support published ones referred to in the editorial: this does not mean that I avoid the peer review process, as was implied. Dr Lawrence and colleagues also choose to disregard the evidence I put forward in favour of transcutaneous electrical nerve stimulation but raise the controversial (and again not physical) point of drug treatment. In summary, they are mistaken to state that there is no evidence for benefit from physical treatments. In my view the *BMJ* rightly and courageously took up the much neglected subject of physical therapy. If the word "disservice" had to be used it might better apply to the misinterpretations that Dr Lawrence and colleagues decided to introduce.

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1 Housley E. Treating claudication in five words. *Br Med J* 1988;296:1483.

Gall bladder lithotripsy

SIR,—Dr Gillian Matthews's editorial on gall bladder lithotripsy misses its targets almost completely.¹ The NHS does not have "a poor track record for resisting the pressure from manufacturers and politicians to invest in new technology." We are way behind other countries such as the United States, Japan, Germany, and Switzerland in adopting important medical advances. For instance, there should be a computed tomography scanner in every British health district with a district general hospital, and this would still be a modest provision in comparison with elsewhere.

The prevalence of gall stones is indeed high, but the given prevalence of "around 9% of the British population aged over 60" is imaginary. For men aged 60-69 the prevalence of gall bladder disease is 15.5%; aged 70-79, 22.8%; aged 80-89, 26.1%; and over 90, 39%. The figures for women are 31.5%, 33.6%, 42.6%, and 42.7% respectively.² A minority of "untreated patients may suffer much pain and illness," but fortunately most of these stones never cause symptoms, and this is surely worthy of a mention.

I do not suggest that there should be a wholesale purchase of lithotripters just for gall stones but that modern dual purpose machines used mainly for urolithiasis should be freely available. It is reasonable to suggest that every health region should have such equipment. Though gall stone lithotripsy (which very importantly includes treatment of choledocholithiasis as well as cholecystolithiasis) may perhaps always be a junior partner in the treatment of gall stones, its true place will never be established if access to the hardware is unacceptably difficult.

All doctors applaud randomised controlled trials to assess usefulness of treatment, but lithotripsy has been shown to work for many patients, who should not be denied it purely on the grounds of parsimony.

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1 Matthews G. Gall bladder lithotripsy. *Br Med J* 1989;299:1060-1. (28 October.)

2 Bateson MC. Gall bladder disease and cholecystectomy rate are independently variable. *Lancet* 1984;ii:621-4.

The destruction of a welfare service

SIR,—Your editorial on "The heart of the white paper controversy" was encouragingly political.¹ Doctors must recognise that the white paper is not a strategy for improving an organisation but the product of a government vehemently opposed to the concept of welfare. Its problem is how to sink the NHS without seeming to do so.

Regulation of the flow of money to the NHS is

and was ever the principal vehicle of government policy. In consequence the NHS is a patchwork of highly variable quality. Much of the service is provided from outdated buildings littered over ugly and crowded sites providing a miserable ambience, which, noticeably, is the first thing that private hospitals eliminate. The unconcern for the working environment is one aspect of the NHS's deteriorating record in man management.

Indeed, so lamentable is the record and so excoriating the hectoring which accompanies the white paper that the process has to be understood as a deliberate exercise in undermining the corporate sense of continuity which marks out a profession and distinguishes a professional from an entrepreneurial career. If we declare ourselves demoralised by the processes used by the administration over several years we shall be castigated for it. But how else, other than deliberately, can a government spend more money than ever on a service which experiences it as nothing but an attrition?

The process of squeezing budgets actually does set doctor against doctor as each squabbles to maintain the integrity of his or her own service to patients. The pressure on funds not only curtails services, it disrupts established clinical teams; it precludes forward planning; and, by declaring the need for less work to be done by certain doctors, it devalues their sense of professional achievement. Each successful attempt to readjust is simply followed by further cuts. Strong doctors who favour an entrepreneurial system, who practise specialties that command public support, whose patients could pay for their services, who work in districts which command majorities of government supporters might see some advantages in what is proposed. Most of the profession's representative bodies have treated the white paper as if it were a well intentioned but wrong headed basis for improvement.

