them, at best, as the sincere opinions held by intelligent men of experience. No more and no less.—I am, etc.,

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Unconscious Motivation

SIR,—Thank you for your leading article "Public Attitudes to Mental Health Education" (13 January, p. 69). You quite clearly develop a sound argument favouring an opinion which I have concluded is axiomatic: presenting the public with the facts may not substantially alter previous opinions. The same results are evident in all sorts of campaigns such as immunization and safety programmes. As you say so well, there must be other less obvious but basically very powerful motives involved in these seemingly irrational decisions. There are indeed. And this is the very mechanism of psychology which we have been told of again and again by those mental health professionals who subscribe to the notion of unconscious motivation. All of us are guilty of the same curious failing you illustrate in the "Public Attitudes" comment: despite our having been educated about unconscious motives, we still try to conduct our studies and arrange our programmes using only superficially rational and objective variables. No one should be surprised by your findings, but many still are. Public and professional attitudes have nearly always been negative about the mentally ill because the afflicted represent (in imagination if not in fact) the very essence of what is contrary to our individual sense of integrity and control. Mental health programmes now enjoy considerable attention and financial support. But not because people's attitude has fundamentally changed about these conditions. No programme which does not take into account unconscious motives will succeed whether it be public education for mental health or strategies for international co-operation. If industry and advertising can help, it will only be because they tap these motives and then work them to the chosen ends. We would be better off to come to terms with the phenomenon of the unconscious directly—for it will not go away. Otherwise there will be a growing feeling of being manipulated against "our wishes."—I am, etc.,

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Community Child Care

SIR,—Your leading article (20 January, p. 134) is to be doubly welcomed. It not only focuses on the needs of children in a social context as of interest to the family doctor but on the work of the National Bureau for the Co-operation of Child Care. Though the book[1] modestly claims to be "a guide for the intelligent layman," the contents are of the greatest significance to family doctors, as well as to society generally.

It is to be regretted that its distribution will be very limited among family doctors. Doctors who have managed to keep abreast of the most revolutionary pharmaceutical advances, so that wonder drugs are used more widely than the "mixtures" of old, have been left behind in the development of the welfare resources available to the community. The further steps in medical organization now being debated are largely concerned with medical integration.

Community child care offers a second chance not merely to the child in care but to the community. The figure of 79,000 may not seem large numerically, but is large by any other measurement. The amount of misery involved for the children and the difficulties of those who care for them has been documented in America by Eisenberg.[2] The incidence of educational retardation, an index of social achievement as well as a forecast for future social competence, has been described by Kellmer-Pringle.[3] Wardle[4] has shown the recurrent cycle of maladjustment in generations of a child guidance population; here the problems are so much more severe.

Your allocation of a very minor role to the family doctors, as intermediaries between helpful adults and the children, ignores the wider contribution that family doctors have in the service to families. Their possible role in the avoidance of family breakdown is so much greater. When breakdown occurs they might play a part in helping the children in crises, as well as supporting those who care for them. Their role in research in these fields would seem enormous.

The small psychiatric contribution to emotionally disturbed children was previously noted in the *B.M.J.*[5,6] Elsewhere[7] I have argued for the need to redeploy scarce resources. In this context the large numbers of family doctors and their strategic deployment in the community offers particular possibilities of integration with social agencies. While some doctors might wish to play a larger part in hospital medicine, there are undoubtedly many who would welcome an opportunity of a greater role in social aspects.

There is no real competition between psychiatric and medical support. It is not to deprecate other agencies to claim for the family doctor a particularly important part in helping to provide an "effective family service." The issue is not an either/or one. The greater the medical contribution the easier will it be for psychiatrists to devote more time to those problems which require the still more specialized help.

Children, particularly those in care, but indeed all children, require the mobilization and co-operation of all branches of medico-social and educational resources. It is important to remember that many children not in care are often "deprived of normal home life." Even before they come into care the family doctors are much nearer and known social figures who can help and channel aid.

Present discussion must not merely centre on whether the new service should be combined in a new local authority department or the enlargement of children's departments. Neither, as constituted at present, makes room for the family doctor in his fullest potential. If he is omitted from the planning and discussion stage the service and the community and the future of the family doctor will be the poorer.—I am, etc.,

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4 Wardle, C. J., *Brit. med. J.*, 1961, **2**, 349.
5 —— ibid., 1967, **2**, 585.
6 Barnett, B., ibid., 1967, **3**, 238.
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Pay-beds in N.H.S. Hospitals

SIR,—When a Minister of Health is asked for comparative statistics on the occupancy of private and general beds the questioner is entitled to a fair comparison. That this is not what the questioner may get is clearly illustrated by the figures you have just published (27 January, p. 259), which should be compared with an earlier Parliamentary answer published in the *Lancet* (16 December, p. 1303).

The earlier answer showed general-bed occupancy throughout England and Wales varying between 83% and 87%, but pay-bed occupancy by private patients ranging from 32% in Newcastle region to 73% in London teaching hospitals, both figures being averages for the two areas. Such figures, published in a number of newspapers and in the medical press, gave the impression that public beds are far more heavily used than private ones. But the Minister had, in fact, included all geriatric and mental hospital accommodation in his N.H.S. general-bed statistics, and these figures could by no stretch of the imagination be regarded as comparable with acute private accommodation.

Mr. Victor Goodhew's question on 18 January, which you now report, shows that general-bed occupancy in the region is anything up to 11.1% lower than was shown in the earlier answer, ranging from 73.8% to 78%. Far from pay-bed occupancy by private patients being so low, as has been suggested by certain hostile political elements, it is now revealed that, especially in the purpose-built private wings of first-class general hospitals, the occupancy of pay beds by private patients is not infrequently higher than that on the general side. Specific examples are available in the North-west Metropolitan Region, where general-bed occupancy was 78% for 1966; but the private beds at Royal Northern Hospital showed 80% occupancy by paying patients and those for the Windsor group 82%.

High occupancy in private wings has been achieved despite the much greater difficulty in maintaining rapid turnover in single-room accommodation, and often under a large number of different consultants. For example, the wing at Royal Northern was used last year by 76 outside consultants (excluding anaesthetists) who are not on the staff of that hospital. Such a wing has been working at an extremely high level of efficiency and providing first-class care for a large number of sick people. In addition, it fed the Treasury with the not insignificant sum of £110,000 in the last year alone. Bed-occupancy figures can admittedly be misleading, but the cost of private beds certainly affords every incentive to early discharge and