considered. Dysphasia places a patient out of communication with his relatives. He is unable to inform them of his difficulties, and his meaningless or only partially comprehensible utterances are interpreted as signs of mental illness by his relatives, and this superficial impression is transmitted to the medical attendant. The perplexity, tearfulness, irritability, and other features of Goldstein's catastrophic reaction[1] so commonly found in the brain-damaged patient may also reinforce the superficial impression of mental disorder. Dysphasia also misleads some doctors into presuming a defect of cognition (e.g., patient's answers to questions appear to demonstrate disorientation, lack of knowledge of age, etc.), where in fact none is present. Associated dyspractic difficulties may also suggest disturbed behaviour, reinforcing the impression of psychiatric illness.

The only psychiatric disorders which could easily be confused with dysphasia are relatively uncommon. Schizophrenic speech disorders with paragrammatism and neologisms are found only in schizophrenics of long standing and never occur with the suddenness of the dysphasia of cerebral disease. The approximate answer of the Ganser syndrome[2] can be confused with nominal dysphasia, but other features of the Ganser state, such as visual and auditory hallucinations and hysterical stigmata, are usually present.

The importance of diagnosing dysphasia when it is present rather than mental illness is that these cases require the appropriate management of cerebral arterial disease—sometimes as a matter of urgency. These cases should not be admitted to a mental hospital but should be referred to a general physician or neurologist.—I am, etc.,

Parkside Hospital, Macclesfield. N. BERLYNE.

REFERENCES

[1] Goldstein, K., *After Effects of Brain Injury in War*, 1942. London.
[2] Ganser, S., *Arch. Psychiat. Nervenkr.*, 1898, **30**, 633.

Castor Plant Seed Disease

SIR,—The condition described by Dr. A. G. A. Rahim (29 January, p. 293) of skin irritation, conjunctivitis, and chest oppression occurring during the crushing of castor oil seed resembles very much the "grain itch" described in dockers in this country. A variety of cargoes—flour, copra, cheese, and sugar—harbour the mites which are responsible for the trouble.—I am, etc.,

Chester. G. WHITWELL.

Mental "Illness"

SIR,—One of the delights of a correspondence column is to pursue the side-issues of the primary subject as far as you, Sir, will permit. From porphyria to the periphery is probably a long peregrination, but already Dr. I. Atkin (29 January, p. 296) has picked up something of much value.

Undoubtedly it has always been, and still is, more respectable to suffer from a physical rather than a mental illness. The feeling of shame arising from superstition and ignorance of causation is still very evident in mental illness, but is also seen in epilepsy, although we have for a very long time given up boring holes in the skull to let out the demons.

Whenever, rare though it may be, one demonstrates the cause of a child's fits to his parents and eradicates it, the relief from the "stigma" balances if it does not outweigh their natural delight in the recovery.

Mentally subnormal children suddenly become respectable as soon as they are called "spastic" because of the physical connotation so successfully advertised to the public by the society. Such is the public's sympathy for physical disability that, even in the absence of a relative possibility of cure, its attitude to mental disability tends to change when a physical aetiology becomes clear. This is better seen at present in the field of mental subnormality than in acute psychiatry, and the emergence of each physical cause is accompanied by an increase of sympathy and enthusiasm on the part of parents and public.

Psychotic illness will never be respectable until the psychiatrist can relieve it quickly and efficiently by some guaranteed physical method, the mechanism of which is known. The time for this may not be as far off as many people think, but meanwhile, as the English, like Mr. Salteena, are "very fond of fresh air and royalties," I am quite sure that Dr. Ida Macalpine and Dr. Richard Hunter's elegant boost to King George III's "respectability" (8 January, p. 65) will help to keep the public's attitude attuned to the physical, rather than the mental, causes of deranged behaviour.—I am, etc.,

Botleys Park Hospital, Chertsey, Surrey. J. M. CRAWFORD.

SIR,—Is it coincidence or is it a sign of a general awakening from a bad dream that two of your correspondents (Drs. P. H. A. Willcox and I. Atkin, 29 January, pp. 295 and 296), writing on different topics in the same issue, have touched on (but not yet dared to ask explicitly) the heretical question "Is it legitimate to extend the term illness to include 'mental illness'?"

Szasz[1] and Mowrer[2] have argued on logical, moral, and practical grounds for answering in the negative. Perhaps the most powerful is the logical argument. A word such as illness only has meaning if it includes some phenomena but excludes others. To quote Szasz: "At first such things as hysteria, hypochondriasis, obsessive-compulsive neurosis and depression were added to the category of illness. Then, with increasing zeal, physicians began to call 'illness' . . . agoraphobia . . . homosexuality . . . divorce . . . crime, art, undesired political leadership, participation in social affairs or withdrawal from such affairs—all these and many more have been said to be signs of mental illness."

