with dominant inheritance. In 1957 Yoss and Daly established the clinical diagnostic criteria, but the condition is still occasionally confused with other sleep disorders, endocrine diseases, or psychiatric illnesses.

Symptoms can first occur at any age from birth to senescence and once established remain life-long and disabling. There are four characteristic features: day sleep attacks, weakness with emotion, sleep paralysis, and dreaming during half-sleep, and these can occur singly or in any combination. Such symptoms can also occur sometimes in normal persons, but in the narcoleptic syndrome they occur frequently and in unusual circumstances. In normal people day-time sleep does not occur with little warning or in unfavourable surroundings, and loss of muscle tone and paralysis of voluntary movement do not result from sudden emotional or sensory stimuli. In addition to these symptoms, patients with narcolepsy may go sleep-walking by day and often wake several times in the night. Many have muscle jerking before or during sleep. Double vision or loss of focus and facial twitching are not uncommon during cataplexy. Minor cataplectic attacks with momentary lapse of posture are most frequent, but major cataplexy with complete paralysis of voluntary movement for prolonged periods is also common. Sport is often a trigger. Unilateral cataplexy, with weakness of one side of the body only, is a bizarre rarity. Day dreaming is a cause of hallucinations and may lead to the mistaken diagnosis of schizophrenia. Epilepsy is not a feature of the narcoleptic syndrome.

There is considerable doubt whether or not narcolepsy alone and the narcoleptic syndrome are the same or different diseases. Clinical experience suggests a single disorder, since the sleep attacks are similar, narcolepsy may precede other symptoms by more than 30 years, and different members of families with narcolepsy may have different combinations of symptoms. Passouant, however, separated the two conditions on the basis of different E.E.G. night-sleep patterns.

The rapid eye movement (R.E.M.) phase of sleep, which is accompanied by dreams and changes in muscle tone, was identified by Aserinsky and Kleitman in 1953. In patients with the narcoleptic syndrome this sleep phase occurs at the start of night sleep, unlike normal subjects. This finding has led to the alternative name of rapid-eye-movement narcolepsy for the narcoleptic syndrome; a night (but not day) sleep E.E.G. will confirm the clinical diagnosis. This mistiming of R.E.M. sleep may partially explain symptoms such as dreams and sleep paralysis bordering periods of wakefulness, but it is not clear why frequent periods of day sleep or weakness with laughter should occur. The first examination of a patient with cataplexy by competent neurologists seems to have been that of Wilson and Critchley. The muscles were tonic, the knee jerks absent, and the left plantar response was extensor. Similar changes accompany R.E.M. sleep in normal subjects but during cataplexy patients are not asleep, though they occasionally dream.

Amphetamines have been used to treat narcolepsy for almost half a century despite the high incidence of side effects, including perhaps hypertension, frequent development of tolerance, and possible drug misuse. There is little evidence, however, for addiction among narcoleptics, to whom these drugs should be available despite the problems of amphetamine abuse. Low doses of amphetamines do not improve cataplexy, and as this symptom can cause considerable disability other treatment is required. Cataplexy responds to various tricyclic drugs, of which clomipramine seems the most potent. Three groups have successfully treated narcolepsy and cataplexy with a combination of stimulants and tricyclic drugs for periods of over a year; and though hypertension was a theoretical hazard, it did not occur in practice. The cause of the narcoleptic syndrome remains a mystery.

In some cases encephalitis lethargica was followed by narcolepsy and cataplexy, but these symptoms tended to improve, and there is no evidence that narcolepsy is preceded in most cases by any form of encephalitis. The dominant mode of inheritance of narcolepsy is consistent with, but not proof of, a genetically-determined error of metabolism. The monoamine hypothesis of sleep has attracted more speculation than proof, though the discovery of direct monosynaptic pathways (containing 5-hydroxytryptamine and noradrenaline) from the brain-stem to the cortex forms a possible anatomical basis for such a theory. Many drugs which affect brain amine systems cause subtle or profound changes in sleep. Unfortunately, we are little nearer to understanding the cause of narcolepsy than Noël Coward's shrewd observation that Hindus and Argentines sleep firmly from twelve to one, but Englishmen detest a siesta.

1 Guilleminault, C., Carskadon, M., and Dement, W. C., Archives of Neurology (Chicago), 1974, 30, 90.
2 Daly, D. D., and Yoss, R. E., Proceedings of the Staff Meetings of the Mayo Clinic, 1955, 34, 313.
3 Yoss, R. E., and Daly, D. D., Proceedings of the Staff Meetings of the Mayo Clinic, 1957, 32, 320.
4 Passouant, M. F., Bordeaux Medical, 1969, 2, 1649.
7 Wilson, S. A. K., Brains, 1928, 51, 63.
8 Young, D., and Scoville, W. B., Medical Clinics of North America, 1938, 32, 537.
10 British Medical Journal, 1975, 1, 223.

Lesson Not Yet Learned

Baby-battering is not always fatal. Last year a 3-year-old boy was admitted to Dundee Royal Infirmary suffering from a massive cerebral haemorrhage from the effects of which he will never recover. For several weeks he had been beaten by his foster parents—a fact suspected by his father and grandmother, whose suspicions had been passed on to the social work department and the family doctor. Yet again, as in the case of Maria Colwell,1 nothing positive was done to remove the child to safety, and the final assault was made while the professionals concerned tried to make up their minds what to do.

