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Pointers

Crossman Pensions: Could well mean for doctors higher contributions for the same total pension. Leader at p. 5.

Royal Free Epidemic: From a re-analysis of the case notes of patients with Royal Free disease two psychiatrists suggest that "epidemic hysteria" is a more likely explanation than organic disease (p. 7). They also review 15 recorded outbreaks of benign myalgic encephalomyelitis and conclude that many were psychological phenomena (p. 11). Leader at this page.

G.P.s and the District Hospital: A leader at p. 2 discusses the role of family doctors in district hospitals.

Disseminated Sclerosis: Contrary to the theory of Le Gac, M.R.C. workers in Newcastle could find no evidence of rickettsial aetiology, nor grounds for an extended clinical trial of his method of antibiotic treatment (p. 30).

Neurological Complications: Refresher course article on neurological complications of diabetes and malignant disease (p. 33).

Ulnar Neuritis: Estimate of improvement that may be expected from surgical transposition of the nerve at the elbow (p. 27).

Human Rabies: Risks of man-to-man transmission (p. 37).

Original Articles: Folic acid and prematurity (p. 16), inferior vena caval obstruction (p. 18), phenformin in diabetes (p. 22), silicone oil injections for chronic arthritis (p. 24), tetracycline and renal function (p. 26), tubo-ovarian abscess (p. 32).

Open E.C.G.: "Undoubtedly an open E.C.G. service allows the family doctor to give a quicker and better service to his patients" (p. 41).

Antacids: "Today's Drugs" article (p. 35).

Personal View: Dr. Ian Oswald on the Medical Research Council (p. 45).

Correspondence: Letters on changes in medical practice, coroner's necropsies, facial pain, axillary hyperhidrosis, brucellosis, leptospirosis, and superannuation (pp. 46-52).

Adenovirus Infections: P.H.L.S. report (p. 56).

B.M.A. Events in 1969: Record of the year's achievements (*Supplement*, p. 1).

G.M.S. Committee: Discusses the financing of the G.M.C., the Central Council for Postgraduate Medical Education and Training, and the Scowen Committee's announcement on oral contraceptives (*Supplement*, p. 4).

Public Health and Junior Hospital Doctors: Meetings of Public Health Committee and Hospital Junior Staffs Group Council (Scotland) (*Supplement*, pp. 7 and 8).

Epidemic Malaise

The epidemic spread of panic-stricken, fanatical, and hysterical behaviour, the so-called "madness of crowds," was commonplace until a few centuries ago and has probably exerted a significant influence on the course of human history. N. Cohn[1] has traced the development of the Messianic revolutionary movements of the Middle Ages. The circumstances under which they arose and the course they followed showed a striking uniformity. The visionary, charismatic leaders of these movements played an important part in generating the fanatical zeal which ravaged civilized communities in the name of deliverance, justice, and freedom. In these and other respects the epidemics of zealotry bore an uncanny resemblance to the totalitarian movements of our own time. J. F. C. Hecker's[2] classical studies of the dancing manias of the Middle Ages drew attention to the many similarities between the spread of physical disease and of mental disturbance; and L. S. Penrose,[3] in his elegant study of crowd behaviour, showed that this analogy could be further explored with the aid of quantitative methods.

Some of the conditions under which mental infections tend to become disseminated have emerged from descriptions of the epidemics that have been studied. Affected communities tend to be relatively isolated and are often marked by a cohesion that springs from common purposes or shared emotions. Ignorance, insecurity, and anxiety are important among the generating factors. It is of interest that states of panic are prone to engender imitation as in the echolalia and repetitive movements of "latah," a neurosis of underdeveloped peoples.[4] While men appear to be particularly susceptible to the more violent and aggressive forms of mass behaviour manifest in Messianic and fanatical movements, the epidemic spread of panic-stricken and hysterical conduct has been more characteristic of women.

Some of these circumstances favouring the swift dissemination of disturbed emotions within a community are shown by Drs. Colin P. McEvedy and A. W. Beard in a paper at page 7 of the *B.M.J.* this week to have prevailed at the time of the epidemic of "benign myalgic encephalomyelitis" at the Royal Free Hospital in 1955 and in relation to 15 other recorded outbreaks of similar conditions which they review at page 11. Eight of the 15 recorded epidemics as well as the Royal Free outbreak occurred among hospital nurses. Patients, male members of staff, and other members of the community appeared to be notably immune to the presumed infection. There was intense malaise and symptoms such as headache, sore throat, lassitude, dizziness, stiff neck, pains in limbs and back, and hyperventilation with tetanic spasms were relatively common. Pyrexia was slight or absent. Motor weakness was common but objective neurological signs were in most cases absent. A probably important associated factor was an epidemic of confirmed poliomyelitis concurrent with some of the outbreaks and the fears possibly generated by a diagnosis of poliomyelitis made in early cases in others.

Comparison of the features recorded in the course of the Royal Free epidemic with those seen in a previous outbreak of hysterical over-breathing among schoolgirls brings to light some lines of resemblance.[5] But an exception was provided by the feelings of panic elicited in 25% of the schoolgirls for which there was no counterpart in the Royal Free epidemic. This reflects some of the limitations of retrospective epidemiological inquiry; much of the positive psychiatric evidence required for a conclusive judgement on the nature of the epidemics under reappraisal is inevitably lacking.

