Perhaps it is best that the two disciplines should be allowed to develop side by side for some time longer, giving a chance for discussion and mutual tolerance to effect further cross-fertilisation. Certainly in my experience behaviourists who deal with cases have at times become more psychodynamic in their attitudes, but there are patients who may need only a relief of symptoms, whereas in other cases the underlying attitudes are much more important. I realise that this can be a point of some disagreement and that we are looking at two opposite extremes of approach. There is no harm in the student's knowing this, but again I think the task of helping students to integrate these considerations with their medical knowledge is better done by a medical man. There is danger in considering qualities only in a way which can be put on a computer.

My general plea is not new. In 1956 *The Practice of Medicine*, edited by John Richardson, appeared with a distinctly psychodynamic first chapter on the nature of disease by Denis Hill, with further elaboration in the chapter on psychiatry. Surely the "humanitarian assistance" allowed by Professor Shepherd must allow that some understanding of emotion can also be common sense?

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SIR,—As a GP with unusually wide experience in psychiatry I should like to express my support of Professor M Shepherd's Personal Paper (15 December, p 1557) and his conclusions about the danger of further extension of the influence of psychoanalytical theory to the health—and may I add the social—services.

There are other shortcomings in the contribution of psychiatry generally which I should have liked to have dealt with at some length but can only mention. It is against the total scene that the strictures on psychoanalysis must be seen. I am well aware of Professor Shepherd's own work, and that of an increasing number of other eminent psychiatrists, which goes some way towards correcting some of these shortcomings but these are not enough.

Psychiatry has lamentably failed to tackle a major health hazard—smoking. What relevance psychoanalytical theory has to this issue has so far not been defined. The increasing number of early teenage pregnancies demands some more positive intervention in family crises both for the teenager and for the family than is currently available. Is this not a crisis situation? What contribution psychotherapy could make here is a matter on which I should like enlightenment.

Psychiatrists are largely to blame, though the medical profession cannot escape censure, for the sad situation by which we now have social service departments in which doctors and psychiatrists play such little part. (I regret to think that psychiatrists would be as little welcomed by obstetric colleagues as by the social services.) As regards the social services, it was and is not merely theory but the deployment of psychiatrists which needed and continues to need correction. As psychiatric adviser to the City of Birmingham children's department I was able to alert the profession to the importance of Seeborn.^{1,2} That I was not constrained by a one-to-one depth psychology or even "group" orientations allowed for a reality assessment of the whole.

The neglect of the medical model in psychiatry generally (in this instance psychoanalytical theory is least culpable) has led to the bizarre situation that in this the most personal of all illnesses and disturbances we have a catchment area for admissions. Only at the cost of enormous effort and good will is it possible to get specialists of one's choice for a particular patient.

In conclusion, I should like to refer back to Professor Shepherd's comments and point to a

further danger. In America the market economy of medical services will eventually discard those theories that become unfashionable or are shown to be unproductive—for the customer. Even there, professional interests will continue to create and maintain some jobs. In this country the National Health Service, as well as a supposedly soft touch for patients, has provided career structures and research deployment for the profession—mostly under professional control or advice. The possible extension of psychotherapy is to my mind less of a hazard for patients than it is for the deployment of scarce and potentially valuable resources. Once established it would be difficult to make changes. The still greater danger seems to me that it would give a further boost to theory in social work which claims to bypass medical help and co-operation in the field of human behaviour.

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¹ Barnett B. *Br Med J* 1966;ii:363.

² Barnett B. *Br Med J* 1966;iii:1076.

Medical charities and prevention

SIR,—In view of the authority carried by a leading article in the *British Medical Journal* (22-29 December, p 1610), it is important to voice the serious concern felt by the Cancer Research Campaign that a professional journal of this standing can publish a somewhat misleading and scantily researched piece of writing on a subject of such vital importance. Your description of current policies in cancer research is inaccurate so far as the Campaign is concerned and you appear to have made no attempt to verify material relating to it, either by comparing allocations of grants listed in annual reports or by consulting with the Campaign's officers. Unfortunately any damage done has been compounded by the subsequent reproduction in the *Observer*, with some additional inaccuracies, of the salient points of the attack.

The Campaign's principal quarrel is with the statement that prevention plays a minute part in the activities of the two major cancer research charities and that in medical research into cancer and heart disease generally the charities pay little attention to prevention and give a far lower priority to it than they do to cure. It cannot be overemphasised that the driving concern of all those who work for the Campaign and of those involved in the research it funds is to eradicate cancer and eliminate the reason for its existence. In support of this aim the Campaign endeavours to aid and promote research that will enable the causes of cancer to be more fully understood and high-risk groups of people to be identified. This must clearly precede preventive education. Epidemiological studies are of increasing importance in this context, as well as other forms of research into causal factors. An article by Professor Sir Richard Doll and Dr L J Kinlen in the annual report of 1971 emphasised the relevance of epidemiology for the prevention of cancer.

