on the letter by Dr. F. N. I. Fawzy and others (8 April, p. 114).

It would be unfortunate if we once more became rigid in our treatment methods, long a problem in psychiatry. The treatment of six patients with dosages of 75 mg per week hardly constitutes a refutation of other statements of the efficacy of higher dosages. I have patients who receive 12.5 mg every two weeks and are maintained on this, but also have a patient who requires 125 mg each week, and if this is spaced to 10 days his chronic hallucinations interfere completely with his functioning. I have also seen an acutely excited patient who, owing to a misinterpretation of an order, received 100 mg four times daily for four days, at which time his mental status had improved markedly and he showed no side effects whatsoever.

These facts are mentioned to emphasize the wide dosage range that may be employed. The ever-increasing interest in tardive dyskinesia suggests that the most desirable treatment is the least amount of medication spaced as far apart as possible. However, patients who have failed to respond to orthodox treatment do merit a trial on high dosages of phenothiazines whether orally or parenterally.—I am, etc.,

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Twins and Cancer

SIR,—There is a biochemical aspect of Mrs. Jean Fedrick's and Dr. Eva D. Alberman's interesting article (27 May, p. 485) which seems to warrant comment.

The incidence of twins in the 20 cases of cancer was 10%, and the incidence of cancer in the estimated 107 pairs of twins was 1.9%. These figures contrast with percentages of 0.62, and 0.12, in the general populations of 17,204 (mothers), and 16,750 (children), respectively, and are therefore approximately a sixteenfold increase.

This may, of course, just be another example of the extremes that go to make up any "average", but having completed a survey of 54 pairs of twins (of school-entrance age) with special reference to their family history of cancer, and having noted that the mortality from cancer of the grandparents was 38%, compared with 22% for a control series (that is a difference of 70%), one wonders if further inquiry into a possible association is indicated.—I am, etc.,

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Rehabilitation Services

SIR,—We should like to comment on some of the points raised by Dr. H. L. F. Currey (15 July, p. 172).

It is, we believe, now generally accepted that the term "physical medicine" is inappropriate in the context of modern medicine, carrying as it does the unfortunate impression of a purely therapeutic specialty concerned with the prescription of physical methods of treatment. Indeed, our association is at present taking active steps to delete the words "physical medicine" from its title.

Since the formation of our association in 1943 the majority of its members have carried out the role outlined in Dr. Currey's letter—that is, combining clinical rheumatology with the administrative control of the ancillary remedial services. Some have become predominantly interested in rehabilitation and have made major contributions to the advancement of this subject. We believe that it is also generally accepted by the medical profession that every clinician, in whatever discipline, should be responsible for the rehabilitation of his own patients. We feel strongly that the interests of the patient and of medicine as a whole are best served if a clinician has overall responsibility for the services concerned. By the very nature of the diseases with which he deals, the rheumatologist must necessarily have the expert knowledge needed for this, but as Dr. Currey says there are many other specialties from which doctors may be recruited to take charge of rehabilitation services.

It is clearly as important that there should be academic centres of rheumatology devoting their whole time to clinical work and research as that there should be specialized rehabilitation centres devoted entirely to the rehabilitation and resettlement of the disabled. Apart from these highly specialized units, the majority of remedial departments in the hospital service should, we believe, be under the charge of one who is primarily a clinician, for only in this way will doctors of sufficient calibre be recruited to undertake this important role. The rheumatologist is as well equipped as any clinician to do this.—We are, etc.,

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President

D. R. L. NEWTON
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Training of Surgeons

SIR,—The training of a surgeon can be subdivided arbitrarily into two parts—theory and practice. To appraise the first we have the Fellowship, and the second is simply recorded as testimonials between consultants.

At the moment surgical trainees may be acting as busy registrars in hospitals at the periphery, while at the same time attempting to learn their Fellowship work. This is a most difficult and unenviable task. Surely this examination should be taken from within a teaching hospital. Herein are facilities for acting as anatomy demonstrator and joining in with the teaching of undergraduates, and attending lectures, specialized clinics, and so forth.

The second, practical part should be the training in surgical procedures by surgeons who have wide general experience. This should be carried out in the regional or district general hospitals. At the moment the reverse is taking place—namely, practice before adequate theoretical training. This is unsound.

The training of young surgeons could be divided into six or eight years, with a rise in salary every year, and the grade be described as registrar with the seniority in the number of years of training in that

grade. The description "senior registrar" should be discarded. It was simply a device to control the numbers in training.

Research should be encouraged after this basic training with posts paid at the top registrar level with minimum clinical demands. Too often the young doctor is imposed upon to act as a busy clinician as well as engaging on work that demands the whole of his mental effort. These changes if implemented would lighten immeasurably the heavy burden that our young doctors carry.—I am, etc.,

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Sickle Cell and Altitude

SIR,—Further to our earlier letter (25 March, p. 803), we understand that it has not been possible to perform further studies to confirm the diagnosis of the sickle-cell trait in Case 1 of our article (4 December 1971, p. 593).

This case was irrelevant to the main theme of our paper, which was to draw attention to the dangers of sickle-cell disease in pressurized aircraft. Furthermore we would not wish this case to confuse the discussion of the relevance of the sickle-cell trait to flight in unpressurized aircraft, when better substantiated cases are available (25 March, p. 803).

We therefore wish to withdraw this case.—We are, etc.,

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Conquest of General Paralysis

SIR,—Dr. J. Purdon Martin (15 July, p. 159) deserves gratitude for reminding us of the introduction of malarial treatment of general paralysis into Britain 50 years ago and its subsequent replacement by penicillin. Although malarial therapy is only of historical interest today it revolutionized the treatment of the major mental disorders, and its repercussions are still with us. The idea of curing mental illness by another disease state caught on in psychiatry. Insulin coma treatment of schizophrenia was introduced in Vienna under Wagner-Jauregg's successor, to be soon followed by various types of convulsive therapy for depressive illness.

For the sake of historical accuracy I should like to correct an error in Dr. Purdon Martin's excellent article. Wagner-Jauregg was not "professor of neurology." His official title was "professor of psychiatry and neuropathology," the latter term meaning neurology. As in most continental universities, psychiatry and neurology formed a single joint clinical specialty in Vienna. The two subjects were separated only last year when special chairs for psychiatry and neurology were established. The same development is taking place in other continental universities.—I am, etc.,

E. STENGEL

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