medical officers themselves should be the principal participants, with community medicine holding a watching brief.

The report of Dr Preston's Working Party on Community Health Doctors, of which I have read only the *BMJ* summary (17 February, p 503), is very disappointing. In effect it preserves the clinical medical officers as a group by renaming them "community clinicians," but it appears that they would still be generalists rather than specialists, and would remain in some sort of hierarchical relationship to the specialist in community medicine (child health) although this is somewhat disguised as "monitoring." The traditional control of clinical medical officers and their work by the medical officer of health is protected by the statement in the summary that "The area medical officer . . . must be able to take . . . the ultimate decision on the disposition of the work of community clinicians in times of emergency or difficulty." Consultant community paediatricians would be grafted on as an afterthought with an uncertain role. The situation is further confused by the simultaneously published report on the state of community medicine (17 February, p 503), which leaves me uncertain about the future status of the specialist in community medicine (child health).

Perhaps the greatest stumbling block to progress will be our rigid and irrational career structure in hospital medicine. A suitable title for the type of doctor proposed by Dr Whitmore and his colleagues might be specialist in child health, but what grade would this be? Such doctors must have clinical independence, but the existing consultant grade would not be suitable, since, on the one hand, training to that degree is probably not essential, and, on the other, insistence on this would close the doors to a large number of competent part-time married women doctors, whom we cannot afford to lose. This is an all-too-familiar dilemma which blocks progress again and again on many fronts and is one of the most urgent problems facing the profession.

If worthwhile progress is to be made in the development of child health services, and the Court Report is not to be wasted, it will require an energetic lead locally from paediatricians, and especially university departments, coupled with imaginative action by colleges, faculties, and the British Paediatric Association at national level.

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Vegan diet and health

SIR,—The paper on child abuse and cult diets (3 February, p 296) may cause confusion about veganism and be of concern to a flourishing society, which appears to be increasing in numbers. As a non-vegetarian I was invited some time ago to give a lecture to a vegan society on the nutritional aspects of preventing chronic adult disease that has its roots in childhood. I therefore sought information in scientific journals, and it was clear that veganism had been thoroughly investigated by experts.

Before the lecture, in company with one of my family and a well-known, if initially slightly sceptical, nutritional biochemist, we were entertained to an excellent supper, during which we observed a room full of healthy looking, kindly people of all ages. After the lecture discussion was prolonged, pertinent, and critical, indicating that they were well informed about the way of life they had chosen, understandably, through concern over lack of compassion for animals and the

disturbing consequences of visiting slaughterhouses and factory farms.

The importance of the vegetarian case and a more vegetarian life were discussed by the agricultural correspondent of *The Times* some time ago and he concluded that vegetarians had a strong case, to be considered by the expected new edition of the Government White Paper *Food from our own Resources*. It would be unfortunate if these healthy, well-informed, compassionate people, who live by example and do not proselytise, were to be confused with extremists following an irrational cult.

The vegan diet has been assessed at the Queen Elizabeth College in London and found to be satisfactory in all respects apart from requiring a supplement of vitamin B₁₂.¹ It is also adequate during pregnancy and lactation, and healthy normal children are born. The general health of vegans has been found in the UK and USA to be good and indistinguishable from that of others.²⁻⁴ Vegans are of normal height but lower weight through having less obesity, which could be an advantage. Professor Dickerson and his colleagues have carried out haematological studies at the University of Surrey and at the Kingston hospitals. Blood counts and blood films were normal and serum folate concentrations higher than in controls. Mean serum B₁₂ was lower in vegans not taking a supplement, but in none was it below 80 ng/l. Biochemically, vegans would seem to be at an advantage, with lower concentrations of low-density lipoprotein (LDL) cholesterol, a higher high-density lipoprotein (HDL):LDL ratio, and a higher HDL:cholesterol:apo A-1 ratio.⁶ There is no suggestion of a deficiency of long-chain fatty acids and phospholipids, as some had expected from the vegan diet.⁷ At the Johns Hopkins University⁸ it has been found that the blood pressure in vegetarians tends to be lower than in others. This cannot be attributed to the salt content in the diet and is probably related to food of animal origin.