Even a cursory glance at our project list for 1979 reveals the extent to which the Campaign is concerned with all forms of aetiological research. About one-fifth of the projects supported are aetiological and thus aimed at the eventual prevention of cancer, the remainder being concerned with treatment and the other

main fields of cancer research. To select two important examples—the Campaign endowed the academic department of epidemiology at the Institute of Cancer Research and continues to provide substantial support for Professor M R Alderson's research programme there, and it awarded one of its relatively rare life fellowships to Dr Kinlen as one of the epidemiologists in Sir Richard Doll's department at the Radcliffe Infirmary in Oxford. Other grants cover the whole field of aetiology and include the screening and identification of carcinogens, diet, viral research, and genetic predisposition.

It is correctly pointed out in your leading article that cancer is preventable in one major field, lung cancer, where action to reduce cigarette smoking is likely to be more effective in reducing mortality than attempts to find a cure. Unfortunately the means of changing people's social habits have yet to be discovered and further research into the subject of preventive education is needed before large sums are committed to propaganda which may well be totally ineffective. The Campaign could certainly not justify to its subscribers the expenditure of funds in public health education which cannot be evaluated in the short term. The people who contribute so generously to the Campaign on the basis of an appeal for research into the causes, prevention, and treatment of cancer might reasonably be unhappy were we to allocate large sums to publicity aimed at changing their life habits. In our view, work of this kind should be left to the expertise of the statutory and voluntary agencies set up specifically for such purposes.

The article appears to equate prevention with education, but in the Campaign's view the latter is merely one aspect of the former. As has been indicated, a substantial proportion of Campaign-funded research is aimed at prevention through discovery of causes, while a separate and considerably smaller sum (approximately 2% of income) has been allocated in recent years for cancer education. Projects are concerned with such subjects as the specialist training of nurses in cancer care, the investigation of the potential of cancer education in the field of further education, health education in primary schools, and the evaluation of education relating to screening for cervical cancer in high-risk populations. Since education can be differently interpreted within different organisations, the comparison the article makes of figures spent on cancer education is not necessarily valid. The public health education carried out by some organisations may also include an element of self-advertisement.

When deciding the priorities between the different research options, the Campaign is very much aware that the ideal aim of eradicating all causative agents has to be tempered according to what is attainable. Even the identification of all causes is unlikely to ensure the prevention of cancer, since some environmental factors may well turn out to be unavoidable. Moreover, the long period between the initiation of the disease and its clinical emergence would still necessitate treatment for cancer patients long after the cause had been eliminated. Research aimed at producing better, kinder, and more effective treatment must therefore continue to have a high priority for many years to come.

In conclusion, the point is made in your leading article that since cancer and heart research charities are funded by donations from individuals the public should have more say on how the money is to be spent. The Campaign

would certainly not dispute the need for public accountability and makes provision for this in various ways. Some 900 local committees throughout the country can take account of any viewpoints expressed and there are opportunities to attend meetings at local and national level. Questions are welcomed at any time and carefully answered. Annual reports and newsletters as well as the inquiry service help to promulgate information about the Campaign's activities.

This is no more than a résumé of the Campaign's reasons for objecting to the tenor of your article. We hope that it will be adequate to show that there is a very real difference between your interpretation of the Campaign's priorities and the aims the Campaign itself sees as being of overriding importance.

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Scientific Secretary
DAVID GRIBBIN
Secretary General

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SIR,—We have read your leader on medical charities and prevention with considerable interest.

Although the British Heart Foundation raises its funds mainly for research, it keeps the subject of educating the public under continuous review and seeks the opinions of the profession both within its committees and outside. To this end, the foundation sought by letter the opinion of 50 leading British cardiologists about what they would advise their patients who asked how they could prevent a heart attack. Apart from smoking, there was no unanimity of opinion in relation to the other risk factors. It would therefore clearly be irresponsible of the British Heart Foundation to publicise views which had not the backing of the medical profession as a whole.

The British Heart Foundation does, however, publish a series of non-controversial booklets on various aspects of heart disease which are available on request by members of the public and are freely available at the meetings held throughout the country by our regional organisers. Last year over 119 000 were distributed. The foundation has also sponsored a cookery book, *Cooking for your heart's content*, which is available to members of the public whose doctors have advised a low-cholesterol diet.

The research funds committee, responsible for the awarding of grants, is made up of experts representing the various disciplines concerned with cardiovascular disease and chaired by an eminent member of the profession who is not a cardiologist. Epidemiology is at present represented by one of our leading epidemiologists, and all applications in this field are carefully reviewed by external and internal assessors and by the research funds committee as a whole.

Finally, we should like to point out that the appeal advertisements are clearly worded for "heart research" and the success of the foundation, in monetary terms, over the last few years is perhaps indicative of what individual members of the public want when they donate their money.

