numbers of beds available regionally per 100 000 population in general surgery in 1971 and the regional admission rates for appendicitis listed in the Report on the Hospital Inpatient Enquiry for 1971.¹ A significant positive correlation was again obtained (coefficient = 0.489; $P < 0.05$).

One possible explanation of these findings is that surgical facilities have developed in accordance with the level of need for them. This is unlikely, particularly since regional standardised mortality ratios do not correlate positively with Health Service resource levels.

Thus it is important to realise that hospital admission rates may be poor indicators of the true incidence rates of diseases even when the likelihood of being admitted to hospital for such conditions is comparatively great, particularly since, as a result, further wild-goose-chase researches may be mounted into factors of apparent aetiological significance.

In this respect it may also be unwise to assume that the increased numbers of hospital admissions for renal stone and colic in the summer months represents the effect of an association between the incidence of these conditions and a rise in atmospheric temperatures. During the winter months, especially in the less well-resourced regions, surgical beds have to be "borrowed" to cater for the increased demand from patients suffering from serious acute medical conditions such as pneumonia. Similarly in winter it may be more difficult to discharge some surgical patients, particularly those with concomitant medical conditions, to poor home circumstances in inclement weather conditions. The stock of surgical beds available for admissions is thereby reduced and the critical level of severity needed to warrant admission may be raised, with a resulting fall in the numbers of admissions for conditions such as renal colic.

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¹ Department of Health and Social Security and Office of Population Censuses and Surveys, *Report on Hospital Inpatient Enquiry for the Year 1977*. London, HMSO, 1973.

SIR,—Although it is plausible to propose a higher incidence of renal stones in the warmer parts of England, the data presented by Drs D J P Barker and S P B Donnan (14 January, p 67) should be interpreted with caution.

Firstly, there are similar regional variations in hospital discharge rates for many other diagnoses—for example, infections of the kidney, appendicitis, or ischaemic heart disease.¹

Secondly, the rank orders by regions presented for renal stones and colic are similar to discharge rates for all causes combined. An inference, not mentioned in the paper, might be that regional discharge variations are related to supply of hospital facilities.² Hospital discharge rates for ischaemic heart disease, in contrast to the death rates mentioned in the paper, also show these variations.

Thirdly, general practitioner consultation rates for calculus of the kidney and ureter in the national morbidity survey³ show neither north/south variation nor much relationship to the hospital regional rankings.

Lastly, people with renal stones may present at hospital more than once in their lifetime and the extent to which the Hospital Inpatient Enquiry includes repeat discharges within one year varies with diagnosis.⁴ The word

"incidence" in the title, therefore, seems to be somewhat misleading.

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¹ Ministry of Health and Department of Health and Social Security, *Reports on Hospital Inpatient Enquiry*. London, HMSO, 1958-77.

² Logan, R F L, et al, *Dynamics of Medical Care*. London School of Hygiene and Tropical Medicine Memoir No 14, 1972.

³ Office of Population Censuses and Surveys, *Morbidity Statistics from General Practice: Second National Study 1970-71*. Studies on Medical and Population Subjects No 26. London, HMSO, 1974.

⁴ Acheson, E D, and Barr, A, *British Journal of Preventive and Social Medicine*, 1965, **19**, 182.

ECT and the media

SIR,—In the correspondence column (22 October, p 1081) a group of psychiatrists from Stratheden Hospital in Fife raise some very important issues relating to the debate on ECT. They wrote to express their concern about the critical publicity that ECT had received in the media. They chose to credit the public's interest in the facts about ECT to the campaigning being done by the Citizens' Commission on Human Rights.

As flattering as this is, I believe that the Stratheden nine have failed to grasp the real issue. The media have taken up the ECT controversy because the public are interested. The public are interested because they feel they have the right to know the facts about what happens to them or their relatives. The authors might well ask themselves if the media are in fact doing the job that the psychiatrists should have done themselves—that is, ensuring that patients and the public are fully informed about ECT.

