of bringing about the wholeness of man. He uses the age-old sacrament of anointing, which dates back to Apostolic times, and also to certain people He bestows a definite gift of healing or charisma. There is nothing unscientific about any of these methods of healing—they are merely examples of the divinely planned interaction of the aspects of man's personality. Spiritual things therefore, far from having nothing to do with healing, hold an equal place with medicine and psychiatry in promoting the wholeness of man's nature.

As the body and mind are the provinces of the physician, surgeon, and psychiatrist, so the spirit is the province of the priest. It is the hospital chaplain, therefore, who should direct the spiritual welfare of patients in hospital, and any spiritual ministrations should only be carried out with his knowledge and approval. Much of the present controversy about admission of "healers" to hospital would have been prevented if the chaplain, as a member of the hospital staff, had been approached first. Mutual co-operation between medical staff and clergy would go a long way to a more integrated and sane attitude to the work of healing.—I am, etc.,

Birmingham, 20. K. E. LUCKMAN.

SIR,—The admission of spiritual healers in British hospitals raises a matter of great concern not only in Britain but throughout the Commonwealth, which receives most of its inspiration and guidance from Britain.

The progress of medicine on scientific lines has not always been very easy; in the past it had to face witch medicines, black magic, miracles, and the rest, and there are "spirit operators." No wonder if in the future it may have to face some other subtle forms. It seems the cunning of men in devising methods of paranormal healing will never be exhausted. It is a pity that these benevolent men with a special healing cult were not born in those "good old days" when their skill would have been better appreciated.

Now the Consultants and Specialists Committee has expressed its view on the subject (*Supplement*, May 7, p. 266) we hope the Council of the B.M.A. will soon make its view known to the profession and the public in unambiguous terms.—I am, etc.,

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Smoking and Personality

SIR,—The paper of Professor H. J. Eysenck and his co-workers (May 14, p. 1456) again points up the highly complex and varied nature of the possible determinants of lung cancer. Here I would like to add to a list of neglected predisposing factors the presence of lymphadenogenous perforative bronchial scars in about 25% of the adult population in both the United States and Europe.[1]

In postulating that a positive relationship exists between these scars, cigarette-smoking, and bronchial carcinoma, one may point out the following: lymphadenogenous perforative scars are often found in major bronchi; material from cigarette-smoke tends to accumulate in respiratory epithelium depleted of cilia or deprived of their protective action,[2] thus causing the scars to be exposed to greater concentrations of carcinogens; cigarette smoking is associated with bronchial changes ranging from basal-cell hyperplasia to squamous metaplasia[3-4]; and carcinomatous changes are sometimes incidentally found in otherwise scarred or structurally altered bronchi. Perforative bronchial scars may thus be related to bronchial carcinoma by a predisposition to metaplasia; by being more exposed to, and possibly also more susceptible to, the malignant effects of carcinogens than normal bronchial epithelium; and by determining the sites where certain types of bronchial carcinoma may originate. One may add that as these scars appear to be caused principally by perforations of tuberculous lymph nodes into bronchi—a not uncommon event during any phase of pulmonary tuberculosis—it is possible that there is currently an increased incidence of these scars in adults because of the declining mortality of populations exposed to, or suffering from, clinical and subclinical pulmonary tuberculosis.[5]—I am, etc.,

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REFERENCES

1 Grosz, H. J., *Dis. Chest*, 1959, **36**, 514.
2 Hilding, A. C., *Ann. Otol. (St. Louis)*, 1956, **65**, 116.
3 Auerbach, O., Gere, J. B., Forman, J. B., Petrick, T. G., Smolin, H. J., Muehsam, G. E., Kassouny, D. Y., and Stout, A. P., *New Engl. J. Med.*, 1957, **256**, 97.
4 Chang, S. C., *Cancer*, 1957, **10**, 1246.
5 Professor Philip Schwartz. Personal communication.

Addiction to Hypnotics

SIR,—Dr. I. Pierce James (May 14, p. 1504) refers to the *Interim Report of the Interdepartmental Committee on Drug Addiction* (1960, H.M.S.O.), according to which cases of habituation to carbromal and bromvaletone were "numerically very few, but individually serious," and he comments that "whilst this may be so in England, there is reason to believe that it is not universally true." The cases of carbromal habituation which Dr. James reports from Australia were "largely confined to . . . neurotic individuals of potentially drug-dependent personality," most of whom had also taken alcohol or other drugs to excess. Amongst this latter type of patient, however, habituation to carbromal preparations seems also to be a not uncommon occurrence also in this country.[1-3] Amongst this small "habituation-prone" segment of the population carbromal preparations and the stimulant phenmetrazine were the most frequently abused drugs. Both have now been put on (Part I of) the Poisons List,[4] and it is to be hoped that this step will markedly decrease their abuse, just as it did a few years ago in the case of methylpentynol. This type of personality seems to be unable to handle any sedative or stimulating drug in moderation, though so far the relative absence of reports of habituation to the phenothiazines seems noteworthy.

Of some interest may be the case of an alcoholic neurotic who had been previously habituated to barbiturates, carbromal, amphetamines, and phenmetrazine; chlorpromazine was prescribed (25 mg. t.d.s.) for him during a state of great tension, but after taking about ten 25-mg. tablets on the first day he threw the rest of the chlorpromazine tablets away rather disgustedly, as they obviously had failed to provide him with what he was looking for. However, writing from Australia a year ago on the frequency of addiction to unrestricted drugs, such as carbromal, Drs. Minogue and Kyneur[5] remarked that "even the new tranquillizers, such as chlorpromazine . . . become drugs of addiction."

