mothers with high concentrations of thyroid stimulating immunoglobulins who may yet be hypothyroid and receiving thyroxine after previous treatment, especially surgery, to ablate the thyroid. Diagnosis of fetal thyrotoxicosis is difficult but may be suspected from fetal tachyarrhythmias if the mother has appreciable extrathyroidal features of Graves' disease or high concentrations of thyroid stimulating hormone binding antibodies. Treatment with both carbimazole and propranolol has been successful, although neonatologists do not like propranolol.¹⁵

Maternal thyroid state after giving birth has been intensively studied in Japan. Thyrotoxicosis often relapses,¹⁶ but after a few months there may then be a clinically important period of hypothyroidism, which is followed by yet another bout of enhanced thyroid function six to nine months after delivery.¹⁷ These mysterious but important changes illustrate the powerful and long lasting but ill understood mayhem that pregnancy causes in the immune system.

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himself that causes distress or significant impairment in social or occupational functioning. So a diagnosis of borderline personality disorder may be made when a patient with longstanding difficulties in his relationships reports symptoms that though not clearly psychotic suggest disordered mental functioning.

The criteria that DSM III uses to define borderline personality disorder may be summarised as: potentially self damaging impulsivity; unstable and intense interpersonal relationships; inappropriate intense anger and lack of control; identity disturbance; affective instability; intolerance of being alone; physically self damaging acts; and feelings of emptiness or boredom. The best way to make the diagnosis is through a semistructured interview.³

Schizotypal personality disorder, which is distinct from schizoid personality disorder, is a better diagnosis when the patient has suspicious or paranoid attitudes, sensitivity to criticism, ideas of reference, poor rapport, and an odd way of communicating. As a category schizotypal personality disorder has replaced borderline schizophrenia, although this term is still used to describe certain peculiarities that are common among the biological relatives of schizophrenics.^{4,5}

Randomised controlled trials have now shown that some borderline and especially some schizotypal symptoms are reduced by neuroleptic drugs in low doses.^{6,8} Thiothixene (a thioxanthene marketed in the United States) reduces illusions, ideas of reference, psychoticism, obsessive compulsive symptoms, and phobic anxiety. Haloperidol reduces depression, anxiety, hostility, paranoid ideation, and psychoticism. Amitriptyline is less effective except in reducing some aspects of depression.

So should those who fit the DSM III criteria for borderline personality disorder be treated with low dose neuroleptics? Some psychiatrists doubt the clinical usefulness of the DSM III categories: some symptoms are reduced by drugs and others by a placebo, and, moreover, these reductions are usually insufficiently general to improve the overall condition of the patient as measured by assessment scales. The disorders as defined by DSM III seem to be mixtures of problems that may have a biological basis and of others that have their origins in childhood and adolescent relationships. Furthermore, the diagnosis gives no indication of possible causes of the condition as DSM III is "generally atheoretical with regard to aetiology."

Difficulties arise in diagnosing all forms of personality disorder. DSM III has more than 10 subclasses but does not define a "significant impairment." Is the standard of social functioning absolute, or does it vary with age, occupational class, or subculture? DSM III helps by including scales for rating adaptive functioning, and these give an indication of the degree of impairment. DSM III is important because it provides a common language for scientists, but it does not help with decisions about how individuals are to be treated. Can then the terms personality disorder and especially borderline personality disorder be dispensed with in the clinic? Obviously they should not be used as either a vague disparagement of an awkward patient or a euphemism for a schizophrenic illness.

The results from trials suggest that the best way to arrive at treatment is to ask more specific questions about each patient. What symptoms are to be treated and how? If social functioning is impaired what should be done through counselling, psychotherapy, or other psychological methods to modify the way in which the patient sees himself and relates to others? If there are borderline symptoms do drugs have a part to play? Anxiolytic drugs may help with anxiety

How useful a diagnosis is borderline personality disorder?

