Accuracy in diagnosis was, of course, important and of great academic interest, but diagnostic history-taking should be postponed if there was any risk that it would antagonize the patient. Most alcoholic patients showed some psychological abnormality, but it was difficult to decide whether the alcoholism was secondary to a neurosis or the neurosis secondary to alcoholism; he thought the latter was more likely to be the case. Very frequently symptoms of anxiety and tension disappeared under treatment. Often, of course, the alcoholic, after he became teetotal, was left with some psychiatric symptoms, and in such cases then proper psychiatric treatment was given. The alcoholic presenting himself for treatment exhibited a sense of shame and failure, and was always on guard against moral accusations. A doctor who was himself an alcoholic had described his own state as an intense dislike of himself, his habits, his behaviour, his reactions to his friends, and imagined himself guilty of unspeakable infamies. An attempt must be made to combat the alcoholic's feeling of complete loneliness and extreme self-reproach. To this end it was preferable to treat alcoholics in groups of two or three at a time rather than in isolation. Fostering a group spirit was one of the ways in which Alcoholics Anonymous was of most help in reinforcing medical treatment.

Team-work

Dr. LINCOLN WILLIAMS pleaded for team-work in the treatment of alcoholism. To understand the alcoholic was to understand his needs. These could be summarized under several headings.

First came his physical needs. It was essential to eliminate organic disease and to repair the ravages of alcoholism by fortified vitamin therapy. Over the last 50 years medicine had concentrated almost entirely on physical treatment—gold cures, courses of atropine and strychnine, and the like—which enjoyed a fleeting reputation, afterwards to be discredited. Modern therapy was carried out by means of aversion conditioned-reflex treatment, using apomorphine and "antabuse" (tetraethylthiuram disulphide).

Then there was the need for a personality diagnosis. It was very important to understand what the patient was like before the onset of his excessive drinking. Was he fundamentally a normal person, or one suffering from neurosis, or had he a mental disorder, or was he a "bad hat" alcoholic with an underlying psychopathic personality? One often came across patients who suffered from a chronic tension state which demanded more and more alcohol to allay it. This type of person responded extremely well to subconvulsive electrostimulation which removed the tension.

Furthermore, the environmental needs of the alcoholic must be considered. His wife must be helped to understand that compulsive drinking is an illness and not a moral failure. Where desirable, contacts might also have to be made with his employer, for many alcoholics held responsible positions in industry and had many years of productive work ahead of them. The social needs of the alcoholic could be met by membership of a group, and here the speaker gave wholehearted support to the work of Alcoholics Anonymous.

Finally the spiritual needs of the alcoholic also called for attention. The effect of religious conversion was well known. The Church to-day showed complete readiness to work with doctors and Alcoholics Anonymous and all others towards the successful rehabilitation of the alcoholic sufferer.

Dr. E. P. SCOTT said that he was disappointed that they had been told so little about the cause of alcoholism, whether physical or psychological, and also about its sequelae.

Three members of Alcoholics Anonymous also contributed to the discussion. One of them said that he had for 22 years been a hard drinker, and he had since spent two years in association with Alcoholics Anonymous and had won through to sobriety. It was very important that members of that organization should work under medical superintendence. Alcoholics Anonymous consisted of men and women

of every social grade who had learnt to live without alcohol and by their fellowship and sharing of experiences to help one another. Another member of the organization said that he was sure that the drinking of alcohol was due to a state of mind and not so much a physical urge.

Complications of Alcoholism

Dr. HOBSON, in replying on the discussion, said that to argue whether the cause of alcoholism was physical or psychological was a trick of language rather than a true dichotomy. As for the sequelae of alcoholism, he had been struck by the very low incidence of cirrhosis in alcoholic patients. He had not seen a case of cirrhosis of the liver in an alcoholic for four or five years. Nor had he seen cases of gout. A disease which was rather similar to gout was diabetes, and there was a high incidence of diabetes not only among alcoholics but among their friends. The complications he saw most frequently were peripheral neuritis and mental changes. With regard to the compulsive craving for alcohol, he mentioned one woman patient who had retrobulbar neuritis and was told that if she persisted in drinking alcohol she would go blind. Her reply was, "Even if I go blind I cannot give it up." In marked contrast with this were patients with tobacco amblyopia. One of these, who was addicted to excessive cigar smoking, gave up the habit at once on being given a similar warning.