Vegans are certainly not cranks. If anything, it is the other way about. Most of us habitually consume an unnatural diet high in saturated fat from animals artificially fed with concentrates; from hydrogenated, and thereby saturated, vegetable oils; and from a huge excess of dairy fat, which has no nutritional value as a constituent of the UK diet. Flour and other cereals are refined, removing the fibre and the germ. Sugar is a concentrated form of "empty" calories which contributes to obesity and dental decay. The vegans are free from such avoidable anomalies.

It seems that plant (soya) milk is satisfactory for the infants of the few mothers who do not breast-feed their infants for nine months, as it is for adults. It has potential advantages over cows' milk, and further research is being undertaken in London. Meanwhile it is being used by hospitals for babies who are intolerant to cows' milk. There are a number of reports on a lower incidence of coronary heart disease and cancer in vegetarians and it is likely, but has yet to be shown, that the situation will be similar, or better, in vegans, who do not consume dairy produce and eggs, as do vegetarians—often to excess.

If those of us who are not vegetarians were to move in that direction by consuming less food of animal origin and more whole-grain bread and other cereals, pulses and other vegetables, nuts, fruit, and so on there is little doubt we should be healthier, and wealthier, improve the British and European economies, and improve a situation in which half the world is undernourished but 90% of the cereals grown are used as animal feed to make meat for man instead of providing food for those in need.

Vegans with their compassionate attitude have proved that no food of animal origin is necessary for health. It is a matter of choice. However, the nutritional problem is to ensure that they are well informed. Information is readily available on request from their societies.

These facts may be of general interest and increasing importance because economic circumstances, if nothing else, are going to enforce change in agricultural methods, food structure, and eating habits.

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¹ Miller, D S, and Mumford, P, *Plant Foods and Human Nutrition*, 1972, 2, 201.

² Hardinge, M G, and Stare, F J, *Journal of Clinical Nutrition*, 1954, 2, 73.

³ Ellis, F R, and Montegriffo, V M E, *American Journal of Clinical Nutrition*, 1970, 23, 249.

⁴ Ellis, F R, West, E D, and Sanders, T A B, *Plant Foods for Man*, 1976, 2, 43.

⁵ Sanders, T A B, Ellis, F R, and Dickerson, J W T, *British Journal of Nutrition*, 1978, 40, 9.

⁶ Burslem, J, et al, *Metabolism*, 1978, 27, 711.

⁷ Ellis, F R, *General Practitioner*, 1976, 12 March, p 21.

⁸ Sacks, F M, Rosner, B, and Kass, E H, *American Journal of Epidemiology*, 1974, 100, 390.

Menetrier's disease

SIR,—Your recent leading article on Menetrier's disease (20 January, p 150) presented a valuable and balanced review on this curious disease. Although this lesion has generated much interest, little has been added to the description first published by Menetrier in 1888.¹ Even though Menetrier's disease is accepted as a benign lesion, its connection with gastric polyposis as well as with gastric carcinoma has been discussed by several authors.²⁻⁶ It has been suggested that the trend of hyperplastic mucosa to develop malign neoplasia is possibly similar to that in gastric polyposis. The coexistence of extra-gastric gastrointestinal lesions has been described in a number of cases,¹⁻⁷ and it has been suggested that after diagnosing Menetrier's disease the whole gastrointestinal canal should be examined. As mentioned in your article, the disease does not seem to be inherited. Nevertheless, in some selected cases a familial disposition has been thought likely.⁶

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¹ Menetrier, P, *Archives de Physiologie Normale et Pathologique*, 1888, 32, 236.

² Rubin, R G, and Fink, H, *American Journal of Gastroenterology*, 1967, 47, 379.

³ Chusid, E L, and Hirsch, R L, *Archives of Internal Medicine*, 1964, 114, 621.

⁴ Martini, G A, and Dölle, W, *Deutsche medizinische Wochenschrift*, 1961, 86, 2524.

⁵ Texter, E C, jun, et al, *Gastroenterology*, 1953, 24, 579.

⁶ Santavirta, S, Inaugural dissertation, Zurich, 1973.

⁷ Scherer, H J, *Frankfurter Zeitschrift für Pathologie*, 1930, 40, 357.

