disease than with nodal disease.⁵ Although these differences suggest aetiological and biological heterogeneity, the evidence that diabetes has a role in either type of non-Hodgkin's lymphoma, as suggested by the Japanese data, is not strong. A cohort study in 1982 of people with diabetes mellitus found an excess of lymphoma,⁶ but the authors attributed this to inappropriate referent population rates.⁷ They also observed no association in a cross sectional study.⁷ Further studies will require more accurate determinations of diabetes and nodal status in non-Hodgkin's lymphoma.

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Treating mental health problems in health care workers

They deserve a confidential service

EDITOR,—Like the author of a recent personal view,¹ I have experience of a very public illness. I was admitted as an emergency to a neurological institute with an acute demyelinating illness. My precise diagnosis was at first obscure, and its aetiology remains undetermined. At the time, however, speculation was rife among the medical fraternity, and many of these stories were a worry to me when I was particularly vulnerable. Colleagues, certainly not friends, were caught reading my case sheet, so that the ward staff had to keep it under lock and key.

Now, when I speak to senior medical staff I often find that they wrongly assume that they know my diagnosis because of what was rumoured. The ward staff handled my confidentiality honourably; the real problem was with my extended medical colleagues, both junior and senior, who discussed my case at length and ignored my right to privacy. The saddest thing is that many of the doctors who have violated my confidentiality do not even realise that they are guilty.

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1 Miracle cure. *BMJ* 1995;310:538-9. (25 February.)

Should be no different from other people

EDITOR,—I was interested to read Elizabeth Sinclair Miller's letter protesting against the closure of the specialised unit at Bethlem Royal

Hospital, Beckenham, for health care workers.¹ That this ward was provided at all in an NHS hospital raises serious questions: it is no more embarrassing for health workers to seek treatment for mental illness or psychological problems than it is for any other section of the community. Instead of operating such double standards—whereby those not "in the club" are obliged to deal with the stigma and the consequent difficulties concerning employment, loss of status, etc, while others award themselves special conditions of privacy—it would surely be more helpful for doctors to realise that the public does not need to perceive them as somehow superior beings. The psychiatric profession seems to have been hypocritical during the past few years in protecting its own while, at the same time, running a high profile public campaign to raise awareness and deal with the stigma of mental illness.

In general, people who use mental health services have much greater respect for health workers who are open about their own fallibility and vulnerability, and they would prefer to be treated by more of those with whom they share the same experience. We perhaps all need a haven at times, but this should be a shared place, not a special privilege awarded to a minority.

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Rationing intensive care

Crisis reactions to shortages should be replaced by analysis of strategic services

EDITOR,—There has been considerable public concern over the need to transfer a man from London to Leeds for intensive care because of a shortage of beds.¹ In 1992-3 I led a detailed study of the use of intensive care facilities in the Yorkshire region (which includes Leeds).² Data (including severity scores based on the Intensive Care Society's national acute physiology and chronic health evaluation (APACHE II)) were collected on 3063 out of 3185 patients admitted to designated intensive care unit beds in 18 hospitals between 1 June and 30 November 1992.³ The main findings were as follows.

Bed occupancy—Every unit accommodated at least as many patients as it had designated beds on 19 or more of 153 days analysed. Nine units were full on 60 days; four units were full on 90 days.

Patients' age—Mean age at admission was 54.9 years. Altogether 1324 patients were aged ≥ 65 and 114 were aged ≤ 4 . Fifty six of these 114 were admitted to specialist paediatric units.

Patients transferred—A total of 202 patients were admitted from other hospitals. One hundred and forty two were transferred to tertiary centres. Sixty patients were transferred from one district unit to an equivalent district unit.

Early discharge—One hundred and one patients were declared by the consultant to have been discharged from the unit before it was clinically appropriate.

Severity—Altogether 840 patients had a severity (APACHE II) score of < 10 , indicating that high dependency care might have been sufficient.

These results and other reports show that pressure on intensive care facilities has been growing for some years and is not confined to the south east.⁴ In six months in 1992, 171 patients were either discharged early or transferred to an equivalent unit because of pressure on beds. This must be balanced by the observation that a considerable proportion of patients may have required high dependency rather than urgent care. The high

proportion of patients aged 65 or over suggests a substantial change in clinical policy towards actively treating and resuscitating critically ill patients irrespective of their age.

With the demise of regional health authorities and the increasing emphasis on locality purchasing in general practice there will be no bodies to sponsor or respond to this type of analysis of strategic services. The NHS will instead have to depend on crisis reaction to individual cases that are reported in the media.

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High dependency units may be the answer

EDITOR,—During the 24 hours in which a patient was moved from London to Leeds for intensive care¹ I admitted two patients from the region and also had a request from a major London teaching hospital. In an immediate crisis, whether it is a road accident or a leaking aortic aneurysm, I believe that the specialist centre has a duty to initiate treatment there and then. It will be some hours before a bed in an intensive care unit will be needed as radiological investigations and surgery take priority. In the interim such a bed will have to be found. This usually means that another, more stable, patient will have to be transferred elsewhere and transferred back when the crisis is over.

I believe that J Bion is correct in stating that high dependency units will solve some of this problem.² It is amazing that only 15% of hospitals in Britain have high dependency units when so much can be achieved in these "half way" and less costly facilities. At a time when resources are stretched it makes sense to concentrate care for patients in more complicated medical and surgical cases, who currently have to take their chance in acute wards, and to provide care in between that provided in the ward and in the intensive care unit. Such provision might also have a beneficial impact on the high mortality in wards among patients discharged from intensive care units.³ Some elective patients could be diverted to a high dependency unit, thereby freeing beds in the intensive care unit (table).

Admissions to general intensive care unit at Freeman Hospital, 1992-4

	1992	1993	1994
Admissions	367	398	386
Elective surgical cases	155	163	163
Cancellations	9	8	9
Transfers out of unit to free bed for new patient	14	10	12
Transfers to unit as no bed available in unit elsewhere	10	12	17

We need to know whether, in reality, a large number of beds are not staffed. The Freeman Hospital's intensive care unit has six beds, but only five are commissioned with a full nursing complement and equipment. Last year we had to use that sixth bed on 88 occasions.

The interim step is to ensure that busy hospitals have both a high dependency unit and an intensive care unit and that frozen beds in intensive care units are staffed. The profession and the public have high expectations of medical care, and a high dependency unit would enable more ill patients to