The authors have performed a valuable service in drawing attention to the possible psychological origins of some outbreaks of illness that are disseminated in an explosive manner and for which a physical explanation is apt to be readily assumed. Communities of young women living in relative seclusion appear to be particularly susceptible, but meeting with other people may lead to a fresh crop of cases and cause the spread and recrudescence of the disorder. In some epidemics the infection appears to have spread in a striking manner by physical contagion.[6] Dramatic public announcements detailing the features of the illness will often initiate fresh outbreaks, even in places far removed from the parent epidemic.[7] An atmosphere of fearful anticipation generated by news of serious disease in the neighbourhood or vague rumour of danger enhances the morbid tendency. Anxiety and closely associated physical symptoms such as headache, malaise, vertigo, vomiting and diarrhoea, tachycardia, palpitations, and attacks of unconsciousness that cannot readily be fitted into any organic category, and feelings of fear and panic, tend to be prominent in the clinical picture. They stand in striking contrast to the absence of pyrexia, and objective evidence of physical disease is nebulous or lacking. Hyperventilation is common, and attacks of unconsciousness, tetanic spasms, and other involuntary movements elaborated from them are likewise frequent. Among the most severely affected cases a previous history of neurotic symptoms, instability, recurrent illness of uncertain origin, or actual breakdown may be elicited. Whether or not prominent conversion symptoms such as hysterical convulsions, paralysis, aphonia, disorientation, and dissociative episodes are observed may depend on whether some leading or popular member of the group, who happens to have been an early case, responded in this manner and thus provided a pattern for simulation. The term "hysteria" is not properly applicable to these epidemics, partly because the many uses of this term have blunted its meaning and partly because anxiety or panic appears to have been the central feature of most of the epidemic cases. Motivated, self-dramatizing, and importunate behaviour, conversion symptoms, and dissociation of consciousness are inconsistent, often fleeting, and may be secondary to anxiety. The pejorative meaning that has come to be attached to "hysteria" adds to the reasons for the use of terms such as "epidemic anxiety state" or "epidemic neurotic reaction" and for referring to "epidemic hysteria" only when strictly justified.

The bearing of these observations on the explosive spread of some presumed infectious conditions requires further investigation, and the assumption that the underlying agent is invariably a micro-organism should not be too readily made, particularly where evidence of physical infection is lacking. In the early stage of epidemics occurring within enclosed communities under the conditions described, a precise diagnosis should be arrived at as soon as possible and made widely known. Psychiatric possibilities should be discreetly borne in mind. Patients who show conspicuously dramatic or bizarre symptoms should be separated from other members of the group. A psychiatric opinion is advisable in the early stages of epidemics in which a wide discrepancy is evident between symptoms, disturbed emotion, and behaviour on the one hand and objective physical signs and evidence of physical infection on the other.

1 Cohn, N., *Pursuit of the Millenium*. London, Secker and Warburg. 1957.
2 Hecker, J. F. C., *Epidemics of the Middle Ages, 1833*. Trans. B. G. Babington. London, Woodfall and Son. 1844.
3 Penrose, L. S., *On the Objective Study of Crowd Behaviour*. London, Lewis. 1952.
4 Yap, P. M., *Journal of Mental Science*, 1952, **98**, 515.
5 Moss, P. B., and McEvedy, C. P., *British Medical Journal*, 1966, **2**, 1295.
6 Knight, J. A., Friedman, T. I., and Sulianti, J., *American Journal of Public Health*, 1965, **55**, 858.
7 McEvedy, C. P., Griffith, A., and Hall, T., *British Medical Journal*, 1966, **2**, 1300.

General Practitioners and the District Hospital

The fact that general practitioners in Great Britain, unlike many colleagues overseas do not normally enjoy direct access to beds in major hospitals has often been cited as an important cause of emigration. Not surprisingly they have fought long and bitterly for this right, for most were trained exclusively in a hospital environment where the possession of beds was equated with higher status.

Three recent reports[1-3] suggest a renewal of interest in the subject. The stimulus to their appearance probably comes at least in part from the relative shortage of doctors in hospitals below the consultant grade, a shortage which has led to the present dependence on overseas graduates and to a failure to provide proper time off for postgraduate education. But this explanation is unjust to genuine reformers who see a rearrangement of medical work as a means of strengthening the bridgehead between hospital and family practice. General practitioners could contribute to the hospital by caring for some of their own patients and by sessional work in a clinical team. Both approaches require careful examination before the profession agrees to large-scale changes.

Progress has been made in obstetrics with the development of maternity units having general-practitioner and consultant beds alongside each other, an arrangement which appeals to many. The Oxford survey[3] has shown that some 28% of family doctors would like clinical control of patients in acute medical beds, and more wish to care for patients admitted on social grounds. Yet consultants remain hostile largely because they fear unrestricted access might prejudice standards of patient care by allowing into the wards practitioners of widely uneven competence. Given imagination and goodwill this objection could be overcome. There is scope for experiment with measures to preserve standards. For example, a group might agree that one or two members with particular skills should look after all partners'

1 *The Functions of the District General Hospital*. London, H.M.S.O. 1969.
2 *The Responsibilities of the Consultant Grade*. London, H.M.S.O. 1969.
3 *The General Practitioner and the Hospital Service in the 1970s*. Oxford Regional Hospital Board. 1969.
4 *The Annual Report of the Chief Medical Officer of the Department of Health and Social Security for the Year 1968*. London, H.M.S.O. 1969.
5 Duncan A. H., *British Medical Journal*, 1969, **1**, 632.
6 *British Medical Journal Supplement*, 1969, **4**, 53.