should be some attempt to signpost these routes. Defining techniques need not mean "splitting hairs." The weakness of the term "therapeutic community" is that it so readily means all things to all psychiatrists. All communities intra-communicate. Many promote mental health.

Presumably what distinguishes the "therapeutic community" from other communities is that it is *psycho*therapeutic. Historically this psychotherapy has had some links with psycho-analysis. Group communication based on analytic technique differs fundamentally in kind from that described by Dr. Mary Lightbody and Dr. S. Jacobson (2 January, p. 47). Either may or may not be therapeutic—this is as yet unproved. However, to identify different communication systems by a common name can only confuse further a confused area. I am questioning Dr. Jacobson's terminology, not his therapy. Incidentally, he asks, apropos the difficulty of using analytical group techniques, "How many analytically trained personnel are available in mental hospitals?" Could this perhaps be re-phrased to "How many psychiatrists take advantage of facilities for training in analytical psychotherapy which are available—at least to those in reach of London?"—I am, etc.,

Claybury Hospital, Woodford Green, Essex. M. J. HERON.

Rapid Estimation of Blood Glucose

SIR,—The recent paper by Dr. V. Marks and Mr. A. Dawson (30 January, p. 293) prompts us to record our own experience with Dextrostix, including its use by patients to determine their own blood-sugar concentration.

The Dextrostix and Somogyi methods of estimating capillary blood sugar were compared on blood samples obtained from 200 consecutive patients attending the diabetic clinic. All estimations were done by the same technician. Dextrostix, when inaccurate, as they were in 77 of 200 estimations, tended to underestimate the blood-sugar concentration at all levels (Table I). This finding differs from the results obtained by Rennie *et al.*[1] and Wilson.[2] In only 10% of cases was the Somogyi value greater or less than the corresponding Dextrostix range by more than 20 mg./100 ml. (Table II).

TABLE I.—*Comparison of Dextrostix and Somogyi Blood-sugar Estimations (mg./100 ml.)*

Dextrostix Colour Range Readings	Total Cases	Readings by Method of Somogyi						
		<40	40–65	65–90	90–130	130–150	150–200	>200
Less than 40 ..	5	4	1	—	—	—	—	—
40–65 ..	6	1	2	3	—	—	—	—
65–90 ..	13	—	1	8	3	1	—	—
90–130 ..	37	—	—	3	22	11	1	—
130–150 ..	49	—	—	—	9	19	20	1
150–200 ..	34	—	—	—	1	4	17	12
More than 200	56	—	—	—	—	1	4	51
Total ..	200	5	4	14	35	36	42	64

Dextrostix were thus not sufficiently accurate for routine estimation of blood sugar in hospital, but it occurred to us that their accuracy was such that they might with benefit be used by certain patients to estimate their own blood sugar, particularly when alterations in renal threshold made urine-sugar tests unhelpful. This consideration applies particularly to pregnant diabetics. Recently, therefore, we supplied Dextrostix strips to a few unstable diabetics, including one pregnant diabetic Mrs. A. B.

TABLE II

Dextrostix Colour Range Readings	Total	Dextrostix Range >20 mg./100 ml. Above Somogyi Value	Dextrostix Range >20 mg./100 ml. Below Somogyi Value
Less than 40	5	—	—
40–65 ..	6	—	—
65–90 ..	13	—	2
90–130 ..	37	—	1
130–150 ..	49	—	8
150–200 ..	34	1	6
More than 200	56	3	—
Totals ..	200	4	17