Case after case that has lodged complaints with our commission have stated that they had not been adequately informed of the pros and cons of ECT before receiving it. Now one could say (as do the Stratheden nine) that such patients received ECT and ECT causes memory loss, so how can they recall the lack of prior briefing with priority. One could indeed find himself firmly lodged in this psychiatric Catch 22. "He has complained that he was not informed about the possible damaging side effects connected with ECT, but you cannot believe him because ECT causes memory loss." I would prefer to rely on the investigations and testimony of such as the Ombudsman's investigation in Glasgow and the committee of inquiry that looked into St Augustine's.

The learned Stratheden nine attempt to equate the programmes put on by television programmes such as "Panorama" with "the classical tradition of Dr Josef Goebbels." Methinks the lady doth protest too much. Psychiatric treatment when given forcibly without prior consent and when of an experimental and potentially hazardous nature that is highly controversial even within the profession is perhaps somewhat closer to the work of dedicated "scientists" of the Third Reich than are the efforts of the media to deal with a topic which is perhaps not very pretty, no matter how you present it.

The view of the nine wise men in Cupar, Fife, that someone is out to get them possibly reveals more about themselves than about the problem they are dealing with. Instead of accusing the media and the Citizens' Commission on Human Rights and other outspoken psychiatrists and doctors of bad faith, perhaps these doctors should examine their own consciences. How many of them in their composite 191 years have given "maintenance ECT" in the 100s or thousands. How many of them have given ECT to a patient without fully explaining it and getting truly informed consent?

Mental distress and problems is not an easily resolved matter that is probably not to be cured by a pushbutton shock and convulsion. Quote from Szasz. Neither ECT nor psychosurgery seems to have resolved the problem of increasing re-admissions to psychiatric institutions.

It might be noted in passing that the commission did extend invitations to the Stratheden nine to attend the recent mental health symposium in London we sponsored, which brought the two sides of the argument together. Unfortunately to our knowledge, none of these attended. It is the commission's view that logical discussion and examination of the facts and not invective will resolve the questions of informed consent and treatments such as ECT and psychosurgery. It is our view that the new Mental Health Act should enact restrictions and safeguards on their use similar to those enacted in the United States, but, whatever the outcome of the debate, the preservation of a free flow of information to public and patient is a responsibility that all of us, media, Stratheden nine, and Citizens' Commission must bear.

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A Mental Health Reform Group
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Physical deformity of Richard III

SIR,—Mr Philip Rhodes's article on the physical deformity of Richard III (24-31 December, p 1650) was particularly noteworthy, as I have always been interested in Shakespeare's references to paediatrics. However, I doubt whether his conjectures about Richard's deformities can be accepted, and I must point out that he has not taken any note at all in his analysis of Shakespeare's description of the leg deformity. If one accepts Shakespeare's words that Richard had a shrunk arm, a back deformity, and unequal legs and that he was born prematurely with his legs forward, surely we have here a description of a premature birth with breech delivery, and the most common complication of such a confinement is cerebral palsy. This would give rise to all the deformities mentioned by Shakespeare, and the picture by Ian Holme of Richard III at Stratford-on-Avon a few years ago was probably a very accurate portrayal of the cerebral palsy child grown to an adult.

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SIR,—Professor Philip Rhodes (24-31 December, p 1650) assumes that Richard's deformity of the shoulders consisted of elevation of the right shoulder. I would like to suggest that the more probable explanation is that the right shoulder was normal and the left depressed. If this is the case the most likely cause would be weakness, or paralysis, of the muscles supporting the shoulder girdle—namely, the levator scapulae and the upper part of the trapezius. Both these muscles, and only these muscles, are innervated by the anterior roots of C3 and 4. Richard's deformity therefore would seem to be due to an injury to the cervical plexus.

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SIR,—Professor Philip Rhodes is to be congratulated on his careful assessment of the data on Richard III's deformity (24-31 December, p 1650).

Inevitably in any discussion Richard III