frequently if the supply seems inadequate, because more frequent feeding increases supply; a simple but little-known fact. Of course, if he is allowed to, the baby will do this himself by demanding more frequent feeds. Thus he will adjust his mother's supply to meet his individual needs rather than the certain number of ounces four-hourly that someone else decides he needs.

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ECFMG and FLEX

SIR,—I write concerning the American FLEX examination, discussed in the letter from Dr B W McGuinness (28 August, p 518), but in my case from six weeks on.

I qualified in London this past May and have occasionally entertained the idea of going abroad for a year or two. Earlier in the year I made inquiries into practising in America. I was told, as Dr McGuinness states, that ECFMG was a mandatory start for entry and sat that exam in January. I was then informed by heads of hospital programmes and by the California licensing authority that if I desired to take an active pre- or postregistration position in, for example, California, I would first have to pass the California FLEX. I thus agreed to sit the FLEX in California this past June, six weeks after completing the MB.

My preparation for FLEX consisted in passing the MB, a five-week holiday, and a week of looking through atlases and the *Medical Examination Review Books* as Dr McGuinness suggests. On sitting the exam I found it taxing and tiring, but many questions could be logically worked out on the basis of medical school experiences. The time factor was not a particular problem, as I and all around me had time to double-check every question before leaving. There were obviously many questions on long-forgotten 2nd MB details and more advanced specialist subjects which were unanswerable. There were a number of questions on American legal and public health schemes which necessitated random guessing. The majority of the questions were, however, straightforward clinical medicine.

After reading Dr McGuinness's letter I became quite concerned about the contents of my mail, but was relieved to hear I have passed the exam. This having been done with a normally relaxed medical school training and final MB revision, I can only conclude that any MB graduate recently qualified should be eminently capable of passing FLEX and need fear it no more than any exam.

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Pathogenesis and epidemiology of schizophrenia

SIR,—In your leading article on this subject (18 September, p 662) you wish "to find an explanation for schizophrenia that will both stand up to scientific criticism and have clinical application." Presumably it is because these criteria are not seen to apply that psychoanalytical insights and advances are not referred to. Yet it is not so long ago that the causes for hysteria were being looked for in brain instead of mind, while it is significant

that we still appear to lack in Britain units designed for a specifically psychotherapeutic approach, in the absence of which provision its wider application to schizophrenia is uniquely hampered.¹

In his Nobel Prize lecture "Ethology and stress diseases"² Professor Nikolaas Tinbergen, focusing on early childhood autism, recommends a return to the old method of "watching and wondering." He reminds us that it can prove premature to comment on the abnormal while neglecting extensive observation of the normal in order to possess ourselves in the first instance of an adequate working spectrum in the absence of which we could be ill advised to rule out environmental traumatisation merely because its specific nature is still obscure and/or possibly unwelcome.

The ethological and psychoanalytical approaches have much in common and should jointly press for a pilot scheme of appropriate units suited to their purposes to provide us with working keys to a language of interpersonal interactions whose prevalence and wider implications could prove one of the major resistances to progress in this area of disarray.

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¹ Rosenfeld, H A, *Psychotic States: a Psychoanalytical Approach*, p 117. London, Hogarth Press and Institute of Psychoanalysis, 1965.

² Tinbergen, N, in *Les Prix Nobel en 1973*. Amsterdam and New York, Elsevier. In press.

Effects of pethidine on the bronchi

SIR,—Whereas morphine is generally considered to be bronchoconstricting in man,^{1,2} pethidine has been reported as bronchodilating³ or bronchoconstricting.^{4,5} Shemano *et al*⁶ reported that pethidine injected intravenously in dogs produced bronchoconstriction in dosages ranging from 0.5 to 2.5 mg/kg body weight. Goodman and Gilman⁷ report that deaths have occurred in patients with pethidine during an asthmatic episode but conclude that death was related to depression of respiratory drive, decrease in cough reflex, and drying of secretions rather than as a result of bronchoconstriction.

In a teaching session we have investigated the bronchoactivity of orally administered pethidine hydrochloride by whole-body plethysmography. Three adult male students with normal ventilatory indices took one 50-mg tablet each on successive days. The figure shows that, with one exception on one day, bronchoconstriction (reduced specific

conductance) was present at 1/2 h and reached a maximum between 1 and 2 1/2 h after taking the drug.

These findings suggest that pethidine should be avoided in patients with airways obstruction and alternative analgesics which have a bronchodilating action—for example, methoxyflurane—should be considered.

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¹ Adriani, J, and Kerr, M, *Anesthesiology*, 1953, 4, 253.

² Higgins, H L, and Means, J H, *Journal of Pharmacology and Therapeutics*, 1915, 7, 1.

³ Eisleb, O, and Schaumann, O, *Deutsche medizinische Wochenschrift*, 1939, 65, 967.

⁴ McDermott, T F, and Papper, E M, *New York Journal of Medicine*, 1950, 50, 1721.

⁵ Mitchell, H S, and DeJong, J D, *Journal of Allergy*, 1954, 25, 302.

⁶ Shemano, I, Wendel, H, and Katinsky, H. Personal communication.

⁷ Goodman, L S, and Gilman, A, *Pharmacological Basis of Therapeutics*, 4th edn. London and New York, Macmillan, 1970.

Further nursing care in general practice

SIR,—There are now many well-documented instances in which nurses are employed by general practitioners, thus allowing the GPs to concentrate on areas where their skills are more definitely needed. Have such GPs measured the increase in the appropriate use of their skills? Are visits by GPs to patients in these practices now more frequently appropriate? I would be interested in these results if they have been documented.

Nursing managers are concerned that nurses undertaking more "medical-type" procedures may well be depleting the district nursing services. The population may in fact be getting less nursing care, particularly as there is an increase in the elderly population. Preventive medicine is important, but who decides the priorities?

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Acute abdominal pain in childhood

SIR,—We were surprised that neither in your leading article on acute appendicitis in children (21 August, p 440) nor in the article on acute abdominal pain in childhood by Mr P F Jones (4 September, p 551) was reference made to a paper by Jackson¹ entitled "Parents, family doctors, and acute appendicitis in childhood." Jackson recorded that parents often delayed calling in the family doctor and that the family doctor himself was often unsure of the diagnosis, especially in the younger child, and often visited again before requesting admission to hospital. The author again drew attention to the increased risk of peritonitis and abscess formation in the child under 6 years old and suggested sedation with paraldehyde before reassessment in the difficult toddler.

Ten years after this paper we reviewed the admissions between March 1973 and February 1974 of children aged 3-15 years complaining