Borderline personality disorders are included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (third edition: DSM III),¹ yet I suspect that many British doctors are unfamiliar with the diagnosis. To understand the term we need to consider its two parts. The word borderline was introduced to describe psychiatric disorders that are difficult to categorise because they lie on the border between neurosis and psychosis. (Its use in psychoanalysis has become specialised.²) A person with a personality disorder has an enduring way of perceiving, relating to, and thinking about the environment and

symptoms and antidepressants with depressive symptoms. Antipsychotic drugs may help. Drug treatment does, however, have disadvantages: adverse effects, such as tardive dyskinesia, may afflict a few patients despite the low dosage; some symptoms may become worse; and some patients may become dependent on the drugs.

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The General Practice Finance Corporation: an unnecessary change

The government's recent decision to nudge the General Practice Finance Corporation towards the private sector could prejudice progress in improving general practitioners' premises (24 January, p 260). As independent contractors National Health Service general practitioners are responsible for providing their own premises. Whether they rent, lease, or buy is a decision for individual practices, but most general practitioners own their surgeries. Since 1967, when it was set up as a statutory body authorised to raise money in the public sector,¹ the corporation has lent around £100m to over 8000 doctors to help them buy, improve, or, more recently, lease their premises. This invaluable source of funds has been influential in the renaissance of general practice that has followed the Family Doctor Charter negotiations in 1966.²

The establishment of the corporation was an integral part of the reforms that increased general practitioners' pay and restructured the arrangements for refunding practice expenses with the aim of improving premises and equipment and expanding the employment of ancillary staff. The corporation's ability to raise money in the public sector and lend it to doctors at reasonable rates of interest was particularly valuable to those practices which because of unfavourable local circumstances found it hard to raise money from commercial sources.

The self financing scheme has been prudently run, building up a wealth of information on providing practice premises. It has used state money cost effectively (general practitioners are reimbursed for the costs of borrowing through the practice expenses arrangements), and its success led to the government endorsing its activities and raising the corporation's overall borrowing limit in July 1984

from £100m to £250m. Yet six months later, when the Treasury was looking for spending cuts, the government suddenly imposed limits on the amount that could be lent annually, irrespective of forecast requirements for loans. Though the corporation's eight man board—chaired by Mr D L Stebbings, a solicitor, and containing representatives from the General Medical Services Committee—made no public fuss about this sudden change of policy, its 1986 report hinted at their disquiet, while the GMSC made clear its dislike of an annual limit.³ In the event in 1985-6 the corporation had to refuse only a few applications because of lack of funds.

The money lent by the corporation was classified as part of the public sector borrowing requirement in 1984 so it was no great surprise that the government announced last year that it was studying the feasibility of reducing "public sector involvement in funding loans to family doctors for the provision of surgery premises."⁴ Hambros Bank conducted the review and without even publishing the report the Minister for Health has now asked the corporation "to invite private financial institutions to participate in loans to family doctors." The minister envisages banks and building societies as being among the sources of funds, and he sees the public sector provision being "reduced significantly over the next three years." His point is reinforced by a reduction to £12m in 1987-8 (from £26.7m in 1986-7) and some ominous blanks against the corporation's future financial requirements after that in the government's expenditure plans to 1990.⁵ Indeed the corporation has already had to impose a temporary moratorium on negotiating any more loans for 1987-8.

The minister is confident that the corporation can attract private sector finance. He may be right, but the *raison d'être* for the corporation has been that the private sector is not a reliable source of funds for many practices, and though private loans are readily available now this may not continue. In any case the commercial sector is likely to want higher interest charges, especially for high risk loans, than the corporation, which has used its "profitable" lending to help fund high risk loans in, for example, deprived areas.

No details of how the new plan will work have been announced, but no doubt the private institutions will be expected to carry their share of the risk of lending by jointly funding the loans—for the public sector borrowing requirement will not be reduced if the corporation has, in effect, to guarantee all loans. Given the scheme's success, the modest size of the loan fund, the fact that it is self financing, and the corporation's prudent management policy, the decision to part privatise the fund seems to be founded more on financial ideology than on the interests of general practice. Furthermore, it is odd that with a major review of primary care still in progress the government has, after limited discussion with the profession, picked out the corporation as ripe for immediate change. It is an unnecessary change at a time when the development of general practice is of greater interest to the public than ever before.

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