irreconcilable division of views exists concerning a proposed College of Psychiatrists.

Most aware of the need for change in the professional representation of psychiatry are those directly engaged in the mental hospital service, with its network of out-patient clinics, domiciliary services, child psychiatric clinics, rehabilitation units, and community care programmes—a developing service second to none in the world. On the other hand are the psychiatrists directly concerned with undergraduate teaching and with scientific research. They have made outstanding contributions to British psychiatry both by their insistence, often against much opposition, on the adequate basic training of medical students, and by establishing a firm yet uncommitted basis for scientific research in this specialty. Their reluctance to form a College can well be understood, for to secure these advantages for psychiatry and to gain acceptance in the medical schools and universities it has been necessary for them to be closely associated with the Royal College of Physicians. Nevertheless, according to the information given by Dr. Sargent and Professor Roth, one-third of them desire to form an independent College.

There are other welcome signs that these two divisions within psychiatry are coming closer together, for at Birmingham, Sheffield, and elsewhere teaching is now closely linked with the mental hospitals, these in their turn being actively engaged in teaching, particularly at the postgraduate level, and in the field of social work training. Valuable contributions to research have also been made by psychiatrists in the mental hospitals.

This activity and enthusiasm, coming particularly from the younger consultants and the senior registrars, clearly cannot be contained in the more traditional setting of the Royal College of Physicians. Nor is it possible to regard psychiatry as a branch of medicine in the same way as paediatrics, dermatology, or neurology, the whole approach to human illness being quite different, as the psychiatrist in training discovers at an early stage in his career.

Perhaps one way to reconcile opposing views, to avoid the split which would be disastrous for psychiatry and for medicine, and to keep the number of examinations within reasonable bounds would be to form a Joint Educational Council from the Royal Colleges of Scotland, the Royal College of Physicians of London, the future College of Psychiatrists, and perhaps the College of Pathologists, to be responsible for training requirements and standards of qualification.

We all need each other, and if in some way such as this medicine can be held together psychiatry need not be afraid to make a free and, let us hope, united decision for its future.—I am, etc.,

Central Hospital,
Near Warwick.

CLIFFORD TETLOW.

Diabetes Mellitus and Insipidus in Two Sisters

SIR,—We reply to the letter from Dr. R. D. Lawrence (29 February, p. 565).

The original diagnosis of diabetes mellitus in Case 1 was established by the referring hospital on the basis of hyperglycaemia as well as glycosuria. When admitted to the Hospital for Sick Children the diabetes was

not well-controlled on the dose of 32 units of insulin zinc suspension and an unrestricted diet, there being heavy glycosuria and slight ketosis. The carbohydrate intake was reduced to 160 g. daily and the dose of insulin increased. Before stabilization was achieved blood-sugar levels varied from 177 mg. per 100 ml. to 344 mg. per 100 ml. The insulin dosage on discharge of the patient from hospital was 60 units.

We thank Dr. Lawrence for drawing attention to this oversight.—We are, etc.,

G. H. NEWNS.

S. RAITI.

The Hospital for Sick Children,
Great Ormond Street,
London W.C.1.

Age and Skin Sensitivity

SIR,—Dr. R. N. Johnston and his co-workers' paper on "Declining Tuberculin Sensitivity with Advancing Age" (21 September, p. 720) undoubtedly points out a correlation between age and skin reactivity. I have investigated skin sensitivity in children towards two substances, O-streptolysin and the lipo-polysaccharide endotoxin produced by *Salmonella typhi* (Type 2 strain). Because of frequent upper respiratory tract infections in childhood many children are likely to have antibodies to the former antigen, though of course it is unlikely with the latter.

The injections were given into the skin of the medial aspect of the forearm; one of 1/2,500 combining unit of O-streptolysin in 569 children (Table, A) and the other of 0.1 µg. of lipo-polysaccharide endotoxin of *Salmonella typhi* in 427 children. The diameters were measured, and their mean value calculated, 24 hr. after each injection. This is the time of the maximum reaction to both substances, though their natures are quite different: thus we may attribute the reaction to the O-streptolysin to a "delayed type reaction," while the reaction to the salmonella endotoxin is probably a primary toxic mechanism.

Table (A) shows a progressive increase of the skin reactivity to O-streptolysin with age. After the first three months of life, in which only a few children (10.5%) react (and all very slightly), the number of subjects with positive reactions increases rapidly (the highest ratio, 96.8%, being reached in the age range of 3–5 years) and the intensity of the reaction also increases progressively (from the 2nd to as far as the 6th–8th years of life). After this age range the mean diameter of the reactions is smaller, but

between the ages of 9 and 17 years the variation is greater than before.

Table (B) shows that the intensity of reaction to the lipo-polysaccharide endotoxin of *S. typhi* increases progressively, at least to the age of 9–11 years. This differs significantly from the reaction to O-streptolysin, and the influence of age is clearly shown.—I am, etc.,

Department of Pediatrics,
University of Perugia,
Italy.

