

ning of the history of man and because of their appearance, particularly their faces, some of them have had certain characters or personalities attributed to them. These resemblances may be quite false, as in the case of the bear, who is, in fact, not an amiable and comforting creature but quick-tempered and treacherous; but the image is irresistible and so it is with lots of animals.

A child can relinquish his own identity and go along with the animal, imagining what it is like to be doing what he is doing, eating what he is eating, belonging to that world. So when a rabbit, for example, is placed on the bed of a child in hospital and he watches its shallow breathing, its alae nasa, and its little sensitive movements he is fascinated, he loves it, he loses himself for a while in identifying with the rabbit, going on a sort of journey with him and so leaving his troubles behind.

Not all children in hospital have troubles that they want to escape from, but many are, or have been, under stress in various ways. Think of a child of 6 or 7 years recovering from abdominal surgery with intravenous drip and nasogastric suction drainage perhaps; watch his expression as a guinea-pig, rabbit, or dog (and they can be quite compatible together in the ward, by the way) comes to be his companion for a time. He is soothed, he relaxes, smiles, and feels better.

All who have pets as a permanent feature of the life of their children's wards will be grateful to Mr Cooper for the useful knowledge and guidance provided in his article and for making it respectable to have animals in the ward and so defending us from the attacks of hygienists.

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Shoplifting

SIR.—Your leading article (20 March, p 675) emphasises the problem of unintentional shoplifting (as suggested in my previous letter (28 February, p 523)) and indicates that the incidence probably varies, being greater in some areas than Dr S Bockner (20 March, p 710) finds. Perhaps this reflects the varying factors, including the number of individuals referred, the wisdom and selectivity of the officers of the court and the lawyers concerned, the type of catchment area (High Street rather than Oxford Street shoppers), and the availability of social and family psychiatric histories. Important also are individual clinical interests, attitudes, and judgments, taking into account the patient's presentation (preferably by inpatient observation), with appropriate social, psychological, probation, and nursing reports also.

Perhaps the numbers concerned imply occasionally but none the less significant rather than esoteric diagnoses, but no one would dispute Dr Bockner's sensible considered view that "greed does not justify dishonesty" and it would be naive and unpractical to be unaware of this majority and non-psychiatric problem. Indeed, before necessary "pruning" because of limitation of space, my previous letter opened by saying, "Regarding the ever-increasing 'business' of shoplifting, little need be said about offences committed for greed."

Concerning organic contributions to shoplifting, an experienced consultant surgeon has told me of cases in which bizarre behaviour

and unwitting shoplifting have occurred in cases of severe hypoglycaemia due to insulinomas. He has asked if other readers could let him know of any similar cases in their experience, either through your correspondence columns or myself.

Your article wisely stresses both the preventive aspects and how the law has struggled with this problem for centuries. Significantly, Sir Roger Ormrod, FRCP, Lord Justice of Appeal,¹ has written that "courts have always to deal with individuals; and their need—sometimes it is almost a desperate need—is for information, knowledge and advice on an individual basis."

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¹ Ormrod, R F G, *British Journal of Psychiatry*, 1975, 127, 193.

Osteomalacia and calcium deficiency

SIR.—In a reply to "Any Questions?" (24 January, p 203) it is stated that "an authoritative review of calcium requirements concluded 'there is no firm evidence that calcium deficiency exists in humans.'"

In the "authoritative review"¹ there is no reference to the work of Dr Marshall Day and myself of over 35 years ago.²⁻⁴ In Palampur in the Kangra District of the Punjab we recorded that 25% of the children had rickets and 50% of the women had osteomalacia. Surprisingly, they had almost perfect teeth, with one of the lowest rates of dental caries and dental hypoplasia. The Punjab Public Health Department carried out an exhaustive nutritional inquiry and concluded that the alarmingly high incidence of rickets and osteomalacia was due to calcium and phosphorus deficiency. The diets contained very little calcium as little or no milk was available because, being a Hindu area, most cows were barren in a hill district with little and poor pastures. The children wore few or no clothes and there was no purdah, so that the skin of everyone had more than sufficient tropical sunlight for vitamin D synthesis.

These old observations are perhaps again important in considering the cause of the high frequency of osteomalacia in elderly people in Britain, many of whom have low intakes of vitamin D and also low intakes of calcium.

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¹ Walker, P P, *American Journal of Clinical Nutrition*, 1972, 25, 518.

² Taylor, G F, and Day, C D M, *British Medical Journal*, 1939, 1, 919.

³ Taylor, G G, and Day, C D M, *British Medical Journal*, 1940, 2, 221.

⁴ Day, C D M, *British Dental Journal*, 1944, 76, 155 and 143.

Geriatics in the cottage hospital

SIR.—Professor J A Davis (20 March, p 713) asks what an enthusiastic general practitioner has to offer his long-stay geriatric patients. Luckily we have clinical assistantships covering 101 long-stay geriatric patients in two hospitals as well as a 50-bed "part three accommodation" home for the elderly within our practice.

However, our cottage hospital population usually has an average age over 65 years, and

here we can offer an efficient and often homely atmosphere for our aged sick. What's more, we can usually offer immediate admission to our acute beds by maintaining a high turnover. This is often difficult to arrange with a district general hospital or "acute" ward of a geriatric hospital, especially at the weekend for a mildly disturbed, sick old person. The terminally ill receive the most caring attention, often from auxiliary nurses who know the patient personally, and bereaved relatives are often dealing with their own GP, to whom they can turn for help themselves.

This does not alter my premise (Personal View, 28 February, p 519) that a 22-bed acute hospital offering casualty, diagnostic, and cold surgery beds should not be allowed to become filled with long-stay old people.

Children we do not admit, for an ill child must be under the care of a specialist, as I think Professor Davis will agree.

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Domiciliary oxygen in chronic bronchitis

SIR.—Your leading article on this subject (28 February, p 484) rather gave the impression that the capital cost of the oxygen concentrator was beyond the reach of most of us. In fact, this unit costs less than the figure which you quote for supplying cylinder oxygen for one year and, what is more, since the running cost when obtaining the same volume of oxygen from the concentrator is only about £100 per annum it is possible to save about £300 in the first year and more than £1000 per annum thereafter.

The work by Stark and Bishop which led to the report in which oxygen concentrators were stated to be noisy¹ was done on the first concentrators ever to be produced. As a result of this report the manufacturers redesigned the unit. Considerable development has taken place in the last few years. The concentrator has been silenced and can now be used in the bedroom without disturbing sleep, while efficient suppressors have been fitted to avoid any interference with television or electronic equipment. Concentrators are now by far the cheapest and best method of obtaining low-pressure domiciliary oxygen.

There is another feature of the concentrator worthy of serious attention: it can be fitted with a time switch to turn it off after a period of use, allowing the patient to stay asleep.

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¹ Stark, R D, and Bishop, J M, *British Medical Journal*, 1973, 2, 105.

Computer-held medical records

SIR.—It is indeed true that changing the structure of records changes the behaviour of physicians (Dr C J Bulpitt and others, 20 March, p 677). Preliminary work in general practice shows that the introduction of a system of problem-orientated medical records markedly affects the way general practitioners manage patients.

We hope to show that merely introducing a hypertensive flow-sheet improves the initial