SIR,—Your leading article (20 January, p 150) on Menetrier's disease seems to offer the patient with this disease little but total gastrectomy. No mention is made of the observation that some cases of Menetrier's disease resolve spontaneously,¹⁻⁵ either with relief of symptoms but no change in mucosal appearances,² with disappearance of the hypertrophy and its replacement with atrophic mucosa,^{1,5} or with a return to apparently normal mucosa.^{3,4}

There is some evidence that anticholinergics

in the short term can reduce the protein loss from the stomach.⁵⁻⁷ Various treatments that can lower hydrogen ion secretion by the gastric mucosa—long-term propantheline,⁷ vagotomy,⁶ and cimetidine⁵—have also decreased protein loss, relieved symptoms, and, in the case of cimetidine and vagotomy, lead to mucosal improvement, though hyposecretion of acid is a prerequisite for making the diagnosis. The fibrinolysis inhibitor tranexamic acid has been reported to relieve symptoms, reduce protein loss, and lead to mucosal recovery,⁹ although here also spontaneous recovery cannot be excluded.

What is clear from reports is that treatment should be expectant, with therapeutic trials of the various agents that have been shown to be of value in some cases. Surgery should be reserved for certain definite indications—namely, prolonged intractable symptoms with severe hypoproteinaemic oedema, gastric bleeding, and neoplastic change.¹⁰

A patient under our care at Hammersmith Hospital indicated the value of expectant treatment. A 29-year-old woman presented with nausea, vomiting, epigastric pain, weight loss, and hypoproteinaemic oedema. She failed to show any definite improvement with anticholinergics and tranexamic acid. With encouragement and symptomatic treatment she improved over three months so that she was without symptoms and could return to work although her gastric mucosa was unchanged. We cannot be sure that surgery may not be necessary at some time, but at least she was spared a total gastrectomy at her initial presentation, when many would have been tempted to perform it.

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¹ Frank, B W, and Kern, F, *Gastroenterology*, 1967, **53**, 953.

² Berman, J R, and Spiegel, E L, *Gastrointestinal Endoscopy*, 1969, **15**, 230.

³ Jarnum, S, and Jensen, K B, *Gut*, 1972, **13**, 128.

⁴ Lesser, P B, et al, *Gastroenterology*, 1975, **68**, 1598.

⁵ Berenson, M M, Sannella, J, and Freston, J W, *Gastroenterology*, 1976, **70**, 257.

⁶ Russell, I J, et al, *Mayo Clinic Proceedings*, 1977, **52**, 91.

⁷ Smith, R L, and Powell, D W, *Gastroenterology*, 1978, **74**, 903.

⁸ Krag, E, et al, *Scandinavian Journal of Gastroenterology*, 1978, **13**, 635.

⁹ Kondo, M, et al, *Gastroenterology*, 1976, **70**, 1045.

¹⁰ Jeffries, G H, and Sleisenger, M H, *Surgical Clinics of North America*, 1962, **42**, 1125.

"The End of an Age of Optimism"

SIR,—In his review of Professor Colin Dolerly's 1978 Rock Carling Fellowship monograph Dr Tony Smith (27 January, p 255) repeatedly takes a side swipe at me. May I reply to his three main charges?

He states, firstly, that "neither Illich nor Bradshaw have [sic] really faced up to the paradox that their books are based on the writings of members of the profession under attack—doctors who were critical of medical care and were trying to improve it." I would now face it but, the motives of the doctors aside, which paradox is it that I am meant to face—from what other group would one expect any evidence to come? Only the expert sinner can confess his expert sins. Only doctors know

the sins doctors commit; and to their modest credit a few doctors confess them, or at any rate reveal them—in medical journals. However, far more doctors reveal their sins unconsciously in their writings; and what doctors write has anyway always to be "translated" for the laity by such as Illich and myself. Lastly in this connection, and I say it in no carping spirit, the exact nature and gravity of the fundamental, though not absolutely identical, flaws Illich and I think we see in high-technology medicine—social and structural iatrogenesis in his case, and technological, cultural, and religious in mine—have not been understood by the vast majority of doctors, including, I am sorry to have to say, Dr Smith (it is as though doctors have a blind spot of which they are quite unconscious). And still less has any doctor addressed himself to refuting the charge that those fundamental flaws exist, or admitted to them.

Secondly, Dr Smith says that "Many of the defects and errors trumpeted by Bradshaw are now of only historical interest; for not only have they been corrected but so also has the system in which they occurred." (Is this the irregular verb "I hint, you state, he trumpets"?) Yes, many faults have been eliminated but only to be replaced by as many more: doctors are as prolific of fresh errors as they are assiduous in the defence of their current ones (and my catalogue is current as well as historical). Yes, the system has been corrected—and has then gone off course again in another direction. What is intrinsically wrong is not to be righted by extrinsic tinkering.