Mrs. A. B., aged 26, had been a known diabetic for 13 years. When first seen at this clinic in September 1964 she was 2½ months pregnant. Her blood-pressure was 160/60 mm. Hg and she had proteinuria and early bilateral cataract. Her diabetes was out of control and, after she was admitted to the ward for assessment, she exhibited frequent swings from hyperglycaemia to hypoglycaemia, and she readily became ketotic. She had a low renal threshold for glucose and frequent blood sugars were essential for controlling her diabetes. She was discharged after three weeks, taking 36 units protamine zinc and 20 units soluble insulin daily, and she was seen at weekly intervals thereafter. Her control continued to be difficult and poor. Her blood sugars at the afternoon clinic ranged from 288 mg./100 ml. to 40 mg./100 ml. On 21 October, when her blood sugar at 3 p.m. was 45 mg./100 ml., she was given a supply of Dextrostix and instructed to alter her insulin according to the Dextrostix blood-sugar estimations which she was to carry out twice daily. Her insulin dose at this point was 32 P.Z. and 16 soluble. No change had to be made for two weeks, but during the next three weeks she increased her insulin to 52 P.Z. and 28 soluble on the basis of the Dextrostix results. This rise from 48 to 80 units daily was amply justified by the Somogyi blood-sugar results obtained at the clinic of 154 and 145 mg./100 ml. Later she decreased her insulin to 44 P.Z. and 28 soluble after a series of low Dextrostix results and probably avoided a reaction. So successful were her dose modifications that further changes had seldom to be made at the clinic.

Undoubtedly her diabetic control improved considerably with the help of the frequent blood-sugar estimations, which she found no difficulty in performing. Unfortunately she later developed acute hydramnios, and on 22 January 1965 she was delivered prematurely of a stillborn foetus showing multiple congenital abnormalities.

Despite the unsuccessful conclusion of the pregnancy our experience suggests that in some cases, particularly pregnant diabetics and possibly brittle diabetics with renal-threshold abnormalities, there is a place for the use of Dextrostix by patients as an aid in the management of their own diabetes.—We are, etc.,

Diabetic Clinic, Victoria Hospital, Kirkcaldy, Fife. A. W. M. SMITH. C. L. K. McILWAINE.

REFERENCES

1 Rennie, I. D. B., Keen, H., and Southon, A., *Lancet*, 1964, **2**, 884.
2 Wilson, I. V., ibid., 1964, **2**, 1062.

The Murder of English

SIR,—Dr. J. G. M. Hamilton (20 February, p. 526) rightly condemns the misuse of the word "clinical." He writes "clinical medicine and surgery are these disciplines practised on and for patients in bed. . . ." In recent years the archaic meaning of the word "discipline" has been revived to such an extent that it has become hackneyed and the word has lost its precision.

Surely the word bears a connotation of mental and moral instruction. Some of our clinical training would, no doubt, have been included in such a category. But much would not—e.g., catheterization, preparing patients for operation, and, yes, even bed-making. One would suggest that to apply the word "discipline" to such procedures is another example of the murder of English.—I am, etc.,

Solihull, Warwickshire. PHILIP JACOBS.

"Doctors' Orders"

SIR,—A local laundry is at present distributing advertising leaflets featuring a picture of a doctor holding a facsimile copy of *Doctors' Orders* and the legend "Doctors deliver books . . . and laundries deliver hygiene." (At last we know our function in the National Health Service.) Following the wholesale endorsement of various firms' products in the booklet itself, it appears we doctors are being used to promote trade indiscriminately. Should we not at least be businesslike about this and set up the British Medical Association Advertising Agency? The fees received through our B.M.A. leaders and other eminent consultants eating breakfast cereals or perfoming their ablutions on commercial television could be used to finance the necessary improvements so urgently needed in the N.H.S. (the less eminent, of course, could not use their own names).

The alternative is to acknowledge the original mistake of issuing *Doctors' Orders* and to scrap any idea of the second edition, which I understand is under active consideration.—I am, etc.,

Plymouth. STUART COVERLEY.

Points from Letters

Combining the Antidepressant Drugs

Correction.—We regret an error in Dr. D. R. Gander's letter (20 February, p. 521). The last sentence should have read: "No side-effects on combined treatment had not been previously seen in patients receiving single drug treatment."

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