Sir,—I must take issue with Mr. P. W. R. M. Alberti on some points in his article (3 July).

(1) "If training is to be centred about large institutes, then inevitably there will be no juniors in the periphery. This need not be a bad thing, and in many instances will only stabilize an already existing difficulty. This takes nothing away from potential general practitioners not normally requiring integration in training schemes for specialists; and when there is no room in larger centres. Why should they not work in peripheral hospitals under adequate supervision by the larger number of consultants Mr. Alberti rightly favours?"

(2) "Some services will be centralised... as communications improve so the need for small isolated units will diminish." Public service communications are in fact deteriorating, not improving: patients who are not car owners are already in difficulty in attending hospitals from remote country districts.

(3) "Hospitals might therefore be built where they can be manned, rather than where political pressure dictates." They should be built where they are needed following political pressure exerted on the Government by local M.P.s etc., endeavouring by their good reputation, to attract junior staff to work there.

(4) "Consultants and general practitioners will have to work much closer together." How? General practitioners are already too few and overworked (a fact recognised by the Minister and by the last Review Body's recommendations.) Third-year medical graduates may be encouraged to do a little more, but medically qualified mothers of small children cannot provide a subsistence to a band of junior doctors in "large institutes will alight from off the periphery," and who do so much of the routine and emergency work, especially at night.

I could say a great deal about rotating schemes, much of it highly critical, but Mr. Alberti and I agree they should not ideally require change of residence. I doubt whether this is so important if there are absolutely no unnecessary expenses or unexpected removals.

Finally, I agree warmly with Mr. Alberti's strictures on the requirements for higher degrees and the Colleges' approval of undesirable posts as suitable for training. I share his feelings that at present specialist training is far too haphazard, and that a shorter organized course of training may mean harder work during that time but at least could be linked to the very high probability of a consultant post in the future, owing either to retiral of an older man or to the creation of a new post planned years in advance from statistical forecasts already available to the Ministry if it would but seek them—I am, etc.,

Princess Elizabeth
Orthopaedic Hospital,
Essex.

M. HOROWITZ.

Oculogyric Crises Due to Phenothiazines

Sir,—During the past year I have seen three young people with oculogyric spasms which I considered to be caused by phenothiazine tablets. In two of these the patients were seen during the past week.

The patients were aged 15, 19, and 21 years. All presented in the same way, with oculogyric crises and hypertension and rotation of the neck recurring every few minutes and, accompanied by persistent mydriasis.

The first two patients were suffering from subtertian malaria, and were being treated with chloroquine. Prochlorperazine maleate (Compazine) given in each instance because of vomiting. In the first patient, a girl of 15, the spasms started after two doses of 10 mg. Pentobarbitalne (Nembutal) 100 mg. was given by mouth, and the attack ceased after about an hour. The second patient, a 19-year-old male, was given prochlorperazine 5 mg. midday on the day of admission, then 12.5 mg. intramuscularly at 4 p.m. the same day, and repeated on the following day at the same time. Spasms started at 6 p.m. and continued for an hour after giving pentobarbitalne 200 mg. The third patient, who was suffering from infectious hepatitis, was given phenperazine (Fentran) 4 mg. on admission to hospital because of vomiting, and this was repeated the following afternoon. Spasms commenced two hours later. He was given 150 mg. pentobarbitalne, following which spasms persisted for about an hour.

These cases are reported to emphasize the risk of using phenothiazines in young people. Jaundice might be expected to potentiate this drug effect, and it is suggested that malaria, chloroquine, or both might do likewise. —I am, etc.,

P. O. Box 2223,
Najrob,
Kenya.

J. R. HARRIES.

National Kidney Centre

Sir,—In view of recent press reports about the closure of the National Kidney Centre I feel constrained to use your columns to place on record a fuller statement of the reasons for closure of the National Kidney Centre on 1 July 1968.

The National Kidney Centre was set up in November 1966 as a non-profit-making charitable trust with its sole aim to determine whether the rate of expansion of home dialysis with a minimum of medical support could be achieved in the British Isles. It has never intended to compete with the National Health Service, as has been suggested, and indeed it was hoped from the outset that the centre would be able to co-operate with the N.H.S. dialysis programmes wherever possible, to ensure the advancement of this form of treatment. Unfortunately the official attitude of the Ministry of Health has prevented any official co-operation with the N.H.S. dialysis units.

To date the centre has been responsible for the training and subsequent maintenance in the home of 27 British nationals and four non-British nationals, utilising the staff of one doctor and three trained nurses. No hospitalisation is needed, but the patients need to be supervised by the centre three times a week. Home dialysis has been necessary during the nine months of its function, and all patients are in good health. The feasibility of expanding home dialysis with integration into existing local community dialysis units from a specialist training centre has been successfully demonstrated in the United States.

However, its present failure in this country has not been due to shortage of funds or resources, but to the inability to find a suitable formula to bridge the dogmatic distinction separating medical practice inside and outside the N.H.S. Full details of the results obtained and methods used will be published in due course. A preliminary report is in the press.—I am, etc.,

London N.3.

STANLEY SHALDON,
Medical Director,
National Kidney Centre.

REFERENCE


Psychological Factors and Ulcerative Colitis

Sir,—I was delighted to read your leading article (1 July, p. 1) and the paper by Dr. F. Feldman and colleagues (p. 14) on psychiatric studies of patients with ulcerative colitis. I have long ceased to believe in the concept of "psychosomatic medicine," which in my opinion is a confession of ignorance on the part of the profession regarding the aetiology of these conditions.

The concept that a disease such as ulcerative colitis, with its complications, blood loss, and exanguination of the patient, could be psychogenic in origin has always appeared to me to be utterly absurd. Recent advances in medical treatment such as steroid therapy and salazosulphapyridine and such successful surgical procedures as proctocolectomy for the removal of the diseased area of bowel have confirmed my belief that the psychosomatic approach is wholly wrong. The spectacle of these severely ill people being subjected to extensive psychotherapy seems to me the negation of all common sense, especially in the light of the new knowledge we now possess in treating this condition. It is equally true with other so-called psychosomatic illnesses, which will no doubt prove to have a physical basis on further investigation.

I note that Dr. Feldman and his colleagues conclude their very comprehensive investigation by stating that there is now a "central problem of whether primary psychosomatic disease exists, and, if so, how it can be explained." I submit that this conclusion is a victory for common sense and that the whole theory of psychosomatic medicine should be subjected to a thoroughgoing analysis, to see on what scientific basis its theories rest.—I am, etc.,

Hornchurch,
Essex.

D. D. COWEN.

Unexpected Foreign Body

Sir,—Dr. G. B. Stein (1 July, p. 51) raises an important matter—the difficulty arising in making a diagnosis when a non-opaque denture has been inhaled—and has a point in suggesting that they should not be allowed to be made.

However, among the innumerable objects which are accidentally inhaled there are many that are radiotranslucent or so small as to be easily missed. Dr. Stein's case report, like several previous reports, including my own, serves to remind us that should a patient who has been unconscious subsequently develop pulmonary symptoms the possibility of a foreign body being present should always be in mind, and that lack of radiological confirmation is no guarantee that one is not present. When real doubt exists the patient