

# Correspondence

Letters to the Editor should not exceed 500 words.

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## Powers of the G.M.C.

SIR,—Although I have the honour to represent my university on the General Medical Council, I am not serving on the Disciplinary Committee, which would seem to be the immediate object of the criticism expressed by Dr. H. Matthew (12 April, p. 114). I therefore feel free to comment, as a private individual, on an important matter of principle arising from his letter.

It is a condition of democratic freedom that the legislature, the executive, and the judiciary should each be independent of the others; the confounding of these three functions of the State was the basis of Burke's indictment of the French Revolution. To come to the specific case (the exorbitant prescription of drugs of addiction), although the G.M.C. has the obvious executive power of removing names from its own *Register*, its function is surely primarily judicial. There would be great dangers if the G.M.C.

was made responsible for initiating what are essentially criminal investigations into conduct which it would later be called on to assess judicially. To be trite, justice must be seen to be done, and no man should be judged in a cause which he has initiated.

From the very highest motives, Dr. Matthew seems to me to be advocating, or at least supporting, a form of direct action against which the individual has no appeal. Even if a man has deserved to forfeit his rights, it remains our duty to observe them. The dangers of freedom are great, but they are less than the dangers of tyranny; and in spite of its obvious emotional appeal it is to tyranny, whether red or black, that direct action, perhaps by devious paths, ultimately leads.—I am, etc.,

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## Perfusion and the "Artificial Heart"

SIR,—There seems no doubt that much misinformed and unjustified criticism has been directed at Drs. Denton Cooley and Salvatore Liotta after their insertion of an "artificial heart" into a patient at Houston. In particular, some have sought to criticize them on the grounds that this particular means of trying to save a patient's life was not backed up by adequate animal experimentation.

It is difficult to justify this point of view on logical grounds, since for many years human open heart perfusions have utilized heart-lung machines in which the damaging blood interface surface is of the order of 800–900 sq. in. (5,000–5,800 sq. cm.). Most cardiac surgeons outside Houston would accept a perfusion time for some routine open heart procedures of two and a half to three hours and many would be prepared to extend this period by another hour. From

the published photographs of the implanted device it seems pretty certain that the blood interface surface area was about 50–60 sq. in. (320–380 sq. cm.). It was therefore perfectly justified to anticipate a perfusion time in excess of 48 hours, and not at all surprising that this was comfortably achieved. It is to be hoped that the significance of the Houston experience in this respect will not be lost among all the criticism of the surgeons involved.

Those of us concerned to develop and improve perfusion apparatus should probably be aiming as a simple first step to at least a ten- or twelvefold reduction in the blood interface area if perfusion times are to be prolonged in an important way.—I am, etc.,

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## Supratentorial Intracranial Abscess

SIR,—Mr. J. Garfield's paper on supratentorial intracranial abscess (5 April, p. 7) is important in drawing attention to the continuing high mortality of this condition, but it is not quite as helpful in suggesting solutions to this problem as it might be. Mr. D. W. C. Northfield (19 April, p. 184) has already added some constructive comments, but the original paper could still be misleading unless certain aspects of this problem are clearly understood.

Stress is rightly laid on the importance of localization as the first step in successful management. But comparisons are made between different investigative methods without even mentioning focal neurological signs as a localizing feature; dysphasia and homonymous hemianopia are sensitive signs of temporal lobe abscess, while focal epilepsy frequently indicates the site of subdural pus. To delay drainage in such cases for 24 or 48 hours to await brain scanning, as is suggested, would seem quite unjustified.

Angiography is held to blame for some deaths, but from the cases described in detail this would hardly seem justified. That some abscesses which angiography failed to localize were subsequently accurately localized on the basis of E.N.T. sepsis suggests a curious priority of investigation. To fail to make immediate burr holes in a patient developing severe hemiparesis soon after mastoidectomy, and in whom angiography showed shift of both anterior cerebral artery and deep veins, seems strange (Case 3); the patient's subsequent death from undrained subdural abscess can hardly be blamed on the angiogram's failing to indicate this precise diagnosis. Indeed, after reading this account the reader is forced to wonder if the increase in the mortality from subdural abscess from 28% to 55% in the second 100 cases might be related to a reluctance to perform emergency exploratory burr holes now that other more sophisticated methods of investigation are available. Most surgeons recognize subdural

abscess from its abrupt onset and profound hemiparesis, frequently associated with focal fits; these features are unusual with intracerebral abscess, but Mr. Garfield asserts in his introduction that the problems of presentation and initial management of these two conditions are similar, and he makes no allusion to the difference between them in his final recommendations. The sharp rise in mortality of abscesses with short clinical histories (from 37% to 74%) in the second series could be largely accounted for by the subdural abscesses, which almost always do present with a very brief history.

The management recommended seems to lean heavily on brain scanning, and this matter is re-emphasized in your leading article (5 April, p. 1). Only three acute abscesses were scanned in the present series, although the experience of others is quoted; many neurosurgeons will want clearer evidence of the efficacy of scanning before accepting the recommendation to delay treatment for 48 hours while awaiting scanning in any patient suspected of a brain abscess. Angiography might well complete the diagnosis within 15 minutes and it might also demonstrate hydrocephalus, which would indicate the co-existence of a posterior fossa abscess; the failure to detect such double pathology is a well-recognized cause of mortality with otogenic brain abscess.