The practical consequence of this medical empire-building is disastrous. We doctors, having been trained only to diagnose and treat illness and to distinguish it from non-illness, are expected increasingly to devote our energies to every kind of undesirable behaviour and unhappiness and to whatever the patient chooses to call illness. We are like television engineers, who, as well as attending to the workings of the set, are expected to deal with pseudo-breakdowns due to such things as failure to prime the electricity meter or defaulting on the rent.

No company could afford to let its engineers attend to the social and personal problems of its customers. Can the National Health Service afford to let its doctors stray so far from the skills they are trained in?—I am, etc.,

Southsea, Hants. J. R. JAMES.

REFERENCES

[1] Szasz, T. H., *The Myth of Mental Illness*, 1962. Secker, London.
[2] Mowrer, O. H. *The Crisis in Psychiatry and Religion*, 1962. London.

The Fifth Freedom

SIR,—For the last quarter of a century Sir Dugald Baird (13 November, p. 1141) in Aberdeen has sponsored a family planning service, offered sterilization to parents, and adopted a liberal attitude to abortion. Thus in that area of the United Kingdom he has provided a fifth freedom—freedom from the tyranny of excessive fertility.

The recent study *The Poor and the Poorest*[1] has revealed the appalling truth that one in six children in Britain to-day is living in poverty. There has been an increase of 45% in the number of families with six or more children during the years 1953–60. It is the families (social classes 4 and 5) who can least afford it who are so prolific. Until a family planning service is included in the National Health Service this tightly packed island will become increasingly uncomfortable—physically and psychologically—to live in. We talk glibly about a population explosion in Asia but are purblind to its presence here.

The medical and nursing professions, teachers, and social workers must lead the way in inculcating the national need for birth control, as is being done in China. Parents must realize that the ideal family is nearer two than three children if we are to avoid the projected extra 20 million people at the end of the century becoming a devastating reality.—I am, etc.,

W. C. W. NIXON.
University College Hospital, London W.C.1.

REFERENCE

[1] Abel Smith, B., and Townsend, P., in *The Poor and the Poorest*, ed. Titmus, R. J., 1965. London.

Abortion Law Reform

SIR,—Dr. M. Sim points out (29 January, p. 294) that the report of the B.M.A. Committee on Abortion has been brought forward with "indecent haste" in order to deal with the problems posed by Lord Silkin's Bill. Dr. Sim suggests the B.M.A. should press for delay in legislation on this important subject, and a leading article (29 January, p. 248) makes the same point.

I do not think it is right to plead for postponement in a matter which so deeply affects the health of a very large number of women. Abortion is not a new condition like some previously unknown virus or unreported drug reaction. I think the present position of the B.M.A. with regard to the public on the matter of abortion is rather like that of a doctor who has made an error of judgment and is faced with unexpected complications. All we can do is to acknowledge that we have

been caught off guard and try to sort ourselves out as quickly as possible. There is much to be done even though we find ourselves in a politically weak position.

I do not think it is fruitful to cavil at the permissive aspects of the legislation at present before Parliament. Many doctors will welcome the possibility of widening the grounds for abortion, but, as Dr. E. A. Gerrard said in the B.M.A. Committee, " no doctor would be obliged to violate his conscience " (22 January, *Supplement*, p. 19).

I think the energies of the B.M.A. can be most usefully spent in working to avoid any legislation which might end by limiting a physician's freedom of action. I am concerned that an amendment to Lord Silkin's Bill includes a system of notification for abortions. Such information will be readily available from the in-patient inquiry service without setting up a special system which could threaten a doctor's relation with his patient.—I am, etc.,

MALCOLM POTTS.
Sidney Sussex College,
Cambridge.

SIR,—In view of the report which you printed (*Supplement*, 22 January, p. 19) of the Special Committee on Therapeutic Abortion, the following points may be of interest:

(1) The Abortion Law Reform Association strongly opposes any special procedure of notification of medical termination of pregnancy for the following reasons: (*a*) adequate statistical information is already available from the hospital in-patient inquiry for all admissions, and this automatically covers termination of pregnancy ; (*b*) each operating theatre in hospitals and nursing-homes is required to keep a comprehensive register of all operations performed, which provides a complete record ; (*c*) inherent in all medical practice is a confidential relationship between doctor and patient which would be jeopardized by a special notification procedure.

(2) The Abortion Law Reform Association persists in its claim that specific provision must be made for medical termination of pregnancy where conception occurs before the mother is 16 years of age. The law is designed to protect girls under 16 against intercourse. It is inconsistent to do this and yet offer no specific relief from what can be the most disastrous consequence of such intercourse.—I am, etc.,

PETER DARBY,
Honorary Medical Secretary.
Abortion Law Reform
Association,
London S.E.11.

Cancer Education

SIR,—In your very interesting leading article (29 January, p. 247) on cancer of the corpus uteri you mention the great importance of treatment whilst still in an " early stage." You do not mention that the best way of achieving this is by educating the women.