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Comfort versus independence in child development

SIR,—I was most interested to read Dr Martin Schweiger's Personal View (12 January, p 107) and feel that many people who have worked in developing countries will share his sentiments. I wonder if I might offer some of my own observations on the question of child-rearing practices based on my experience in Tanzania?

If in this country a school-age child is seen sucking its thumb, biting its nails, or clutching its cuddly toy, one takes it as a possible indicator of stress. Yet we seem to think it acceptable and almost as a sign of normal development in the preschool child. Mothers are often recommended to encourage their infants to use such comforters to help them feel secure; yet the security for which the child craves is its mother.

In Tanzania such thumb sucking and the use of cuddly toys was not apparent at any age, which leads one to ask whether even in the preschool child its prevalence in this country may be an indication of stress, and whether our child rearing practices are not ideal. In many developing countries the child is closely attached to its mother at all times and breast-feeding into the third year of life is in no way unusual.

How often in an outpatient clinic here one meets parents who admit with guilt or at least embarrassment that their cherished infant sleeps in the same room with them. How do the neighbours react when a 2-year-old runs in from play for a breast-feed? Indeed, how do we and the health visitors feel about it?

We seem in this country to feel that we must teach our children how to become independent by making them sleep alone from a very early age and find comfort away from the breast. Yet independence is a natural stage of development, arriving in its own good time and probably better achieved by a less prematurely stressed child. Is it really that we want the child to be independent, or that the mother wants her independence from the child?

I am not suggesting that all mothers in our society would find it possible or desirable to rear their infants in the same way as a Tanzanian mother. Those who try, however, should not be made to feel abnormal, but encouraged in what may be a method more beneficial to the child.

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Dietary fibre and blood pressure

SIR,—Angela Wright and others (15 December, p 1541) suggest that dietary fibre has a blood-pressure-lowering effect. Their results from 94 university staff and students divided into two groups according to their daily intake of fibre showed that the group with the higher intake had both a lower mean systolic blood pressure and a lower mean diastolic blood pressure. If we assume that their observed systolic and diastolic blood pressures followed a normal distribution in both fibre groups, and use their calculated means and standard errors, it is unlikely that more than two (2.5%) of their subjects had a systolic pressure greater than 140 mm Hg or a diastolic pressure greater than 90 mm Hg. Thus although they showed a shift to the

right in distribution of both systolic and diastolic pressure in the lower fibre group the blood pressures in this group were within the accepted physiological range.

We have examined the daily intake of dietary fibre from cereal sources in 112 middle-aged men working in industry, and examined the relationship between cereal fibre intake to both systolic and diastolic pressure (table). The method used to estimate

Differences in intake of dietary fibre from cereal foods (DCF) in 112 subjects grouped by systolic blood pressure

Blood pressure (mm Hg)	No	Mean ($\pm$ SD) DCF intake (g/day)
<i>Systolic</i>		
≤ 109	4	6.94 $\pm$ 1.21
110-119	11	5.87 $\pm$ 1.59
120-129	28	9.48 $\pm$ 4.86
130-139	27	9.19 $\pm$ 4.79
140-149	19	9.17 $\pm$ 4.47
150-159	11	9.92 $\pm$ 6.61
≥ 160	12	8.18 $\pm$ 3.10
<i>Diastolic</i>		
≤ 69	6	10.18 $\pm$ 4.23
70-79	36	8.54 $\pm$ 4.95
80-89	37	8.77 $\pm$ 4.91
90-99	18	9.17 $\pm$ 6.41
100-109	10	7.87 $\pm$ 2.21
≥ 110	5	9.29 $\pm$ 3.26

intake of cereal fibre (to be published elsewhere) was a four-day consecutive unweighed record, which is suitable for distinguishing the intake of individuals. Our results in this homogeneous population over a wide range of blood pressures lend no support to the suggestion of Angela Wright and her colleagues of an association between a low cereal fibre intake and hypertension. They also suggested that their finding might explain why Morris *et al*¹ found a decreased risk for coronary heart disease in those with a high intake of cereal fibre, despite the fact that Morris *et al* stated in their paper, "No association was found between blood pressure and the nutrient factors studied."

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¹ Morris JN, Marr JW, Clayton DG. *Br J Med* 1977; 2:1307-14.

The need for gynaecological oncology units

SIR,—Your leading article on cancer chemotherapy (24 November, p 1312) highlights some of the very real and aggravating problems confronting cancer patients and their medical attendants, be they surgeons or physicians. It raises the point of specialist centres and this needs emphasising. Complex and indeed dangerous agents, often in combination, are now employed and are significantly improving the outcome for many patients whose condition was previously considered hopeless. These agents may be used in conjunction with radical surgery. After all, even when ovarian carcinoma is not considered totally resectable surgery is often necessary as a debulking procedure. The aim is to reduce the total tumour volume and to leave no masses over 1 cm in diameter in the abdominal cavity at the end of the procedure.

Experience in America has shown that units specialising in this kind of work not only have better results than more general units but are more capable of combating problems that may arise from treatment. In no field of cancer is