Dr. DENT, also in reply, said that he had his doubts about the value of psychoanalysis in these cases, but he had no prejudice against psychotherapy. He had never suggested, however, in dealing with patients that he had an interest in their past. The past had to be forgotten so far as possible. He had seen several alcoholic patients with diabetes, but not a single case in nearly 20 years with cirrhosis of the liver.

Correspondence

Because of the present high cost of producing the Journal, and the great pressure on our space, correspondents are asked to keep their letters short.

Press Publicity

SIR,—As chairman of the Association of British Science Writers, I have been asked by our members to thank you for your tolerant and constructive leading article on "The Press and The Profession" (*Journal*, January 16, p. 141), and to tell Professor Ian Aird that we fully appreciate the circumstances which provoked his letter (p. 153).

No responsible journalist will defend or excuse the behaviour of certain newspaper men on that occasion. Such conduct (of the few) brings discredit on the press—except that when there is a matter of wide public interest, a "human story," like the case of the Siamese twins, there is no such entity as "the press," only a large number of competitive newspapers and competing representatives, each trying to secure an individual account or an exclusive picture. It would be an exaggeration to say that the jobs of those representatives depended upon getting the story, but it would be true to say that they would be unpopular with their news editors or picture editors if others got what they did not. Any newspaper (even the most dignified) likes a scoop, but every newspaper is aggrieved by a "miss." It is the proper function, therefore, of every journalist to get the information which his newspaper wants by fair means. But not by foul.

The question which Professor Aird raised and your leading article discussed was: What is "fair means" in terms of the medical profession, with its concern for the special relationship between patient and doctor and of the ethic of anonymity of both patient and doctor? The further question was raised of the proper understanding, and competent handling, of medical facts.

As to fair means: there must be proper channels of communication if the Hammersmith "scrum" is to be avoided, and these channels must be facilitative and not restrictive; the non-committal hand-out will satisfy neither the conscientious journalist nor the justifiable public interest. There must be access to information and to individuals competent to give that information and to answer those questions which give a newspaper the sense of getting its own story.

Anonymity is a more difficult problem. The medical profession has established its own code of ethics and its own stern attitude to self-advertisement. Perhaps journalists, like the public, do not quite understand why certain doctors when they attain eminence seem to be outside this ethic, and, while not directly encouraging publicity, do not exactly discourage it; or why it is wrong to give a doctor's name in ordinary circumstances but permissible to quote him when he writes to the medical journals; or why, in circumstances in which there is no obvious professional advantage, naming a doctor, is regarded as "unfair competition." Historically, the discouragement of medical self-advertisement grew out of notorious abuses, and only the medical profession itself can re-assess its *mœurs* in these *autres temps*. One thing is obvious: in circumstances such as the Siamese twins case, anonymity cannot hold. With the greatest sympathy, I, for one, could not suggest how Professor Aird could have remained anonymous; he was a part, and a creditable part, of the human story.

On the question of the proper presentation of facts, most newspapers have medical correspondents, concerned with clinical affairs, and all the leading national newspapers have scientific correspondents. They are supposed to grasp, intelligently, the essentials and to have skill in their presentation. In normal instances (the Siamese twins case was abnormal, journalistically as well as medically) they would be dealing with a case. With access to facts and with guidance, they could be expected to treat the facts with proper respect. They would neither claim nor expect that there should be a protocol which would, to the exclusion of their fellow journalists, restrict to themselves the access either to information or to informants. They would, however, suggest (and the newspapers recognize it by employing them) that there are areas of specialized information which are best explored by specialized journalists.

The Association of British Science Writers, which has full members, academic members, and associates, includes in its full membership the science editors or science correspondents of all (except one) of the leading national newspapers. It is not a bread-and-butter organization. It was formed primarily to raise the standards of scientific writing and the status of scientific writers, and, while it is concerned to ensure professional facilities for its members, it offers in return the proper handling of facts and of those responsible for those facts.