It must be seen by individual doctors as the first major battle in the war of attrition against a welfare service. The word "national" is pointedly lost in the white paper on the health service. The purpose of its chaotic content is less to promote debate than to ferment disillusion, division, and demoralisation in the hope in the longer term of foisting a divided service on a divided profession, wherein the welfare component of health care is abrogated to local governments.

Already in those services which excite least public sympathy—those for the mentally handicapped, mentally ill, chronic sick, and elderly—erstwhile forward looking policies are used to relocate patients "in the community" but with devastation of their funding, management, and organisation. The move by stealth of the disadvantaged into the community is betrayed in the cardboard hovels on our city streets. Most doctors now practising were trained by a welfare system for a welfare service. That service has provided some of the best value for money in the world. It deserves better government.

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1 Smith T. The heart of the white paper controversy. *Br Med J* 1989;299:929-30. (14 October.)

Mental Health Act 1983: guardianship order and definition of mental impairment

SIR,—The recent case of Beverley Lewis in Gloucester¹ shows a glaring deficiency in the Mental Health Act 1983 in its legal criteria of definition of mental impairment and severe mental impairment.² For the local authority social services to use the guardianship order the mentally handi-

capped adult has to be mentally impaired or severely mentally impaired—which means such a person should also be of "abnormally aggressive or seriously irresponsible conduct." It is by any means a stretch of the imagination (and semantics) to apply this definition to severely and profoundly handicapped adults like Beverley Lewis who do not fit these criteria. I am not sure how much an issue the protection by guardianship order was in this case, but surely there must have been and still are a considerable number of such cases falling through the safety net. Ironically, one of the objectives of the Mental Health Act 1983 was to protect and safeguard the rights of mentally handicapped patients. Six years after the act's implementation there is an urgent need to review and rectify some of these serious deficiencies without further delay.

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1 Sapskad D. Beverley: 'natural death.' *The Times* 1989 Nov 2:1 (col 4).

2 Singh TH. Mental Health Act: definition of severe mental impairment and mental impairment. *Br Med J* 1984;288:149-50.

Overprescribing

SIR,—During one of the hottest days in July this year my 16 year old daughter, who was on holiday near Lyons in France, was overcome by heat and fainted. A doctor was called and he told her that she had a low blood pressure and he prescribed some capsules to be taken six times a day. The proprietary preparation was called Tensophoril. This compound contains dopamine hydrochloride 15 mg, boric acid 15 mg, amylobarbitone 15 mg, and ascorbic acid 250 mg.

The effectiveness of dopamine hydrochloride when given by mouth is not well documented but *Martindale: The Extra Pharmacopoeia* states that the drug is inactive when given by mouth.¹ It is rapidly degraded by gastric acid but it might, in theory, cause some gastric vasoconstriction. Boric acid has now been discontinued for local use in most countries because it is toxic to tissue. Boric acid poisoning leads to vomiting, diarrhoea, rash, and meningeal irritation. *Martindale* states that this drug "should not be used internally." It has weak bacteriostatic and fungistatic properties but has been "superseded by more effective and less toxic disinfectants." Amylobarbitone is a long acting barbiturate and the total daily dose in six Tensophoril tablets would amount to 90 mg. Finally, the amount of ascorbic acid in each of the capsules amounts to that found in five average oranges. My daughter opted not to take any of the capsules and later that day felt entirely well.

As in the case of Professor J G Scadding's grandchildren,² this treatment was unnecessary.³ Hypotension is not a syndrome commonly recognised in the United Kingdom.⁴ The general view is that, with very few exceptions, it is not possible to have too low blood pressure. The British, however, have their own pet diagnoses—often related to colonic function. When treating strange national variants in disease it is perhaps best to avoid drugs that are potentially pharmacologically dangerous. In that respect, aperients may be less harmful than antihypertensive drugs.

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1 Reynolds JEF, ed. *Martindale: the extra pharmacopoeia*. 28th ed. London: Pharmaceutical Press, 1982:9.

2 Scadding JG. Overprescribing. *Br Med J* 1989;299:853. (30 September.)

3 Pemberton J. Constitution hypotension: does it exist? *Br Med J* 1989;298:660-1.