sick basin." On the other hand, demands on the nursing staff are very heavy and, if morale is to remain high, a high vocational commitment on the part of the nurses is as important as their qualifications.

I do not feel that any outline of the functions of a younger disabled unit should omit reference to the immense contribution made to such units (certainly to ours) by voluntary helpers. Our "friends organisation" has not only raised considerable amounts of money (for minibuses, holidays, trips, parties, etc) but has implemented and supplemented the prime aims of the unit—rehabilitation and caring—to an extent far beyond the scope of a purely National Health Service enterprise.

That such units exist is good. Let us not delude ourselves, however, that they satisfy entirely the needs of our community. For large numbers of all-time losers and no-hopers, who do not easily fit our defined categories, gravitation to long-stay geriatric and psychiatric accommodation seems inevitable—inevitable, that is, but for the existence of such charitable organisations as the Cheshire Foundation, to which this and other countries are grossly indebted not only for their sharing so well the burden of caring but for providing for us all an inspiring example of practical compassion.

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Tuberculosis

SIR,—May I be allowed the indulgence of joining Dr J E Wallace (25 August, p 499) in referring to Dr Neville Oswald's article on tuberculosis (21 July, p 188). In my case it has reawakened the gratitude I have had for the last 27 years for the treatment, care, and understanding I received as an inpatient with pulmonary tuberculosis in a sanatorium at Robertsbridge, and later as an outpatient at Keycol in Kent.

It does seem incredible now that, at the age of 21, I apparently resigned myself to the then common realisation that, even if drugs were used, the success rate and complications of streptomycin and para-aminosalicylic acid could ensure only a limited reduction in the tried and trusted remedy of fresh air, rest, and good food. Did the open-air cubicles with snow on the end of the bed in winter play the biggest part in ensuring that we developed the will to recover? Did we really spend eight months in bed and five months gradually walking again? And, after the phrenic crush, did I actually attend a pneumoperitoneum refill clinic weekly and then fortnightly for a period of years? I prefer to forget about the radiation risk and remember only that thousands of us in the early 1950s literally (and everlastingly