The emphasis on the localization of suspected supratentorial abscess has diverted attention from the alternative pathological diagnoses. The problem facing the otologist, the physician, or the neurosurgeon is usually that of suspected intracranial infection and they must consider meningitis and encephalitis as well as abscess. We have recently had several successes in Glasgow from treating acute necrotizing encephalitis due to herpes simplex with anti-viral agents, and such patients have commonly presented as abscess suspects. In such instances we aim to complete electroencephalography, angiography, and brain biopsy within a few hours of admission, but on the regimen suggested by Mr. Garfield there would have been little chance of success. As with subdural abscess, a burr hole should be regarded as an investigation rather than an operation.—I am, etc.,

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### Benign Diseases of the Breast

SIR,—I would like to congratulate your leader writer on his excellent appraisal of the above subject (19 April, p. 135) and would add three further small points.

I have regularly treated cysts of the breast over the past 15 years by means of aspiration, and as far as I am aware no single case in whom the lump was dispersed completely by aspiration has subsequently developed carcinoma.

Routine supervision would presumably entail three-monthly visits to a follow-up clinic. I see approximately five new cases of benign breast disease every week, mostly in young women. This would mean that in 10 years' time 200 additional cases would be attending every week a follow-up clinic already stretched to the limit.

Women who have already attended for benign breast disease are bound to be very breast conscious, and as soon as a further lump appears will hurry to their doctor and reach a surgical clinic probably within a fortnight. If, on the other hand, they are paying three-monthly visits to an outpatient clinic, they are far more likely to conceal the lump until their next appointment with a possible delay of three months.

I would therefore suggest that the routine follow-up of all cases of benign breast disease, as has been suggested, is practically impossible, physically dangerous, and above all psychologically disastrous.—I am, etc.,

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### Mothers and Children in Hospital

SIR,—My study<sup>1</sup> on the effects of maternal attendance during hospitalization of young children was of similar design and drew many of the same conclusions as that of Brain and Maclay.<sup>2</sup>

My methods and results were as follows. Interviews were held with 60 mothers of children hospitalized for acute organic disorders. Three interviews were held with each mother, one before or on the first day of hospitalization, the second one week after discharge, and the third one month after discharge. Thirty mothers stayed with their children for the entire period of hospitalization, while the other 30 mothers visited daily during the visiting hours set by the hospital. The two groups of mothers were compared in selected attitudes of child-rearing through use of the scores achieved on a parental attitude questionnaire.

The responses to the interview questions were rated for the following variables: reaction to temporary, brief separation from mother; emotional dependence; eating patterns; sleeping habits; toilet training and auto-erotic behaviours. Comparisons were made of pre- and post-hospital behaviour in each group and between the groups. Other relevant aspects of the data were also examined. The hypotheses being investigated were:

(1) Children who have been attended by the mother during hospitalization will not show a significant difference between pre-hospital behaviour and post-hospital behaviour.

(2) Children who have not been attended by the mother during hospitalization will show a significant difference between pre-hospital behaviour and post-hospital behaviour in a regressive direction.

(3) There will not be a significant difference between the two groups of mothers in their negative attitudes towards child rearing.

Analysis of the data confirmed hypotheses (2) and (3). Hypothesis (1) was confirmed in part; that is, children who were attended by the mother showed no significant regressive change between pre- and post-hospital behaviour. Significant changes in a regressive direction were found in several variables, suggesting that growth was not impeded by hospitalization when the child was not separated from the mother.

Differences between the two groups were most apparent in reactions to mother leaving, emotional dependence, appetite, manner of eating, food finickiness, sleep behaviour, and

urine training. In all of these areas regression occurred among the children whose mothers did not stay. Progression towards more mature behaviour was experienced by those children whose mothers remained. Further study of the behaviour changes of the children whose mothers scored high in the negative attitudes supported the aforementioned conclusion.—I am, etc.,

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### REFERENCES

- Fagin, C. F., *Effects of Maternal Attendance During Hospitalization on the Post-hospital Behaviour of Young Children*, 1966. Philadelphia, F. A. Davis.
- Brain, D. J., and Maclay, I., *British Medical Journal*, 1968, 1, 278.

### Alcohol Dependence

SIR,—Most medical practitioners have had at some time personal illnesses and problems which make them sympathize deeply with patients who have had similar illnesses and problems. The understanding of a doctor who has had acute cholecystitis will be greater towards a patient who is having an attack. The sympathy of a doctor with a diagnosed cancer or rheumatoid arthritis for a fellow sufferer must be extreme. A personal bereavement or the loss of a child will give a doctor more understanding for a patient who has also suffered such a loss.

In few illnesses, however, can the rapport be so great as in alcoholism. A doctor who has suffered from alcoholism and has recovered must of necessity have undergone a complete personal analysis before identifying himself with the disease, admitting and accepting his diagnosis and prognosis, which is of course conditional on his complete abstinence from alcohol. He is then in a better position to understand the fears and doubts of a patient who has this disease. Moreover, the patient quickly appreciates that he is discussing his problem with someone who understands implicitly. This leads to that frankness and unburdening which is so necessary for good psychotherapy and provides the recovering patient with the necessary confidence to face the stresses and strains of life without alcohol. Much encouragement is required to change a life which has previously been completely dominated by alcohol. It is an enormous problem involving the whole community and requiring expert advice.

There are several reasons why so few alcoholics are treated. Many do not know they are ill. Some are protected by their families. Many are afraid of the diagnosis and will not admit their illness because they have become so dependent that they want to keep on drinking. Some deceive themselves by deliberately misunderstanding and refusing to identify themselves with the disease. Many have attempted discussing their problem, albeit diffidently, with their medical advisers only to be dismissed by the practitioner owing to his lack of comprehension. Not only general practitioners are at fault. Many psychiatrists have not worked with or understood alcoholic units, and have failed to realize that much depression is secondary to alcoholism and not vice-versa. Hospital