the psychiatric and urological confusion which has enshrouded the subject for so long. In brief, they have found, what anyone who has seen a large number of these children must know, that their only consistent deviation from normality is their inherited developmental delay in learning to be dry at night. Not one single enuretic, of course, will be helped by all this unless doctors take up the challenge and teach them to be dry by means of the buzzer. In the past, psychiatrists have obstructed its use on the grounds that, if the child is prevented from "weeping from his bladder," his emotional disturbance will break out in some other way. Had psychotherapy been effective in the treatment of enuresis psychiatrists would have had opportunities for observing the tremendous improvement in the confidence and well-being of a child who has been cured; one can assess the result of therapy simply by looking at the child's face as he walks into the consulting-room.

Since publishing my series of 100 children treated with the buzzer up to 1958¹ my out-patient clinics have been inundated with enuretics, and the results to date of completed cases personally supervised by me prove the value of the treatment:

Dry	330	(74%)
Improved .. .	40	(9%)
Wet	75	(17%)
Total	445	

In addition, the result was unknown in 33 cases and 36 required refresher courses for relapses. Many others have been passed on by me to welfare clinics in Essex from whence it has been possible to borrow a buzzer in the last two or three years, but their results have not been collected. In Middlesex these facilities are still not generally available.

There are still many who, for one reason or another, fail to treat these miserable children; that about 75% of them can rapidly be dried up by this simple apparatus should dispel any doubts that remain.—I am, etc.,

IAN G. WICKES.

Stock, Essex.

REFERENCE

- 1 Wickes, I. G., *Arch. Dis. Childh.*, 1958, 33, 160.

SIR,—It is refreshing to find a psychiatrist willing to admit that he finds no evidence that enuresis is basically a psychiatric disorder, for the myth that it is dies hard and has delayed progress. However the alternative concept put forward by Dr. R. G. Barbour and his colleagues (September 28, p. 787) that enuresis is a "disorder of development" leaves much to be desired.

In a loose sense enuresis is no doubt a disorder of development: so too are knock-knee, squint, and cretinism, yet the label does nothing to help explain why these occur. Similarly it does not explain why bed-wetting continues year

after year, often for a decade or more, in an otherwise healthy and normal child.

The explanation of its persistence is surely that by the age of 5 years (the youngest age in Dr. Barbour's series) these children have developed a "habit," or fixed pattern of response, whereby they allow the bladder to empty itself night after night with little or no control from the higher centres. Every time this occurs the pattern is reinforced, thus helping to ensure that it will continue to do so. It is, in fact, self-perpetuating, needing no external factors, physical or psychological, to keep it going. Little wonder then that Dr. Barbour could not find these factors, for they do not exist.

External factors (e.g., illnesses and emotional stresses) do, of course, play a significant part at the outset of enuresis,² but this is outside the scope of our present discussion.

Dr. Barbour states that "the disappearance of this symptom is dependent more upon age than therapeutic intervention." This must be firmly refuted. By means of electric alarm therapy the habit of bed-wetting can be broken in the majority of cases. In a matter of weeks results are obtained equal, and in many ways superior, to those reported by Dr. Barbour and his co-workers in their follow-up five years after their initial assessment. It is therefore no longer justifiable to allow this depressing condition to linger on throughout childhood without at least offering the sufferers the chance of a quick and speedy relief.—I am, etc.,

T. H. GILLISON.

Ikeston, Derbyshire.

REFERENCES

- 1 Cust, G., *Lancet*, 1958, 2, 1167.
- 2 Miller, F. J. W., Court, S. D. M., Walton, W. S., and Knox, E. G., *Growing up in Newcastle upon Tyne*, 1960. Oxford University Press, London.

Fitness for General Anaesthesia

SIR,—Recently we have encountered several instances where patients requiring emergency procedures involving anaesthesia are unduly anxious. The reason is they have been told by a practitioner, because they are prone to attacks of asthma or are the possessors of a heart murmur, that they should "never on any account receive a general anaesthetic," irrespective of long intervals between attacks or a normal exercise tolerance.

Although appreciating that these sufferers should be aware of their condition, and that they should probably avoid anaesthesia in a dental surgery or out-patients department, we feel that a great deal of unnecessary anxiety is occasioned. There are, we consider, very few absolute contraindications to general anaesthesia provided the exigency is sufficient, and that the patient will ultimately derive benefit from the procedure.

