## Postgraduate Education

SIR,—I can only concur with Dr. C. Watson (27 September, p. 783). The situation at present would appear to be that if you don't collect the requisite number of "signatures" your seniority pay is forfeit.

But what about the next artifice—that is, that you must pay for such education, whether you take it or not, for fear of losing your registration? Are we still schoolboys? Which other intelligent group of people agrees to such pressures? Which other section of the community is so beset? Does not "general practitioner" mean something?

If all this goes through, which heaven forbid, our little outposts will have to go unmanned, and the local contentment that we have been trying to foster will revert to distress and anger.—I am, etc.,

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## Future of Chest Physicians

SIR,—Dr. P. E. Baldry's letter (6 September, p. 599) advocating two types of training for chest physicians is understandable, but is it realistic? Surely all those specializing in respiratory medicine should have a broadly similar, but highly flexible, basic training which will enable them either to practise respiratory medicine exclusively or respiratory medicine combined with general medicine. All require a wide background of general medicine, and this is as true of those in professorial respiratory units as of those working in district hospitals. No one can know, at an early stage in his career, what will be the exact responsibilities of the consultant post which he eventually obtains. On the other hand it is only the patients who will suffer if men are appointed to posts involving "general medicine with a special interest in chest disease" who in fact are mainly general physicians with a mere dilettante knowledge of chest medicine. It will be equally unfortunate if those highly trained in respiratory medicine are so overwhelmed by general medical work that they are unable fully to practise, or further to enhance, their special skills.

We must aim at a broad training which will allow a man later to develop whatever emphasis is appropriate to his geographical setting, to the other facilities available, and to his personal enthusiasms—always remembering our primary responsibility to provide the highest standard of service to the community.—I am, etc.,

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## Potassium Supplements

SIR,—Some years ago we carried out tests on both Slow-K and Slow-Na (Ciba Laboratories, Ltd.) to satisfy ourselves that potassium or sodium administered in this form would be absorbed. We did not publish our findings at the time because we felt that absorption of Slow-K had been proved adequately by Professor Wynn in 1965.[1]

It appears that recently there has been some confusion whether Slow-K, a wax-based tablet, is absorbed, or whether it passes through the gut unchanged (17 May, p. 430; 12 July, p. 118; and 23 August, p. 457). We would therefore like to present our data, which demonstrate that both in normals and in patients Slow-K is completely absorbed. We are also including some investigations which we carried out on the absorption of Slow-Na.

In a preliminary experiment 40 mEq of potassium/day as Slow-K was given to a patient in addition to 68 mEq/day in the diet. Only 7·2 mEq/day was recovered in the faeces during a period of 6·7 days measured with continuous chromium marking. There was a possibility that this result might be due to incomplete recovery caused by inadequacies of sampling or homogenizing of the faeces. A further test in vitro was therefore performed to ensure that if the tablets do indeed pass through the gut unchanged they would be detected by our technique. Tablets of Slow-K and Slow-Na were added to a sample of homogenized faeces. The faeces and tablets were then homogenized for a further 20–30 min., the time normally taken to homogenize a five-day faecal collection. Potassium and sodium in the faeces were then estimated and recovery of potassium and sodium added as Slow-K or Slow-Na was calculated. Recovery of Slow-K was 99·6%, while recovery of Slow-Na was 99%.

Five potassium and two sodium balance studies were then carried out in the metabolic ward. The subjects received the same diet throughout the balance. They were studied during a control period of 3–13 days and were then given potassium or sodium supplements in the form of Slow-K or Slow-Na. Details of the subjects and results of the balance studies are shown in the Table. The results show that both Slow-K and Slow-Na are totally absorbed.