A detailed report3 on the affair published last month criticizes the doctor and the social worker concerned, and further efforts are to be made to help local authorities deal with the problem. Greater alertness by doctors and social workers should help in the earlier recognition of children at risk, and there is surely enough evidence to convince all concerned that children should be taken into care whenever there is suspicion of abuse. Long term, however, the solution is social and economic and not medical. The depressing feature of the Clark case is its close conformity to the pattern described in studies such as those of Selwyn Smith and his colleagues. Poverty, illegitimacy, heavy drinking, overcrowding, and the acceptance of violence as a solution to family conflicts—these
are the recurrent factors. While adverse social conditions remain, and perhaps even get worse, in the centres of so many of our cities, child abuse, wife battering, and all the related evils will continue.

1 British Medical Journal, 1974, 3, 641.
3 Smith, S. N., and Hanson, R., British Medical Journal, 1974, 3, 666.

Reward for Work Done

Last week Mrs. Barbara Castle and the professions’ representatives each published their version of the exploratory talks (22 February, p. 468) which both sides had hoped would lead to a resumption of the negotiations so dramatically ended on 20 December (4 January, p. 4). Mrs. Castle’s response disappointed the doctors taking part (a tabulated summary of the outcome appears on p. 530). Though long and superficially conciliatory, her letter contained, in their opinion, insufficient evidence that she was prepared to negotiate rather than to procrastinate. Does she hope that consultants would conveniently forget their two-year struggle for better contracts in the euphoria of a “substantial April award”?

On 20 February the Central Committee for Hospital Medical Services heard a report on the talks, and its members overwhelmingly endorsed their representatives’ conclusions, deciding as well that the work to contract should continue. The Hospital Consultants and Specialists Association took a similar view. No consultant can be happy with an outcome that will further inconvenience patients. Nevertheless, having come this far most senior staff will be determined to support their negotiators’ two-stage objectives: a proper award for the present contract (the hopes of joint Government/professional evidence to the Review Body for the April award have been frustrated by the delays) and significant reform of their terms and conditions of service.

The first aim is a matter for the Review Body. The second could be readily negotiated given a constructive approach by the Health Departments, but it has, unfortunately, become entangled in the Labour Party’s dogmatic attitude to private practice. At present the profession’s demand for new contracts that match rewards for work done seems irreconcilable with the Government’s intention to maintain “the existing differential between whole-time and part-time consultants.” But the gap between the B.M.A. and an earlier administration was probably just as great at the start of the family doctor negotiations in 1965.

Mr. Walpole Lewin, Chairman of Council, reminded the C.C.H.M.S. that the present position of the part-time consultant—devoting a substantial part of his time to the N.H.S. —was the outcome of a gentleman’s agreement between the profession and the Health Departments in 1961. Differing interpretations of this arrangement over the years and its generous elasticity in response to rising work load had led to discontent among consultants. As the Owen Working Party’s questionnaire to senior staff showed the amount of work done for the N.H.S. by part-time and whole-time consultants seems now to be broadly the same. In a few areas, however, those on a nine-eleventh contract keep fairly strictly to nine sessions. No one can complain if a doctor doing nine sessions is paid for what he does or that 11 sessions should attract a full salary—that is a fair differential. It seems unjust, however, for the Government to insist on paying a doctor committed “full time” to the Health Service more than a “part-time” colleague who is devoting as much time to N.H.S. work. The implications of this policy for the professions’ independence have already been spelt out.

This difference in principle is a negotiating bridge that need not be crossed immediately: doctors in any case must marshal their own ranks before arriving there. The interests of patients lie in a quick end to the dispute—which is why since December the B.M.A. and the H.C.S.A. have concentrated on the immediate objective of bettering the existing contracts (see section two of the tabulated summary). The consultants’ adverse reaction to the Secretary of State’s promises on this score has almost certainly been influenced by her previous utterances. Nevertheless she has some champions in the profession. The Chairman of the Association of University Clinical Academic Staff suggests (page 517) that somewhat different accounts of events were given by many B.M.A. “link men” to local meetings of consultants. Few accounts of events by various witnesses tally exactly in the retelling. Dr. Lowe’s own information was derived from discussions with some of the Owen Committee’s members. Doctors will judge for themselves whether the responsible professional associations on the working party—the B.M.A., the British Dental Association, the H.C.S.A., and the Joint Consultants Committee—would make such a dangerous and elementary negotiating error.

As we went to press the Prime Minister’s refusal to meet the profession on the consultants’ dispute was announced (page 527). This is an unfortunate reaction, which the B.M.A. Council would be considering at its meeting on 26 February, because the consultants’ discontent is centred as much on the falling standards of the N.H.S. as on conditions of service —and he would have been told once again of the widespread disquiet about inadequate resources. Does the N.H.S. have to collapse before there is a fundamental reappraisal of its workings?

1 British Medical Journal, 1974, 3, 424.

“Psychological Medicine”

For several reasons general practitioners get more calls for psychiatric help then they used to do. One is the more prevalent belief among patients that a doctor can help them. They are not always right, but psychotherapy and drug treatment can together offer something better than was formerly available. Another reason for the increase of mentally disturbed patients in general practice is their reduction in hospital. It is hoped, therefore, that a series of invited articles, mainly on the use of drugs in psychological medicine, will be found timely. The first, by Dr. A. K. Zealley, of Edinburgh, appears at page 497 this week. In it he surveys some of the main problems to be discussed in greater detail later.