We do not wish to give the impression that intercurrent disease does not increase the difficulty or risk of an anaesthetic, but would emphasize that with intelligent

use of modern techniques these are reduced, and that anyone who tells a patient that he is unfit for any anaesthetic should be in possession of all the facts. In our experience such an opinion, once expressed, cannot be completely eradicated from the patient's mind, and fear can still kill.—We are, etc.,

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Jejunal Biopsy in Childhood

SIR,—In his informative article on "Coeliac Disease in Childhood" (September 21, p. 701) Professor D. Hubble discusses the merits of the various techniques employed for diagnostic biopsy of the small intestinal mucosa. He rightly points out the advantages of the Crosby and Kugler capsule over our own and the one described by Brandborg, Rubin, and Quinton,¹ the two last-mentioned being modifications of Wood's gastric biopsy tube and acting on a pull-wire system. These advantages are easier handling, less screening time, and less mucosal fragmentation.

I find it, however, of doubtful justification to employ a technique which has produced fairly serious complications in close to 4% (three in 80 children) of Professor Hubble's own series, although if the number of biopsies performed by other members of his own group are added this rate would appear to be only 2% (three in 150 children).

The capsule originally designed by Crosby and Kugler² was never intended for paediatric use. The biopsy aperture has a diameter of 4–5 mm., compared to that of Brandborg *et al.* of 2 mm. and our own of 2×3 mm. (oval shaped). The size of the biopsy specimen will depend on the size of this aperture as well as on the amount of negative pressure used to suck the specimen into the biopsy capsule. The Crosby and Kugler capsule uses negative pressure both for sucking in of the specimen and for firing off the biopsy knife, the amount of pressure depending on the release of the knife. In the other two tubes suction is employed solely for drawing the specimen into the biopsy capsule, and the amount of negative pressure required can be carefully regulated by the use of a manometer, thereby adding safety to the method. A third cause of trouble is sometimes due to incomplete cutting by the knife when too large a piece of tissue is sucked into the aperture. The mucosa may thus be "nipped" between the knife and the wall of the aperture. This may happen with all three tubes. However, in the Crosby and Kugler tube control of the knife is lost once it has been released. Thus freeing the specimen can be accomplished only by traction on the tube through the mouth in

the hope of severing a partly cut off tissue or by cutting the tube and allowing the trapped specimen to slough off so that eventually the capsule may be recovered in the faeces. With the tubes designed by Brandborg *et al.* and ourselves the knife movements are controlled at all times by the pull-wire, and thus any nipped mucosa can be released without trouble.

To summarize, we believe that a smaller biopsy aperture, carefully controlled use of negative pressure, and indirect control of the movements of the knife make for safe biopsies. With our own child's-size biopsy tube no complications were encountered in 104 successful child biopsies.

The investigator has therefore to choose between safety on the one hand, and simplicity of method and perhaps technical superiority on the other hand. Small intestinal biopsy in children must be regarded as a specialized procedure and requires skill and knowledge of technique, whatever method is used. We believe that the pull-wire tubes should not be discarded in favour of the Crosby-Kugler tube, especially in paediatric work. They could certainly be improved technically. Would any paediatrician be interested in trying?—I am, etc.,

London N.W.10.

MARGOT SHINER.

REFERENCES

- ¹ Brandborg, L. L., Rubin, G. E., and Quinton, W. E., *Gastroenterology*, 1959, 37, 1.
- ² Crosby, W. H., and Kugler, H. W., *Amer. J. dig. Dis.*, 1957, 2, 236.

Psychiatric Units in General Hospitals

SIR,—Dr. H. S. Capoor's letter on psychiatric units in general hospitals (August 17, p. 443) is of great interest, and I felt it might stimulate discussion and inquiry if I constructed, on the replies to the questionnaire, the profile of a model unit of this kind, founded on the majority opinion on each item.

