abnormal movements, such as those of paralysis agitans, chorea, and spasmodic torticollis, ceased during sleep. This difference might not be fundamental, because chorea had many of the features of a symptom due to "spontaneous" discharges.

The theory provided explanations for, and enabled one to see a certain unity in a number of symptoms for which the current explanations were unsatisfactory. Dr. Martin recalled a quotation from Pasteur: ". . . the characteristic of a true theory is its fruitfulness."

Correspondence

Telling the Patient

SIR,—Major J. C. Hogarth's letter on this subject (Oct. 13, p. 513) is timely and deserves more than a passing comment. Observations of the same kind have been made to me by a number of thoughtful Service medical officers—usually with unit experience—who have been frankly shocked by the impersonal methods which prevail in many Service and E.M.S. hospitals. I had frequent occasion to make similar criticisms, during the first three years of the war, as the result of my numerous contacts with E.M.S. and teaching hospital medicine.

How have these strange habits of thought and action, this routine of intensive and often repeated investigation and multiple specialist opinions, but with so little said and done for the patient *as a person*, come to characterize hospital practice? What is the function of the physician, what is the object of medicine if it is not to help the patient's mind and body in every way possible and at every stage of his illness? There can be no greater disservice than to leave him puzzled or in the dark. It is a sad reflection on the trends of our clinical teaching in recent decades that institutional medicine should now so frequently be allowed to degenerate into a kind of mechanical bedside pathology; that it should prefer reports and labels to human histories, and diagnoses and treatments to "treatment," and delight so selectively in what is called the "interesting" case. "Examination, explanation, and reassurance" should be as much in the mind of the student and young doctor as "inspection, palpation, percussion, and auscultation," if—that is to say—he cannot be human without a mnemonic.

In another letter in the same issue Wing Cmdr. Bergin comments on some of the consequences of the modern "passed to you, please" ritual of investigating and handling patients. What a travesty of our old clinical discipline it is to employ a succession of specialists to exclude organic disease and then to ask a psychiatrist to make the final diagnosis, and, too often, to confirm the invalidism. The technological age in medicine has added much to our investigatory powers and has done much for many patients, but it is time our science and humanism resumed a more equal co-partnership. Two books have recently been sent to me from the United States, where similar trends are, I gather, all too common. One is called *The Patient as a Person* (by G. Canby Robinson); the other *Patients Have Families* (by Henry B. Richardson). We stand on the threshold of large reforms in our teaching and our practice. May we hope that the teachers of the new generation will take every occasion to remind their students and house-officers that "patients" are, above all, "persons" and not just "cases," and also that they have families and that they get better more quickly or accept their adversities better if they and their families are simply and clearly told what they most need to know?—I am, etc.,

Oxford. JOHN A. RYLE.

SIR,—How cordially I agree with Major Hogarth's suggestion that the patient be given constructive information about his complaint. I would go further, and suggest that therapy is incomplete until the disease is evaluated to him in terms commensurate with his intelligence, education, and emotional maturity, and until he is helped to adjust to it.

One of my first lessons in psychotherapy—from Dr. T. A. Ross; I have never forgotten his advice—was that the patient should be completely overhauled physically and the nature of his physical complaints precisely delimited and evaluated to him. How much more important, surely, where the complaint is predominantly physical; or in the extending field of the psychosomatic complaint—i.e., the physical symptom due to emotional stress.

Hypochondriasis is due to—or at any rate encouraged by—ignorance or fractional knowledge. It is surely the function of the doctor—specialist or G.P.—to dispel that ignorance. In doing so he will tend to clarify his own clinical conceptions and amplify his own therapeutic influence; by failing to do so he may become the creator of suffering. In doing so he will also help dispel the suspicion—explicit in many intelligent laymen and implicit in many more of their less articulate brothers—that much of the doctor's business is a defensive jiggery-pokery of false magic.

The doctor who has not the patient's full trust is crippling his own therapeutic influence. That trust can be more easily gained if a more rightful conception of the doctor's business is encouraged: that his influence is based, not on symbols, prestige-attitudes, or an implicit claim to a higher esoteric level of understanding, but on compassion fused with skill and experience and the ability to help the patient to see his complaints in their proper perspective.

Much avoidable psychotherapy, suffering, and distrust of the medical profession could be prevented if more doctors—specialist or G.P.—were to spend the few moments necessary to complete their therapeutic effort by bringing the patient "into the picture." It would also help those of us who come after to get a reasonable medical history. I am continually being surprised by the number of intelligent young officers who have vague ideas about quite serious illnesses and who are naturally worried because no one has told them what to expect or what to do about it.—I am, etc.,

Witley, Surrey. H. HARRIS, Major, R.A.M.C.

SIR,—Major J. C. Hogarth (Oct. 13, p. 513) surely realizes that in the out-patient department of a hospital the patients are referred for an opinion by the general practitioner. The majority of these practitioners, I am sure from personal experience, would resent the out-patient physician discussing in detail the diagnosis, prognosis, and treatment with the patient. This is the function of the general practitioner, and it is the physician's duty, in my opinion, to communicate only with the doctor concerned. Only in exceptional cases and at the doctor's request should the physician discuss the diagnosis with the patient. Otherwise, surely, essential trust and harmony between patient and general practitioner are apt to be jeopardized.—I am, etc.,

Northwood, Middlesex. E. IDRIS JONES.

Rehabilitation of Fractured Limbs

SIR,—The letters of Dr. R. Murray Barrow (Sept. 8, p. 332) and Dr. Vaughan Pendred (Oct. 6, p. 475) prompt me to point out that in 1899, when a student at Edinburgh University, I demonstrated to Prof. Annandale and Mr. J. W. Dowden at Edinburgh Royal Infirmary an electrical method of producing controlled contractions and relaxations of any of the muscles of the body. With their assistance I treated various types of fractures, particularly Colles's fractures, the latter being put in plaster and the case split in four to eight days; then daily contractions of the extensor and flexor muscles were produced by the apparatus described, so as to cause movements of the wrist and fingers. I showed that contractions and relaxations were so finely controlled that only the slightest movements of the muscles were discernible at first, and gradually increased to the maximum required without pain until the wrist and fingers were put through their full range of movements. About the year 1905, when I was in charge of the *X*-ray Department of Great Ormond Street Children's Hospital (which I started as a department), I showed the same method to Sir Arbuthnot Lane and Mr. Stansfield Collier, who were so impressed with the results that they sent many of their fractures to me for treatment by this method. In spite of the recent literature advocating long periods in plaster I have continued to carry out this method with consistent success, and full functional use of the wrist is obtained in much shorter time than when treated by the present-day so-called orthodox method.

By the method I advocate, which has stood the test for so many years, an important factor is that the muscles can be

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