ception that a psychiatrist has an innocuous job, dealing exclusively with "harmless" psychoneurotics. On the contrary, psychiatrists have far-reaching decisions to make, both from the medical standpoint and in regard to the community, e.g., whether to deprive a patient of his liberty by certification, or to allow certain psychotics to continue at work; whether a patient is fit to be safely discharged from hospital; advising how far he is responsible for his acts in case of crime; administering physical therapy by no means devoid of risk. Questions of life and death are acutely raised every time we have to assess the degree of suicidal risk in a depressed patient—a very frequent problem—or the danger of violence in a paranoiac or in a manic, with the possibility of assault or even being murdered as the penalty of mistaken judgment. And the latter risk even the surgeon does not have to run!

No, Sir, I submit there are no grounds for differentiating one specialty from another because of differing responsibility. The reason a specialist gets more pay is surely fundamentally because he has had a longer, and consequently more expensive, training than his non-specialist colleague. Dr. Clifford Allen invites the views of other psychiatrists. I think it would be of interest to hear the views of other specialists as well on what is a particularly important subject at the moment.—I am, etc.,

London, W.1.

W. LINDESAY NEUSTATTER.

Negotiations with the Minister

SIR,—We are told in your issue of Aug. 2 (p. 178) that since the first formal meeting which the present Negotiating Committee had with the Minister it has never met him personally but has conducted the negotiations only with officials (Civil Servants), and that during this interval of six months, while complete secrecy has been observed by the Negotiating Committee, it has had to depend for its contacts with the Minister wholly upon what the officials reported.

One cannot but recall the experience of an earlier Committee called the "Representative Committee" of the medical profession, which had been created at the invitation of the Minister, Mr. Ernest Brown (1942-3). The Minister had promised that the negotiations would be "conducted from the ground," but at his very first meeting with the Committee (March 9, 1943) the Committee was informed by the Minister that "negotiations must be based on the acceptance of the decision by the Cabinet that a single unified health service, covering 100% of the population, would be instituted, the local administration of which would be in the hands of the local authorities, under the ultimate control of a Minister who would be responsible to Parliament," thus breaking his previous promise that the negotiations would be "conducted from the ground." (See my letter in *The Times* of Sept. 17, 1943.)

On April 12, 1943, *The Times*, apprised—not by the Committee—of this development, declared that "the medical profession must recognize that the settlement of the future of medical practice has been reached." This experience is not a good augury for the outcome of the present negotiations, conducted in the same atmosphere of secrecy enjoined by the Minister upon the Committee, but without any corresponding restriction of his own activity. Indeed, the Minister has been extremely assiduous in carrying on with his plans, while enforcing confidentiality upon the Negotiating Committee. He has been busy appointing the Regional Boards which are to govern the profession (his selection largely ignoring the B.M.A.), and his choice of his own partisans to serve thereon has been the subject of criticism in the House.

Still more recently he has given a new exhibition of autocracy in the creation of the wholly novel category of "general practitioner obstetricians," whom I think one can fairly describe as "pseudo-consultants," their selection being governed by the Minister who has the power under the Act of designating any registered medical practitioner as a specialist or consultant. His proposal is to issue a list of general practitioners so selected, whom registered medical practitioners not upon that list are enjoined to consult in midwifery cases. The necessary consequence of this creation must, as I see it, be a denial of the present right secured to every registered medical practitioner to practise medicine, surgery, and midwifery. This contemplated restriction affects at present midwifery only, but unless

now resisted successfully by the profession will, I submit, be extended to other basic branches of medical practice.—I am, etc.,

London, S.W.1.

E. GRAHAM-LITTLE.

The Lazy Eye

SIR,—It is common to see young children wearing spectacles with one eye occluded, in order, it is intended, to "train a lazy eye." One hand, usually the right, is by nature more apt in learning to write, and one eye, usually on the same side as that hand, is more effective in the visual discrimination of the graphic symbol. If that eye is prevented from use, the result is equivalent to immobilizing the dominant hand, and, given equal bilateral vision, the "lazy" eye is never the master.

The general result of this procedure is educational backwardness, which should never be taken lightly, because it is the commonest associated symptom in behaviour disorders, and, in predisposed subjects, it may even initiate neurosis. The backwardness depends on these specific disturbances of reading, spelling, composition, and written work generally, including arithmetic, which follow interference with the development of the natural dominance of hand and eye, and are described in detail in works on education such as Burt's *The Backward Child* and Schonell's *Backwardness in the Basic Subjects*. Disturbances of speech are not uncommon.

These effects are neuro-physiological, and follow only after the "treatment" has been continued for a considerable time, but a "lazy" eye is not quickly trained. Since the condition is nearly always optical in origin, often a hypermetropia, surely the rational treatment should be optical too.—I am, etc.,

London, W.1.

WILLIAM MOODIE.

Manifestations of Malnutrition

SIR,—Dr. R. G. S. Whitfield in his interesting article (Aug. 2, p. 164) mentions the fact that the classical conceptions of beriberi and pellagra fail to illustrate the clinical pictures presented by malnourished or starved populations. This was further emphasized, for those who worked in the prisoner-of-war hospital camps in Singapore from 1942 to 1945, by the fact that among many hundreds of cases of malnutrition and deficiency disease scarcely a single clear-cut case of beriberi, and probably no clear-cut case of pellagra, was seen. In fact, these terms were not used after the first few months' captivity, and instead a diagnosis was stated as "avitaminosis B," followed by the principal symptom, such as "avitaminosis B, peripheral neuritis."

The list of conditions thus recognized as clinical entities was:

Avitaminosis B ₁ , oedema and dyspnoea	
"	abnormality of heart rate, bradycardia
"	abnormality of heart rhythm, multiple premature systoles
"	abnormality of blood pressure, hypotension, rising diastolic pressure
"	abnormality of digestive tract, anorexia
"	abnormality of cerebral function, Wernicke's encephalopathy
"	peripheral neuritis
Avitaminosis B ₂ , scrotal dermatitis	
"	angular stomatitis with marginal glossitis
"	ulcerative stomatitis
"	pellagroid skin changes with ulcerative stomatitis and permanent skin discoloration
"	pellagroid dermatitis
"	seborrhoeic dermatitis of face
"	corneal degeneration
"	retrobulbar neuritis
"	"painful-feet" syndrome
"	spastic paraplegia

These conditions occurred either alone or in combination with one another, and a notable feature of their occurrence was the epidemic nature of their appearance. Thus at one time the most urgent problem was the pellagroid dermatitis with ulcerative stomatitis; at another, retrobulbar neuritis; and at another, the "painful-feet" syndrome. Although the "epidemics" overlapped, and although some conditions, especially angular