The model unit would be sited either in a wing of the general hospital or in a separate building. The number of beds would be between 15 and 80, under the supervision of one or two consultants, for a population of 100,000. The ratio of male to female beds would be two to three. There would be no security arrangements. Patients of both sexes would be mixed for meals, occupational therapy, and for social and recreational activities. Day hospital accommodation would be provided in the same hospital, either as part of the in-patient unit or separately. Facilities would be available for electroplexy, modified insulin, abreaction, and group therapy. A day nursery would be provided for the use of patients with pre-school children, and facilities would be provided for the admission of puerperal patients with their infants. Out-patient clinics would be held in the unit. Informal patients and patients under Section 29 or 25 would be eligible for admission. Stay would be limited to three months. The nursing staff would be mixed, student nurses from the

general hospital spending three months, and nurses from the psychiatric hospital six months, in the unit. The medical administration would be the responsibility of a consultant attached to a psychiatric hospital; medical, nursing, and ancillary staff would rotate or interchange between the psychiatric hospital and the general hospital unit.—I am, etc.,

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Psychiatry and the Law

SIR,—May I as a psychiatrist who is engaged in the treatment of offenders be allowed to comment on Lady Wootton's address on "The Law, the Doctor, and the Deviant" (July 27, p. 197)? I entirely agree with all her criticisms of the state of the law regarding "diminished responsibility." If this concept has a meaning it is a purely moral one on which psychiatry has nothing whatever to say. Psychiatrists as humanitarians may feel strongly about the problem but nothing in their training permits them to make *ex cathedra* declarations about it. I must agree also that psychiatrists themselves are to blame for the present muddle. The difficulty is that psychiatrists tend to be looked up to as oracles by the general public and it is most tempting when asked for an opinion to make an oracular pronouncement.

In my view psychiatry has very little to say about the guilt or innocence of a person before conviction. I think however that we have a role to play with convicted offenders. We are often able to clarify for the magistrates some of the complex factors which lie behind the committal of any individual offence. As a member of a psychiatric team working at a boys' remand home I have the opportunity to discover much about the individual which is germane to his offence, and much more which is relevant to his general wellbeing and which the magistrate can incorporate into a humane decision about his future. I am also asked for an opinion as to the best method of treatment. Here clearly my role as a psychiatrist comes into juxtaposition with my role as a member of society. I do not find any real conflict in this since I am of the opinion that what is best for the boy is in the long run also best for society. In any case the ultimate decision is rightly the magistrate's and not the psychiatrist's.

On the occasions that I recommend psychiatric treatment my recommendation is conditioned not only by the degree of the offender's psychological disturbance but more particularly by his acceptance of his need for help and his willingness to receive psychiatric treatment. I happen also to work in a clinic which deals in the treatment of offenders and I do not regard my work here as being anything but medical; in particular, I do not see myself as being "an agent of the State—part of the machinery of law enforcement." The blame for this

muddle lies with the magistrates quite as much as with the doctors. Patients referred to this clinic come for the most part quite freely. Occasionally there is a "condition of medical treatment" written into their probation order, but I find such conditions a hindrance, and my first task in dealing with them is to explain that my concern is first and foremost with their own wellbeing, that I am no part of the machinery of law enforcement, and that if they do not wish for my help I do not feel under any obligation to give them treatment. The great majority of patients are then willing to agree that they have a problem quite apart from what society may say in the matter.

The treatment that I am able to offer—psychotherapy—is aimed at helping them to understand and cope with whatever problems they may bring and not to enforce any particular moral code, either my own or that of society. Unless there is free consent on both sides I would regard psychotherapy as meaningless. Some psychiatrists take a different view, but the one Lady Wootton quotes, Maxwell Jones,¹ until recently ran a unit for the treatment of psychopaths to which admission was almost entirely voluntary and the quotation which she lifts out of its context gives a false impression of his article.

Finally, I think that a vital question is begged in Lady Wootton's address. If we agree that psychiatrists should not dictate the treatment of offenders, then who should dictate it? There can be few who are satisfied with the present penal system on any count. Of course, "action is necessary for the protection of others," and it is nonsense to suggest that this notion has been dropped. The question is—what action is most expedient? On humanitarian grounds I am tempted to say that humane treatment is likely in the long run to produce better results than some of the crasser inhumanities that have existed in the past, but I am of course straying outside my psychiatric role.—I am, etc.,

London S.E.22.

H. M. HOLDEN.

REFERENCE

- ¹ Jones, M., *Brit. J. Crim.*, 1963, 3, 267.

Mental Retardation

SIR,—What used to be (and in some places still is) called mental deficiency has in recent years been called by so many names that it is time simplification and clarity were introduced. The pot boiled over with the passing of the Mental Health Act (1959). In this Act two terms were introduced—"severe subnormality" and "subnormality"—and subsequently the General Nursing Council adopted the term mental subnormality for its syllabus, examination, and certificate. But now the Ministry of Health has emphasized that the Act is concerned almost exclusively with compulsory patients, and it follows that the terms severe subnormality and subnormality are not applicable to the majority of our patients who are admitted