Our findings suggest multiple sources of infection and that environmental spread, especially in contaminated water, may be a factor in the epidemiology of human campylobacter infections of the *C coli-C jejuni* group. It may be that the known avian excretors of campylobacters are responsible for our seawater isolates, but the fact that a sewage-polluted sample also grew campylobacters is suggestive of the strain having come from a human source. Clearly a strain identification scheme is required to distinguish between isolates before source tracing can be carried out efficiently.

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[1] Véron, M, and Chatelain, R, *International Journal of Systemic Bacteriology*, 1973, **23**, 122.
[2] King, E O, *Journal of Infectious Diseases*, 1957, **101**, 119.

Campylobacter-associated diarrhoea in Edinburgh

SIR,—We were interested to read the correspondence in your columns following Dr M B Skirrow's article (2 July, p 9). Since his earlier report[1] we have examined 196 stools submitted from general practice for enteric pathogens, including *Campylobacter* spp. In addition we have examined specimens from 50 asymptomatic individuals (not matched for age and sex). Our results are summarised in the accompanying table.

Pathogens isolated from 146 faecal specimens

Presumptive pathogen isolated	No (%) of positive samples from:	
	196 patients with diarrhoea	50 controls
Salmonella sp	5 (2·5)	0
Shigella sonnei	19 (6·7)	0
Giardia lamblia	13 (6·6)	0
Campylobacter sp*	17 (8·7)	0

**C coli* of Veron and Chatelain[2]

Campylobacter organisms were the only presumptive pathogens that were isolated from 14 (7·1%) specimens and vomiting was not a feature of the illness in these patients. In two cases campylobacter organisms were isolated in association with giardia cysts and in one case with *Salm agona*.

In contrast with Dr Skirrow's results and those of Dr B A S Dale (30 July, p 318) we found that 47% of our patients were children of less than 10 years of age (7 male and 1 female); we recognise the limitations of the small sample size.

We have routinely cultured our specimens on selective media at 25°C as well as 42°C in order to look for the presence of those members of the genus *Campylobacter* which grow at low temperatures. Included in this group is *C fetus* ss *intestinalis*, mentioned by Dr N A Simmons and Mr F J Gibbs (23 July, p 264), which has been shown to be present in birds. We have found none of these low-temperature growers in our human samples. It seems, therefore, that, although members of the genus *Campylobacter* may be an important cause of diarrhoeal illness in Britain, the epidemiology of this disease is as yet largely uncertain.

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[1] Skirrow, M B, PHLS Communicable Diseases Report, 25 February, 1977.
[2] Veron, M, and Chatelain, R, *International Journal of Systematic Bacteriology*, 1973, **23**, 122.

Inhumanity to man

SIR,—The medical staff committee of this hospital commends the change of editorial policy which has taken place in respect of the recognition of the needs of the chronically psychiatrically disabled patient in the community and which is expressed in your recent leading article (3 September, p 591).

The plight of this group of patients has increased since the hostel function of mental hospitals has been whittled away. It is unfortunate that the only sanctuary that our society can find for so many such individuals is in the asylum of the prison service. Since 1961 this very unsatisfactory situation has escalated as a result of persistently erroneous planning based on false premises, a policy with which the Department of Health and Social Security has persisted in spite of protests from clinicians. The result of this policy has been to remove unremittingly the ability of the psychiatric hospital to care for its chronic population.

False hopes and promises have been made in respect of an alternative service—for instance, the Government made great play with the commitment that the local authorities and the social services would undertake in respect of this group of patients following the passing of the Social Services Act in 1972. In fact, far from realising these hopes, there has been a persistent failure to provide adequate hostel places or to give even minimal support to those patients discharged from psychiatric hospitals.

A further pious hope that has proved to be wholly fallacious was based on the proposition that psychiatric units in district general hospitals would be able to replace the facilities offered by established psychiatric hospitals. The members of this committee who have worked in a general hospital psychiatric setting are only too aware of the incapacity of such hospitals to offer the total range of facilities which are provided by the traditional mental hospital. However, the DHSS chooses to ignore the impoverishment of services which would result from a planning commitment wholly to the district general hospitals and continues deceitfully to refer to an expanded service in the general hospital as a reason for not proceeding with improvement in the mental hospitals. This intransigent attitude has tended to undermine the confidence of staff, particularly nursing staff, working with the chronically ill psychiatric patient.

Moreover, we note that many such patients who have been discharged from the psychiatric hospitals, or who are being cared for as day patients by the district general hospitals, live in accommodation which is often characterised by highly unsatisfactory debilitating squalor.

Finally, it is our opinion that the DHSS has pursued a policy of surreptitious reduction of facilities, particularly nursing facilities, in respect of the psychiatric hospitals. Our experience suggests, and the work referred to in your leading article shows, that the present policies of the DHSS should be reversed, that as soon as the economy allows the inpatient provision of the psychiatric hospitals should be increased by 10%, and that both financial and personnel resources should be redirected to meet this need.

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ISABEL C A MOYES
U V NAYLOR
V L DOUGHTY
J F BRANDON
Members,
Medical Staff Committee

Broadgate Hospital, Beverley, N Humberside

**We are not aware of any change in our editorial policy regarding the treatment of the mentally disabled. On the contrary, if Dr Crumpton and his colleagues will consult the six previous leading articles that we cited they will find that it has remained virtually consistent throughout the past 10 years.—ED, *BMJ*.

The community physician: will he survive?

SIR,—The paper by Drs W H Parry and J E Lunn (27 August, p 589) makes gloomy reading but serves to remind the rest of the profession of the effects of a drastic reorganisation on those of their colleagues who have been personally affected.

For those of us attracted to preventive medicine who chose careers in public health it has been evident that the separation of treatment services from preventive activity is artificial and undesirable. We therefore accepted that a reorganisation to bring about a functional unification between "prevention" and "cure" was the next logical step. Equally we are aware that to pursue the achievement of prevention of disease and promotion of health simply through medical treatment services is impossible. Environmental control and housing and social and educational policy remain important influences on health. It is therefore important to ensure that an appropriate medical voice is heard in the places where these matters are discussed, and decisions taken.

For this reason there is a need for an organisational link between the NHS and the two-tiered local government structure. The community physicians' involvement in both these fields of activity was foretold by Professor J N Morris.[1] A career as "epidemiologist, administrator of local medical services, and community counsellor" combined with the traditional medical officer of health's function of "teacher, watchdog, and trouble-maker" were the terms he used to describe the community physician. The future seemed rosy, so why the gloom revealed in Drs Parry and Lunn's analysis?

The fact is that few of us are able to follow the Morris model. Community medicine has been subordinated to institutional management. Almost in spite of itself the hospital service has an insatiable appetite for administration, and the mere fact that community physicians are involved in management teams ensures that the day-to-day running of the service becomes their all-absorbing preoccupation. It is a hard struggle to find any