We would suggest that the recent confusion about the absorbability of Slow-K was due to a misapprehension that Slow-K was a resin-based tablet.—We are, etc.,

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REFERENCE

[1] Wynn, V., *Lancet*, 1965, **2**, 1241.

| Subject No. | Details of Subject | Faecal Collection Period Days | Potassium: Average Plasma K mEq/l | Potassium: Intake mEq/day | Potassium: Urine mEq/day | Potassium: Faeces mEq/day | Potassium: Absorption mEq/day | Potassium: Balance mEq/day | Sodium: Average Plasma Na mEq/l | Sodium: Intake mEq/day | Sodium: Urine mEq/day | Sodium: Faeces mEq/day | Sodium: Absorption mEq/day | Sodium: Balance mEq/day |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Normal | 3·8 | 4·5 | 34·0 | 45·0 | 3·5 | +30·5 | −14·5 | — | — | — | — | — | — |
| | | 3·6 | 4·5 | 134·0 | 111·1 | 4·5 | +129·5 | +18·4 | — | — | — | — | — | — |
| 2 | Purgative addict | 5·0 | 2·9 | 47·4 | 4·2 | 50·0 | −2·6 | −6·8 | — | — | — | — | — | — |
| | | 16·4 | 4·2 | 85·4 | 53·8 | 6·6 | +78·8 | +25·0 | — | — | — | — | — | — |
| 3 | Hyper-tension | 5·0 | — | 50·0 | 37·6 | 7·5 | +42·5 | +4·9 | — | — | — | — | — | — |
| | | 6·4 | — | 90·0 | 75·7 | 8·4 | +81·6 | +5·9 | — | — | — | — | — | — |
| 4 | Chronic renal failure | 12·7 | 4·8 | 45·0 | 28·0 | 15·4 | +29·6 | +1·6 | 137·0 | 22·0 | 50·0 | 1·9 | +20·1 | −29·9 |
| | | 3·7 | 5·8 | 101·0 | 49·0 | 20·7 | +80·3 | +31·3 | 137·0 | 78·0 | 76·9 | 2·0 | +76·0 | −0·9 |
| 5 | Normal | 5·0 | — | 85·0 | 74·5 | 6·5 | +78·5 | +4·0 | — | 20·0 | 16·5 | 0·5 | +19·5 | +3·0 |
| | | 14·3 | — | 135·0 | 135·3 | 7·5 | +127·5 | −7·8 | — | 120·0 | 106·6 | 1·4 | +118·6 | +12·0 |
| | | 9·2 | — | 185·0 | 177·1 | 12·7 | +172·3 | −4·8 | — | 120·0 | 110·2 | 1·5 | +118·5 | +8·3 |
| | | 16·7 | — | 200·0 | 241·0 | 9·9 | +190·1 | −50·9 | — | 120·0 | 110·0 | 0·2 | +119·8 | +9·8 |

## Approach to the Psychotic

SIR,—I was glad to see Dr. P. D. Scott's comments (20 September, p. 715), and I agree entirely with what he says. In particular the concept of altered attention or perception arising from a disturbance in the function of the reticular system I find a useful hypothesis clinically, and I am in the habit of offering it as such in teaching. One can scarcely doubt the existence of some such endogenous factor in most psychotics.

However, in dealing with psychotics we have a chance to influence this endogenous factor only occasionally—for example, by administering drugs. By contrast, from the outset of the relationship we are participating in the world as perceived by the patient. How we, as doctors, nurses, or laymen, approach the patient and how we view him ourselves is likely to contribute for good or ill to any therapeutic process, and I suggest that this is more so rather than less so in dealing with psychotics as opposed to, say, neurotics or normal people. A doctor who is too exclusively "endogenously" orientated, or a nurse who just sees the patient as the carrier of a "disease," or a layman who just sees him as "mad," inexplicable, and dangerous—all are likely to be perceived by a psychotic (plus or minus distortions) as aloof or unsympathetic or frankly hostile. Most of us have seen psychotics do well with one doctor and badly with another and all on the same tranquillizer.

I suggest that the expectations of those who see too exclusively in terms of an endogenous and psychologically inexplicable

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