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

everything in their power to produce the above-mentioned unpleasant psychological states one could quite reasonably argue that alcoholism is indeed a political problem—at least in part.

With regard to physical dependence on alcohol, it is strange that this takes so long to develop. It is also strange that sudden withdrawal can be achieved in most alcoholic patients without any dramatic ill effects. Why does the alcoholic not demand alcohol once in hospital or make attempts to get some himself (the latter is easy in an open unit with frequent visiting). Again why do so many alcoholics relapse after weeks or months of total abstinence. This surely can have nothing to do with physical dependence on alcohol; it is much more likely to be due to the continued presence of the various factors which led to the patient getting into difficulty with alcohol in the first place.

W J STANLEY

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SIR,—Your leading article (10 February, p 361) opens by stating that the average per caput consumption of alcohol in Britain is higher now than it has ever been. This is not the case: the evidence is available in Spring and Buss's full historical account, in which they show that consumption was probably even higher during parts of the eighteenth and nineteenth centuries.¹ Professor R E Kendell (10 February, p 370) clearly knows that this is so.

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¹ Spring, J A, and Buss, D H, *Nature*, 1977, **270**, 567.

SIR,—In his paper on alcoholism (10 February, p 367), Professor R E Kendell makes a number of refreshing and stimulating proposals. Many will agree with the suggestion that to consider alcoholism as a disease is now unhelpful and the problem is more political than medical. But perhaps he slips just a little into his own trap when he categorises the alcoholic as suffering simply from a condition of drug dependence. It may well be (as he says) that alcoholics differ little from other people. But that is hardly the point. Most of the patients seen at psychiatric outpatients differ little from other people except that they are suffering from, say, symptoms of anxiety and depression. I think it is up to me, as a psychiatrist, to try to understand what is happening to them in terms of individual conflict and stress in the context of each person's personality and relationships. Some patients can be helped by drugs and some (particularly those who are well motivated) by psychotherapy—individual, group, marital, and family. Is the alcoholic any different? Maybe the disease model has outlived its usefulness for many of our patients whose "illnesses" are often more usefully recognised as psychosocial in nature and derived from the way we all live in our cultural, political, and family systems.

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SIR,—A feature not mentioned in your leading article (10 February, p 361) on the Royal College of Psychiatrists' report on alcoholism is the alarming rise in morbidity and mortality from alcoholic liver disease in the UK.¹ In

Scotland alone the rise in morbidity from alcoholic cirrhosis has been threefold between 1968 and 1976.²

The so-called "drinks limits" in the report, in terms of daily alcohol ingestion, are as follows: beer (four pints per day) 60-140 g ethanol/day (depending on the strength of the beer); spirits (four double measures per day) 56-88 g ethanol/day (depending on the size of a single measure); and wine (one bottle) 60 g ethanol/day.³

Despite the benefits of moderate alcohol consumption in reducing the risk of ischaemic heart disease, recent epidemiological evidence suggests that risk of liver damage increases exponentially above daily consumption levels of 60 g ethanol/day in men, and 20 g in women.^{1, 2} This means that British beer drinkers in particular, although they may not become psychologically dependent on alcohol, could still damage their livers at the "target" consumption set out in our psychiatric colleagues' report, with all its attendant mass-media publicity.

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¹ Williams, R, and Davis, M, *Proceedings of the Royal Society of Medicine*, 1977, **70**, 333.

² Scottish Home and Health Department. Personal communication.

³ Mellor, C S, *British Medical Journal*, 1970, **3**, 703.

⁴ *Lancet*, 1978, **2**, 353.

⁵ Pequignot, G, *et al*, *Revue de l'Alcoolisme*, 1974, **20**, 191.

Kielland's forceps

SIR,—The paper on Kielland's forceps by Drs M L Chiswick and D K James (6 January, p 7) contributes little to obstetric knowledge, merely confirming that if misused these forceps are potentially lethal.

Kielland's forceps are not used as an alternative to spontaneous vertex delivery. They are used to expedite delivery in a variety of abnormal situations, and it will surprise no one that babies delivered in such abnormal circumstances compare unfavourably with those delivered normally. The alternative to the use of Kielland's forceps is some other form of intervention—non-rotational forceps, ventouse, manual rotation, or caesarean section—and it is with these alternatives that a more meaningful comparison may be made. A comparison of Kielland's forceps with other mediocrity forceps in Aberdeen¹ is briefly summarised in the table printed below. There were no significant differences in babies delivered by these two methods, and there were no deaths associated with trauma in either group.

An audit of 213 perinatal deaths in 10 539 deliveries over a four-year period (1974-7) in Brisbane² included four deaths associated with trauma. None of these was associated with any of the 384 Kielland's forceps deliveries in the survey. Adding together the figures from these two audits there were no traumatic perinatal deaths associated with 510 Kielland's deliveries. No experienced

obstetrician would deny that there are sometimes problems associated with the use of Kielland's forceps. However, the horrendous mortality stated by Chiswick and James, three deaths from tentorial tears among 86 babies delivered by Kielland's forceps, is reminiscent of an era which in most obstetric hospitals has long since passed.

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¹ Keeping, J D, Northern Obstetrical and Gynaecological Society, Perth (Scotland), October 1974.

² Chang, A, *et al*, submitted for publication.

SIR,—The excellent papers by Drs Malcolm L Chiswick and David K James (6 January, pp 7 and 10) have opened a much needed discussion on Kielland's forceps delivery. We previously recorded the same higher incidence of neonatal jaundice¹ but found it not to be associated with significant external bruising. Their finding of slightly higher morbidity with induced labour was similar to ours. The precipitation of delivery of a fetus which has not activated all its required adaptive parturition mechanisms will explain its unprepared state for delivery and postnatal life. The conjugation of bilirubin is but one of many perinatal biochemical changes, most of which we do not fully understand. The presence of fetal asphyxia and the excessive force used in delivery will further slow adaptation as well as having their own independent effects on the fetus. It seems logical to a paediatrician that a fetus already poorly prepared for life and in distress should not be exposed to more trauma than necessary. To some doctors the achievement of the almost impossible may become enough of a challenge to cloud judgment of what is best for both mother and child.

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¹ Eden, O B, Adjei, S, and Revolta, A, *British Medical Journal*, 1974, **3**, 573.

SIR,—The papers on Kielland's forceps delivery by Drs Malcolm L Chiswick and David K James (6 January, p 7 and p 10) and the subsequent correspondence (27 January, p 266 and 10 February, p 408) invite comment and criticism. There are several errors of assumption and omission. Firstly the authors' criteria for diagnosing fetal asphyxia are inadequate: an abnormal cardiotocograph trace without a fetal scalp pH measurement is not diagnostic of asphyxia. Fetal heart rate abnormalities may give a false impression of acidosis in up to 75% of cases.¹ This impression will often precipitate the doctor to interfere unnecessarily.² Statistically therefore one can say that in three-quarters of the cases associated with abnormal cardiotocography Kielland's forceps may have been used prematurely. Secondly, the statement that "some facial bruising from use of the Kielland's is probably

Mid-cavity forceps deliveries: Aberdeen 1972

	Maternal injury "	Mean Apgar score		Admission to neonatal nursery "
		1 min	5 min	
Kielland's forceps n = 126		20.6	7.3	9.1
Other mid-cavity forceps n = 149		22.1	7.5	9.0
				18.8