Dr. James states that, in such cases of drug habituation, "the seriousness from a prognostic point of view stems more from the patient's personality defect than from the particular drug of habituation." Long-term prognosis seems to rest mainly on underlying

personality, attitudes, etc. Treatment, therefore, has to be concerned with more than mere withdrawal of the drug which happened to be the "offender" on this particular occasion. Otherwise the hope that the patient will not find an as yet unrestricted substitute drug will, as a rule, sooner or later prove futile.—I am, etc.,

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REFERENCES

1 Seager, C. P., and Foster, A. R., *Brit. med. J.*, 1958, **2**, 950.
2 Copas, D. E., Kay, W. W., and Longman, V. H., *Lancet*, 1959, **1**, 703.
3 Glatt, M. M., ibid., 1959, **1**, 887.
4 Ibid., 1960, **1**, 1139.
5 Minogue, S. J., and Kyneur, F. J., *Brit. med. J.*, 1959, **1**, 238.

"Honour a Physician"

SIR,—I have been infinitely depressed at reading your reviewer's castigation of Philip Auld's little masterpiece, *Honour a Physician* (May 28, p. 1625). As a market-town G.P., complete with cottage hospital, I ought to manage medical life on a higher plane than Auld's hero from the industrial north, but I can honestly claim personal experience of most of the predicaments in which he finds himself. So far from Auld's book being a catharsis, it is a very adequate commentary on the way in which a sizable minority use the G.P. part of the Health Service. I think he must have found his niche in industry, or he would never have had time to write the book. And as a conscientious G.P. being ground between the N.H.S. millstones, I cannot follow him too soon.

The book should be made required reading for every member of every committee that has to do with the running of the general medical services. It should also be a textbook in preclinical medical schools. Finally, it should be given to every Member of Parliament immediately upon election. Then we might get the right sort of person in general practice, if it is possible to design a sufficiently submissive donkey with the required intelligence.

Philip Auld is a pseudonym. Lest my patients identify me, may I sign myself

"UNHONOURED."

Postgraduate Study for G.P.s

SIR,—I read with great pleasure of the Nuffield Foundation's recently announced grant for general-practitioner postgraduate study in periods of six months (May 14, pp. 1491 and 1516). The greatest handicap to a general practitioner in regard to postgraduate study is lack of time. The opportunity to set aside for a period the exacting day-to-day matters of practice and to devote himself exclusively to postgraduate study will give a great boost to his morale and to the quality of his work.

May I, however, make one small criticism? Such study as envisaged, which is not concerned with the nature and management of general practice, could surely be carried out more effectively at a centre within the British Isles, where the student would be already familiar with hospital and university procedure and layout, and where the question of accommodation for self, wife, and children on holiday would be more straightforward, and so where the student would be able to apply himself more completely to the primary object of study. From the point of view of clinical or research material, there is a vast supply available in this country with a more pertinent application to general practice here, before one would wish to add the doubtful advantage of an international flavour. Furthermore, the age group aimed at, with practices based in many cases on their homes, and with the ties of children and school, would probably be reluctant to go to Canada, the U.S.A., etc., but would be able and most willing to go to the centres in this country. Possibly some of the most representative and most suitable general practitioners would lose the opportunity in this way.

There is a further extension of this conception which perhaps deserves thought. In essence the Nuffield Foundation Grant provides awards for suitable practitioners, and at the same time stimulates a better quality of work—both of which considerations constitute the purpose of the much debated general-practitioner merit award scheme. Could not a proportion of the £500,000 be devoted to this type of plan? May I conclude by expressing appreciation of the generosity of the Nuffield Foundation, and of the initiative of the College of General Practitioners.—I am, etc.,

Ash Vale, near Aldershot. S. G. A. BARTLETT.

Diploma in Dermatology

SIR,—May I commence by complimenting Dr. H. R. Vickers on his most interesting and enjoyable Watson Smith Lecture (March 26, p. 893)? He has very rightly emphasized the importance of a sound training in clinical medicine, with which dermatological conditions so frequently overlap and are an integral part. He likewise emphasizes the importance of dermatology in general medicine as a whole. I would point out, however, that his opinion that "it would be a retrograde step to introduce a diploma in dermatology" is not the prevailing opinion throughout the world. This will be seen from the fact that at the International Congress in Dermatology in Stockholm in 1957, when the teaching of dermatology was under consideration, the representatives of every country present, *except one only*, were in favour of "proof of knowledge of dermatology" by examination.

How else can it be ascertained that a person commencing to practise dermatology (or who has been practising dermatology for several years) has a proper knowledge of the subject fitting him to deal with all aspects? With the exception of the F.R.C.P. Edinburgh, where a man can "major" in dermatology, I know of no other fellowship qualification in the British Commonwealth in which a reasonable knowledge of dermatology is required. To be properly qualified to practise dermatology, an individual should possess proof of acquired knowledge by examination (as in the diploma in dermatological medicine at the University of Sydney) of (1) dermatology and its associated ancillary subjects—for example, embryology, physiology, histopathology, mycology, etc., (2) radiotherapy, including the clinical uses of *x* rays, radium, and radioactive isotopes, the associated physics and electrotechnology, and (3) a reasonably good knowledge of general medicine, particularly in the overlapping fields.

May I say here, that I am also very much in favour of a dermatologist becoming an F.R.C.P., or F.R.A.C.P. as well, if he can afford to do both. The point I wish to emphasize is that a well-qualified dermatologist must be "essentially a good dermatologist with a special