G. R. BURGIO.

Antibiotics in Myasthenia Gravis

SIR,—It is common knowledge that some of the antibiotics related to streptomycin and polymyxin have non-depolarizing blocking action on neuromuscular transmission.¹⁻⁴ When used in combination with non-depolarizing muscle relaxants or ether they may cause severe dyspnoeic complications. The importance of these facts in choosing antibacterial drugs for the treatment of patients with myasthenia gravis has, however, not been sufficiently emphasized, and only very few words of warning have been uttered in the literature up to now.^{5,6}

Recently I had the opportunity to observe and test with various antibiotics several patients with myasthenia with marked weakening of muscular strength after the intramuscular administration of streptomycin. Neostigmine and edrophonium antagonized this effect, though incompletely in some cases. I should like to present two of these cases briefly.

The first was a 36-year-old farmer's wife with the history of myasthenia gravis of seven years' duration. She developed acute appendicitis and for her operation was anaesthetized with intravenous barbiturates, succinylcholine, and N₂O+O₂ inhalation. No intraperitoneal antibiotics were administered. Post-operatively she received intramuscularly a mixture of 800,000 units of procaine penicillin and 1.0 g. of streptomycin sulphate once a day for four days. Both the patient herself as well as her doctors observed prominent weakening of her muscular strength after each injection, starting about five minutes after the injection, increasing to its maximum in about 15 minutes, making chewing, swallowing, and breathing more difficult and reducing her strength in general. These effects lasted many hours, slowly decreasing. The detrimental effect of the daily injections increased every day until after the fourth time the injections were stopped. Three weeks later antibiotic tests were performed: 1.0 g. of streptomycin intramuscularly caused ptosis to increase within 15 minutes. On the following day the same test injection caused considerably more pronounced general weakening and difficulties in chewing and swallowing. The symptoms dis-

Age Range	Test Antigen							
	(A) O-Streptolysin				(B) Lipo-polysaccharide Endotoxin of <i>S. typhi</i>			
	No. of Children Examined	Positive Reactions (%)	Mean Value of the Diameters (mm.)	Variation (%)	No. of Children Examined	Positive Reactions (%)	Mean Value of the Diameters (mm.)	Variation (%)
0-3 months ..	76	10.5	6.5 ± 1.50	0.28	45	93.3	12.85 ± 1.23	0.32
3-6 " ..	40	75.0	8.9 ± 1.16	0.35	32	100	14.37 ± 2.13	0.41
6-12 " ..	55	83.6	15.0 ± 1.31	0.29	44	100	19.54 ± 1.34	0.23
2 years ..	90	94.4	18.8 ± 1.34	0.33	35	100	21.77 ± 1.72	0.23
3-5 " ..	94	96.8	20.7 ± 1.61	0.37	79	98.7	23.61 ± 1.05	0.20
6-8 " ..	70	82.8	21.7 ± 2.64	0.46	73	100	25.69 ± 1.28	0.21
9-11 " ..	60	86.7	15.1 ± 2.65	0.63	69	95.7	26.98 ± 1.46	0.23
12-14 " ..	57	80.7	15.5 ± 2.42	0.52	50	98	25.44 ± 2.33	0.32
15-17 " ..	27	77.8	15.9 ± 4.73	0.65				

appeared slowly within a few hours. 800,000 units of procaine penicillin intramuscularly did not cause any detrimental effects.

The second patient, a 24-year-old woman with severe myasthenia gravis of six years' duration, was also tested in a stationary phase of her illness when she had no superadded infection. 1.0 g. of streptomycin sulphate was administered intramuscularly. Her walking became distinctly more difficult in 15 minutes. After 20 minutes she was incapable of standing; after 25 minutes sitting and supporting her head was difficult; and after 30 minutes she became dyspnoeic, while the pulse increased to 150/min. She had to be carried to bed, where dyspnoea diminished and her condition improved, though an obvious and profound muscular weakness continued for about 10 hours. On the following day a placebo test was without any effects on her condition. The streptomycin tests were later repeated with similar reactions. Neostigmine and edrophonium antagonized the weakness clearly but incompletely.

These observations emphasize the importance of the right choice of antibiotics, especially for such myasthenic patients whose illness is severe and balanced only with difficulty.—I am, etc.,

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Lapinlahti Hospital,
Helsinki, Finland.

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A View from Australia

SIR,—I have just had the pleasure of reading the issue dated 4 January (p. 50), in which the future of general practitioners in hospital practice was discussed by a meeting of the Royal College of Physicians, and I wonder if my experiences here would be of any interest.

I am the radiologist to the north-west area of Victoria serving a population of some 80,000 in a widely scattered district of at least 10,000 square miles. The largest town is only 20,000 and the medical care is in the hands of 23 general practitioners, of whom four practise as general-practitioner surgeons (having the F.R.C.S.), and an ophthalmic surgeon, an E.N.T. surgeon, a skin specialist, a pathologist, and a radiologist. There are a number of country hospitals with limited facilities, and the Base Hospital with full facilities. At none of these hospitals is there any resident medical staff, the duties being carried out entirely by the private practitioners. The great bulk of the medicine is, of course, private, with a limited 5–10% of public work.