Thirdly, Dr Smith states that "The Jeremiahs have been given excessive publicity; and their complaints have combined with unrealistic expectations . . . to persuade many non-medical intellectuals that high technology medicine has failed. In fact it has succeeded. . . ." (And those non-medical intellectuals had best take a quick course of Coué—from the doctors, naturally.) Excessive publicity?—But it was Dr Smith's own *British Medical Journal* that gave more space to Illich's *Medical Nemesis* than to any other book published in the last thirty years and has now, I think, given more to my own *Doctors on Trial* than to any book since *Medical Nemesis*. And I wonder if Dr Smith has studied *Health Care: The Growing Dilemma*,¹ produced by the American firm of McKinsey and Co, the conclusions of which were, firstly, that while expenditure on health has been increasing in all Western countries for many years health has not; and, secondly, that of 22 nations surveyed in 1975 and placed in an order of health status the 21st (next to last, above only Portugal) was the United States, which spends more absolutely and per caput on health than any other nation, and is the Mecca of all good high-technology doctors. (And, please, don't anyone write and tell me about the falling USA coronary mortality: it is the total picture that counts.)

Finally, pace Dr Smith, Ivan Illich and I are not pessimists, unless to find our critics ostrich-like is to be pessimistic. We are realists in the superficial sense: *Medical Nemesis* contains some 500 references, and *Doctors on Trial* some 800—most of them from impeccable medical sources. Not that it is the particular sins of doctors that are of prime interest, but rather their origin in the deeply flawed nature of the Western medical institution, and of the sad Western, high-technology society of which it is a central and integral part. To see and to acknowledge that, and to seek

remedy for it for the sake of the young, is to be, I suggest, not a pessimist but a realist in the deepest sense.

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¹ Maxwell, R, *Health Care: The Growing Dilemma*, 2nd edn. New York, McKinsey and Co Inc, 1975.

Action on alcohol

SIR,—I was interested to read your leading article (10 February, p 361) on the above subject, and the excellent paper in the same issue (p 367) by Professor R E Kendell. The implications for the general practitioner are no less than for the psychiatrist. One has seen a very real increase in alcoholism in general practice over the last decade, unfortunately in a much younger age group and among women. Almost always the presentation is because of marital disharmony or financial or family problems, often with already present advanced liver or cerebral damage, or even frank dementia. Earlier diagnosis can be achieved only by educating the dependants to recognise the danger signals, when counselling would be more acceptable and effective.

It is clear that the concept of alcoholism as a disease has produced the public attitude that this is a problem to be handed over to the medical profession. The problem is a by-product of affluence, uncontrolled advertising, excessive leisure, and the decline in religion. The public does not want to know, or treats the problem with levity, as occurred recently in a BBC *Any Questions* programme from Bristol. Many general practitioners have the same attitude—and as a group doctors do not lead by example.

While I do not advocate prohibition or total abstinence, in view of the undoubted social benefits of alcohol, clearly a programme of health education to change public attitudes is overdue. Politicians must face the problem sooner or later—the tax on alcohol and tobacco should be trebled, and serious alcohol-related offences, such as drunken driving, should be punished by life suspension. Health education should commence with the medical profession itself leading by example, counselling, caring, by asking, "Am I my brother's keeper?"

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SIR,—I found Professor R E Kendell's paper (10 February, p 367) very interesting, but I was surprised that he devoted so little attention to the psychological aspects of this "disease." The following quotation from the *Encyclopaedia Britannica* on "Drunkenness" is of relevance: "Excessive use of alcoholic liquor appears to be referable to desire on the part of the individual to escape from or ameliorate some unpleasant situation. Persons who are in grave difficulty whether real or imaginary, or who suffer from an inescapable feeling of inadequacy, impotence, frustration, or failure, often turn to alcoholic liquor as an avenue of escape. Leaning more and more on this escape mechanism leads to habitual drunkenness." It is significant that the consumption of drugs used in the treatment of anxiety and depression has also increased dramatically.

Professor Kendell asks whether alcoholism is a medical or a political problem. In the sense that the politicians seem to be doing