pointed out to Mr. Chambers the outstanding difference between the approach of A.A. and the psychotherapeutic approach—namely, that the former accepted the emotional immaturity and supplied a crutch for it, whereas psychotherapy attempted to supply insight into the emotional immaturity, and helped the patient towards emotional growth and maturity, as a necessary adjunct to abstinence.

Leisurely Personality Diagnosis

Psychotherapy might include a great many different approaches and various techniques. The lecturer outlined briefly the method which he and his colleagues had found practical and effective with a certain group of patients. He asserted that the first and often neglected step in the treatment of pathological drinking is a personality diagnosis. This diagnosis should be avoided during the intoxication symptoms and withdrawal symptoms. Even after a state of sobriety had been reached, the physician should delay opinion as to the best method of treatment until he had had ample opportunity to study the personality of his patient. Personality problems presented by patients varied enormously, as did the underlying causes for their addiction. "We have found," said Mr. Chambers, "that the germ of alcoholism reaches far back into childhood, and that most patients are suffering from unconscious feelings of guilt and rejection coming, usually, from these childhood experiences. We are beginning to see more clearly that drinking alcohol in itself did not create their problem. Rather it was their neurotic insecurity which created their addiction. We see in the paranoid patient a tendency to project his personality discomfort outward, in the psychoneurotic a tendency to project personality discomfort inward, and in the alcoholic a tendency to reach for a drug to anaesthetize his personality discomfort. In the abnormal drinker, emotional immaturity plus the addiction problem preclude emotional growth. The alcoholic, when intoxicated, is on an infantile level. When sober, he is a very uncomfortable child in an adult body in an adult world."

Correspondence

Because of the present high cost of producing the Journal, and the great pressure on our space, correspondents are asked to keep their letters short.

Admission of Poliomyelitis Cases to General Hospitals

SIR,—Dr. A. H. Gale, in a comprehensive and well-balanced contribution to this problem (August 30, p. 516), presents the evidence of obvious danger that cannot be honestly refuted. He thereby rightly questions the wisdom of the views of your contributor who answered a question on the subject ("Any Questions?" August 9, p. 349) and who favoured the admission of poliomyelitis cases to general rather than to infectious diseases (I.D.) hospitals. That writer, while expressing concern for the welfare of the patient as his sole reason, is, I trust, free from any taint of self-interest in his advocacy.

In addition to the cases of apparent cross-infection in general and other hospitals referred to by Dr. Gale, there have been a number of cases of poliomyelitis affecting nursing staff of general or special hospitals. This is in contrast to the rarity of such an event in the I.D. hospitals.

I had not seen the criticized opinion until Dr. Gale's letter drew my attention to it, and I wonder if it did not also escape the notice of some of my I.D. hospital colleagues with vast experience of tracheotomy, for they, with me, will be surprised to learn that only in the general hospital can this emergency be coped with. I know that the race of tracheotomists is fast dwindling with the disappearance of diphtheria and cannot be brought up to strength. I am also aware that the type of tracheotomy advocated recently for bulbar poliomyelitis in American literature is not that normally practised by I.D. hospital staff. There was an implication, however, that we are isolated from our surgical colleagues. In fact, the grouping of our hospitals under the N.H.S., which ran parallel with the rise in poliomyelitis incidence, has left us far from isolated from the laryngologist, thoracic surgeon, or anaesthetist, who may be required to make up the team dealing with the more complicated of the bulbar cases. The main difficulty, as I see it, may lie in convincing the experts called in that perhaps a planned tracheotomy or bronchoscopy may be needed.

As this hospital (probably with other of the larger I.D. hospitals) has given training in respirator (breathing machine) technique and nursing to the nursing staff of the more advanced of the large general hospitals in London, it is with some surprise that we read that the skill required to deal with respiratory paralysis is only rarely to be met in the I.D. hospital, but is never lacking in the general hospital. Most of the larger I.D. hospitals are to-day fast becoming I.D. units within a general hospital plan, whether within the same curtilage or in the same group. Structurally, with well-separated pavilions and open corridors, they are admirably suited to such development with safety. Conversely, the large, many-floored blocks of the average general hospital with internal corridors and common passenger or patient lifts are far from ideal for the purpose of nursing medical cases of an infectious nature whether of notifiable or non-notifiable classification.

I contend that a normally practised aseptic technique (so seldom carried out as routine by staff in the medical wards of the average general hospital) is most important in prophylaxis of known or unsuspected infections. Of probably much greater importance is *the structure of the I.D. hospital plan with its emphasis on free, even uncomfortably free, ventilation of wards and corridors and the proper spacing of buildings.*

Finally, I quote from an article by Mr. H. J. Seddon, the orthopaedic surgeon (*Practitioner*, 1948, **160**, 175): "A surgeon called upon to deal with patients suffering from poliomyelitis will be faced with an important question of hospital policy; if the disease is epidemic the answer is of paramount importance. Should a patient suffering from poliomyelitis, or suspected to be suffering from it, be admitted in the initial stage to a fever hospital or to an orthopaedic hospital? It is generally agreed that the responsibilities of the orthopaedic surgeon begin as soon as paralysis is present, and for this reason many favour immediate admission to an orthopaedic hospital. There are, however, certain practical objections. The suspected case may be found, after all, to be suffering from some other condition, such as meningitis or rheumatic fever; an efficient fever hospital is in a better position to treat or place cases of this kind. In established poliomyelitis, barrier nursing is desirable for a period of about three weeks. In fever hospitals such measures are common form; in orthopaedic hospitals they are not, and the structure of the hospital is often unfavourable for efficient isolation. . . . For all these reasons, therefore, the most sensible plan is first to admit poliomyelitis patients to a fever hospital. . . ."—I am, etc.,

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SIR,—I feel that the reply to the question about admission of poliomyelitis cases to general wards ("Any Questions?" August 9, p. 349) is somewhat misleading. The impression created is that if a patient suffering from poliomyelitis is admitted to a general hospital he is more liable to be nursed by staff experienced in the handling of such cases, particularly in regard to respiratory and bulbar paralysis. This is quite the reverse of the position as it exists. In the fever hospital, the ward sisters and staff nurses will have had extensive experience in the use of the respirator, whereas in the general hospital they will have had little, if any, such experience. The same applies to tracheotomy cases. Resident medical staff accustomed to the management of these patients will also be available. In fact, fever hospitals experience great difficulty in getting general or orthopaedic hospitals to accept patients while still, to any extent, dependent on a respirator. Consequently they have to retain such patients for long periods, sometimes years after they have ceased to be infectious. The limited amount of physiotherapy which is beneficial in the early stages of poliomyelitis is also, so far as I am aware, generally available in fever hospitals.