My reason for writing this letter is to restate something which is of course obvious enough to anyone in general practice, but which is often forgotten by those in the higher reaches of the profession—namely, that an overwhelming percentage of illness is best treated by the patient's own personal doctor—that is, his general practitioner. With the aid of full ancillary services and with modern drugs, surely the number of illnesses which the general practitioner is not equipped to treat is few? I can see no earthly reason why the general practitioner should not treat patients with coronary artery disease, pulmonary infections, asthma, arteriosclerosis in its various forms, osteoarthritis, dyspepsia, and simple fractures (of which there are far more than complicated ones). I can well see that in many of these simple cases there will be times when the general practitioner will need to call in a consultant, but how much better for all concerned if the general practitioner undertakes the care of these illnesses.

From my reading of the discussion between the senior members of the profession I have the very definite impression that their view of medical practice is distorted in the sense

that they believe the hospital service does not really need the general practitioner, but he could be fitted into, some nook or cranny where he cannot do too much harm. I do not know if things have changed since I left the North of England, but in the early part of this decade the majority of the surgical registrars in the big cities were from overseas, and most of the emergency surgery was done by them; surely this is fundamentally wrong. This I know does not happen in the teaching hospitals, but it does happen outside, and I think any discussion which does not put this at the top of the list is pointless. What the Royal College of Physicians should be asking itself is not do we need them, the general practitioners, but how can we organize matters so that (1) we can do without the great numbers of foreign registrars we are using as cheap labour at the present time, (2) encourage general practitioners to do a period of training in a specialty before entering practice, so that they can fill the present registrar positions on a part-time basis.

This modern trend to increasing specialization is surely only a temporary phenomenon and is based on the false idea that medicine is a pure science. If we take out infective disorders the great bulk of illness is degenerative in nature, and for this all that the medical profession can do is to help the patient to live with his disabilities, and this must surely always be the job of the general practitioner.

I think that if there were any prospect of using their specialty in general practice far more doctors whose eventual aim was to enter general practice would be anxious to do two or three years' training in a specialty; but it would have to be made worth their while. Finally, I feel that payment by item of service is the only course which will encourage the doctor to do all he can, and not how little, and the Government made to think of the savings in terms of patients' time, hospitals' time, and the stoppage of the present drain of highly valuable doctors to the rest of the world—quite apart from a better service.—I am, etc.,

Mildura Base Hospital,
Victoria, Australia.

H. G. Row.

The Australian Scheme

SIR,—I should like to offer a few comments on the letter of Dr. J. A. Jackson from Penrith, New South Wales (11 April, p. 986). He thinks that the Australian "modified N.H.S." satisfies all Australians. This is not so. I have just returned after working a year in two of the larger, more specialized Sydney hospitals. I am now in general practice here, and, although I have started too recently to offer a fair comparison, I can certainly view the Australian scheme dispassionately and see its faults. I am not suggesting the English N.H.S. is perfect (far from it), but I feel that unqualified praise of Australia might mislead potential immigrants.

The Medical Benefits Fund, about which Dr. Jackson enthuses lyrically, is not a perfect instrument for reimbursing medical services costs to patients. The refund is a variable proportion of the outlay, there are many exclusion clauses and invalidating circumstances, and there are heavy administrative delays. Many of the population are not insured and I had to deal personally with many patients discharging themselves before completing essential treatment simply because they could afford no more. No doubt they *should* insure, but it does not help pointing this out at trouble times. English compulsory contribution ensures full cover. The Fund pays no unemployment money (only medical costs), so if a wage-earner is sick and his employer will not pay him his family may be in great difficulties. Some people feel this is an incentive to work more and malingering less; others feel it merely adds extra worry to a sick person and slows his recovery.

Most essential drugs can be supplied to the patient for 5s., it is said, but there are many exceptions of what are, in my opinion, essential drugs; and strict limitations on the prescribable amounts of listed drugs.

Australian doctors can make a much larger income than can their English counterparts for the same amount of work. However, Australian patients tend to suffer financially much more than English ones, and I was not impressed that the scheme works so well that everyone was happy. I was very happy working in Australia and many of the medical points are very good, but if I was forced to choose between the Australian and the English schemes and not allowed to modify either, I would choose the latter. To prove my contention, I have returned at my own expense.—I am, etc.,

Birmingham 15. ANTHONY JOSEPH.

F.R.C.S.(Glasg.)

SIR,—A year or so ago when this College acquired its new name one of our first acts was to resolve that since we shall now confer a diploma of F.R.C.S. we must ensure that it will be demonstrably at least equal to that of other Colleges. We have now agreed that candidates for our examination be required to have undergone a four-year period of post-graduate instruction (three years in addition to the pre-registration year) with a precise but flexible programme of appointments in approved posts, including general surgery (or rotation posts covering general surgical experience), and optional periods in various specialties or in teaching or research departments.