importance of the employment of both birthplaces and residences in the study of distribution of multiple sclerosis, using survey data from the State of New South Wales, Australia. We hope that the following short observations may help to clarify this.

In 1974 a postal survey was conducted of the distribution of the disease in Australia through various state societies of multiple sclerosis. Responses of patients were followed up and the diagnosis was confirmed by their attending general practitioners and neurologists. In this way a total of 233 patients were sampled and 17 of these were excluded because they were diagnosed as having only possible multiple sclerosis or a disorder other than the one under investigation. The remaining 216 patients were confirmed as definite cases of multiple sclerosis. The table shows the analysis of patients by birthplace and by residence, the residence being classified as private dwelling or hospital in the metropolitan Sydney area and in areas outside metropolitan Sydney.

Distribution of multiple sclerosis patients by both birthplaces and residences of New South Wales

Birth-place	No of patients	Residence			
		Sydney		Other	
		Private dwelling	Hospital	Private dwelling	Hospital
New South Wales	141	73	23	43	2
Outside New South Wales	20	8	8	4	0
Overseas	55	39	13	3	0
Total	216	120	44	50	2

There are significant differences ($\chi^2 = 14.48$, $p < 0.001$) in the distribution of patients between those living in Sydney and those outside Sydney with reference to three categories of birthplaces—namely, New South Wales, outside New South Wales, and overseas. In addition, the analysis of patients by residence does not correspond with that by birthplaces, the difference being significant ($\chi^2 = 6.77$, $p < 0.01$).

The conclusion to be drawn from the data is that any epidemiological study of multiple sclerosis should include birthplaces as an adjunct to residences and population censuses.

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Abortion (Amendment) Bill

SIR,—Mr J Corrie's Abortion (Amendment) Bill will reach the report stage in the House of Commons on 8 February. Clause 1 would allow abortion up to 20 weeks if there was a risk to life or of *serious* injury to physical or mental health. The risk of continuing the pregnancy would have to be *substantially* greater than the risk from abortion. The words *serious* and *substantial* do not appear in the 1967 Abortion Act. The decision to request abortion is often difficult and usually distressing for the woman. Counselling, the skill of helping her to come to the best decision, can be honest only if the doctor feels free to recommend and perform the

abortion, or to help her to continue the pregnancy once she has examined all aspects of her situation. The word *serious* is difficult to define and would make doctors feel less free to offer neutral counselling. Consequently some women would not obtain the legal abortions they considered essential.

Clause 4 of the bill would result in extreme difficulty for the woman who wished to obtain a private abortion. She would have to find three independent doctors. The first two would counsel her and would sign the statutory green form if they felt that her abortion would be within the law. The third would have to be willing to perform the abortion on the basis of the two signatures on the form. It would be illegal for the operating doctor to advise the woman about her abortion decision or for him to have advised any other pregnant woman about abortion in the previous six months.

Mr Corrie and his sponsors appear to believe that doctors who see private patients do not offer neutral counselling but, instead, persuade women to have abortions they do not really want, so obtaining a larger fee. In fact, most women consult a doctor about abortion only after they have reluctantly taken the decision that the pregnancy is unwanted. Only a minority are uncertain about their need for abortion by the time they consult. In my experience in the Health Service 93% of women who are referred for consideration of termination have an abortion. Five per cent change their minds after counselling and 2% are not actually pregnant. Those who have talked to women requesting abortion know the strong motivation felt by these women, motivation so strong that they will risk illegal abortion if refused.

Clause 4 is designed to prevent legal abortion by the gynaecologist with a private practice and by the charitable organisations, the British Pregnancy Advisory Service and the Pregnancy Advisory Service. The latter perform 30% of all the abortions performed on British women. They provide neutral counselling and perform terminations on 95% of the pregnant women they see, a proportion similar to my own and that of many other units in the Health Service. The proper management of a woman who has an unplanned pregnancy calls for a team to give continuity of care—counselling, safe abortion, contraceptive advice, and post-abortion support. This occurs at present but would not be possible if the three doctors necessitated by Mr Corrie's bill were not allowed to work together.

The Health Service lacks the resources to meet the abortion needs of the community and for the last few years has performed only about 50% of legal abortions on British women. The charitable organisations perform 30% of British abortions. The Health Service would be unable to cope with the large number of extra abortion requests that must occur if Mr Corrie's bill becomes law. There would be many more illegal abortions and an increase in the birth of children to women who lack the physical and emotional resources to be adequate parents. The 1967 Abortion Act has provided satisfactory legal abortion and has not been shown to have been abused. It does not need amending in the manner proposed by Mr Corrie.

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Psychoanalysis, psychotherapy, and health services

SIR,—After reading Professor M Shepherd's (15 December, p 1557) sometimes entertaining article, one is left wondering whether he has really grasped the nettle or only a minor one, and at the same time given vent to various traditional fears which used to concern psychiatry in general, and partly still do. Is he also not too precise about a diffuse subject still developing in directions which appear conflicting, but may be different aspects of the same thing? Quoting Freudian excesses in America—that land of extremes—and the cautious opinion of a lawyer, however eminent, does not necessarily clarify the situation in England.

Equally, I am aware that there is not much space here to support my views. I am, however, describing how psychotherapy actually works and is accepted in a teaching hospital. I would admit that my results are somewhat better with private patients, and there may be other factors here, but this is not a reason for denying psychotherapy under the Health Service. The lack of time has been consistently pointed out, finally with some effect. The witch doctor could indeed be the forerunner of the physician as well as the psychiatrist and the psychotherapist, and most patients in their feeling of illness can be immaturely dependent on their doctor. Are psychotherapists' patients really so much different from psychiatrists' and for that matter physicians' patients? There are indeed difficulties, but I find Professor Shepherd's attitude alarmist. Has he forgotten the long line of physical treatments scientifically validated in various degrees—insulin coma and modified insulin, acetylcholine, carbon dioxide inhalation, cardiazol and methedrine injections? Even now electric convulsive therapy and the major tranquillisers and antidepressants come under dispute. This is the march of science and it is the doctors' duty to learn and discriminate.

I am certain there are many psychotherapists who have worked in the NHS since it started, as I did. Further, I never made any bones about my basic approach being analytic, but I also learned the use of drugs and abreaction, and later looked hard at behaviourist approaches, noting that in some ways one could restate the process of analysis in terms of conditioning. No originality is claimed. All this time one continued to work in a teaching hospital noted for its physical approach. My colleagues never failed to refer more cases than I could comfortably treat in four sessions, and there has always been referral in both directions, with discussion, mutual respect, and help. Surely, with their strongly held views, they would not have gone on referring cases if the psychotherapeutic approach was valueless? I agree that with so many variables it is extremely difficult to arrange controlled trials.

Other special lines of development must be allowed to continue; but I believe that more and more psychotherapists, at least in hospital practice, are admitting that their equipment should not be too one sided, though they may feel more at ease with certain lines of approach. Certainly in a teaching hospital I think it is extremely important that students should be shown the emotional as well as the chemical links between symptoms and how the picture can be influenced in either direction. Contrary to what a casual reader might glean from the article, explicit provisions exist in the Health Service for the appointment of psychotherapists, and before I retired from my hospital the Royal College of Psychiatrists had estimated that the job needed two consultant psychotherapists with nearly three times the sessions between them.

The position of psychologists undertaking psychotherapy presents a further complication as they are highly trained people and there may be a tendency to repeat the struggle for ascendancy which occurred in the Army; and of course they play a considerable part in selection in industry.

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