When in practice, in common with other gynaecologists, I saw hundreds of women with irregular vaginal bleeding, and when asked why she did not come before the answer invariably was, " I thought it was only the change," sometimes backed up by the remark, " I talked to my neighbour and she said, 'Don't you worry, my dear, it is " only the change." I had to go through it.' "

For years my Cancer Information Association has been giving lectures to women's institutes and other women's organizations stressing the importance of irregular bleeding, and we distribute thousands of pamphlets for the same purpose.

I regret to say that occasionally it is the overworked general practitioner who tells his patient, " It is only the change," without examining her.

My association sends free leaflets to lay people who apply to the honorary secretary. —I am, etc.,

MALCOLM DONALDSON.
Cancer Information Association,
6 Queen Street,
Oxford.

Following up Cancer

SIR,—I have always supported the view that a diagnosis of malignancy should be concealed from the patient if possible. It is often said that patients have a right to know the truth, but I think they have a right to be spared the truth when the truth involves mental pain, because the infliction of mental pain is no more ethically justifiable than the infliction of physical pain. The question " Have I got cancer, doctor ? " almost always conceals a desperate plea for a categorical and convincing denial.

Even in cases carrying a good prognosis the wise clinician does not tell. But the patient's suspicions may be aroused during treatment, and the long follow-up period in out-patients is likely to convert suspicion into certainty. Reassurance will not be possible until final discharge from any further attendance.

I have in mind a case of carcinoma of the cervix treated successfully in London 15 years ago, and followed up afterwards every six months. For the past 12 years the patient—an intelligent woman—has been living in Bermuda, where the " follow-ups " followed her. She is still being examined every six months, and the long-drawn-out period of probation has coloured her whole life. Fifteen years may be an extreme example, but the same considerations must apply to much shorter periods.

I am well aware that surgical and radiotherapeutical progress demand the protracted follow-up of cases to assess results. But I wish there were some way of doing it without sacrificing the patient's peace of mind on the altar of the god of statistics.

There is irony in a situation where the patient is cured but is never allowed to believe it.—I am, etc.,

LUCY TURNER.
West Runton,
Norfolk.

Death after Shipwreck

SIR,—Recent letters by Mr. H. B. Lee and by Dr. Sybil D. D. Jones and Mr. L. Bonvini (29 January, p. 295) raise the questions of how Channel swimmers survive their long immersion in cold water, and of what can be done to prevent shipwreck survivors dying of cold after rescue from the water.

Channel swimmers have an unusual amount of subcutaneous fat,[1] and since there is a close correlation between fat thickness and body cooling in water[2 3] there seems little doubt that they owe their survival to this.

The most useful steps that rescuers can take in small boats are probably to take the victim from the water as soon as possible, remove wet clothes, and replace them with dry blankets to prevent further heat loss from the body. Although there will no doubt be occasions when cooling would be slower if the victim were to be left in the water than taken out into very cold air, they must be very rare. Nor unfortunately do measures like rubbing the skin transfer enough heat to be of much value ; they can in theory even do harm by increasing blood flow and so accelerating heat loss from the body core to the skin. Crews of larger rescue ships should clearly try to give severely chilled survivors an immediate hot bath, since there is strong evidence that this can save lives, and when possible it is advisable to take the blood-pressure at intervals during warming so that the patient can be tilted head down if it falls.

I can only agree about the importance of providing potential rescuers as well as potential victims with proper information on how to reduce the risk of death from immersion hypothermia. There seems no doubt that a considerable part of the large loss of life from this cause is avoidable. Though there are numerous official bodies on life-saving at sea it is often difficult for them to distribute such information to people who can use it, and informed advice from doctors could well be the most effective way of doing so.—I am, etc.,

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The Radcliffe Infirmary,
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REFERENCES

1 Pugh, L. G. C., and Edholm, O. G., *Lancet*, 1955, **2**, 761.
2 Keatinge, W. R., *J. Physiol.*, 1960, **153**, 166.
3 Cannon, P., and Keatinge, W. R., ibid., 1960, **154**, 329.

Vaccination Against Leprosy

SIR,—In his letter (22 January, p. 232) Dr. W. H. Jopling refers to the preliminary communication by Pettit and Rees[1] in order to assert that dapsone-resistant strains of *Mycobacterium leprae* already exist.

He does not, however, mention my letter[2] objecting to the interpretation of Pettit and Rees on the ground that it is by no means certain that dapsone acts directly upon *M. leprae*, if indeed we are even justified in the implication that this organism is a true bacterial species.

There is some evidence against a direct action of dapsone upon lepra bacilli. For example, during ten years' observation of many thousands of tuberculoid lesions in Nigeria—lesions from which mycobacteria were absent, or if present were so only in minute numbers out of all proportion to the cellular infiltrate—I noted differences in methods of healing.

Spontaneous healing of these lesions occurs as a centrifugal spread of repigmentation, whereas dapsone-induced healing is an almost uniform fading of the lesion—that is to say, a uniform recovery of pigment over the