Therefore, while the Association cannot speak for journalists in general, it can speak for its own responsible members and say that it welcomes the understanding attitude of the *British Medical Journal* and that it will do anything it can to promote a working relationship between the press and the profession.—I am, etc.,

London, W.1.

RITCHIE CALDER.

SIR,—The letter from Professor Ian Aird (*Journal*, January 16, p. 153) and the accompanying leading article (p. 141) are timely and welcome. They illustrate a difficult and as yet untackled problem. Most doctors have a dread of newspaper journalists because of the frequent unforgivable distortions, inaccuracies, and inventions they create from incomplete information acquired by devious methods. But might not the self-protective, ostrich attitude on the part of the profession be responsible in part for the highly undesirable, albeit understandable, methods of getting a story by some journalists?

Newspapers, both local and national, play an important role in the relationship between the community and the profession. An unnecessarily large gap exists between the

public and the medical services (as exemplified by general practice, local authority, and hospitals). The appointment of members of the lay public to hospital management committees was a step towards bridging this gap, but, as they are not necessarily representative of community groups with the responsibility it implies, their so-called "public opinion" is often very far from real current opinion and feeling. A case in point is the daily visiting of children in hospital. Most parents would like the opportunity, but they accept the rule of the individual hospitals where it is not allowed as though it were the law. We are told there is nothing to stop the individual writing and expressing his views to the management committee, but there is a natural reluctance to be a complainer or "agitator," particularly when individual doctors and nurses are being so kind to their child.

The medical services have been in isolation too long from the public for whom they are designed and out of whose money they are maintained. Both suffer by it. The public would appreciate and benefit from more information about the medical services; this might in turn increase the civic sense and active interest as well as indirectly increasing the number of potential nurses. The doctors might benefit by knowing in a more realistic way what the public thinks and feels on different community issues. The press could be a vital link in this chain. A selected member of the administrative staff or the group management committee, executive council, or local authority could be appointed press officer; through him all press information would be given. Regular meetings between him and the journalists would go a long way in eradicating the circumstances responsible for the unfortunate experience of Professor Aird, and at the same time be the means of raising the standard of medical news in our newspapers.—I am, etc.,

London, W.1.

DAVID MORRIS.

Controlled Hypothermia

SIR,—It seems that more care should be taken by writers of leading articles and annotations in the *Journal* to acquaint themselves not only with the literature on the subject but also with the papers which quote this literature and which inspire leading articles.

In your leading article on "Hypothermia" (*Journal*, December 5, 1953, p. 1256) we and our colleagues are taken to task for failing to corroborate that chlorpromazine produces autonomic block. In our paper in the same issue (p. 1237) we referred to the work of Courvoisier *et al.*¹ to justify our approach, and your more recent annotation (*Journal*, January 9, p. 89) takes cognizance of this work but fails to withdraw the comments made in the leading article. In this annotation on "Chlorpromazine for Hypothermia," it is suggested that we subscribe to the view that chlorpromazine was a ganglion-blocking agent. The original wording which we and our colleagues deliberately employed was: "This latter (chlorpromazine) is known to be a profound depressor of autonomic activity (Courvoisier *et al.*)."¹ Dundee *et al.* (*Journal*, December 5, 1953, p. 1244) have also shown that chlorpromazine is an inhibitor of shivering more effective than pethidine, but stated that it was not their "purpose . . . to consider the mode of action of these drugs. . . ." In no place in either of these articles was it suggested that this substance was ganglion-blocking. It has, in fact, been established in as yet unpublished animal experiments that ganglion-blocking agents are, as might be expected, ineffective in preventing shivering.—We are, etc.,

JOHN W. DUNDEE.

T. CECIL GRAY.

Liverpool, 7.

REFERENCE

¹ *Arch. Int. Pharmacodyn.*, 1953, 92, 305.

**We referred this letter to the writer of the annotation "Chlorpromazine for Hypothermia," who writes as follows: "The annotation said that 'suppression of shivering by curare or other substances has nothing to do with autonomic or ganglion blockade.' Drs. Dundee and Gray, how-