Brit. J. Psychiat. (1967), 113, 1317–1319

Correspondence

THE *JOURNAL* AND ITS CONTENTS

DEAR SIR,

I am writing to suggest that now might be the time to see whether the ordinary membership of the R.M.P.A. could not have a greater say in the type of Journal which they are, as it were, obliged to receive. I had in mind, for instance, that the Editor might circulate some sort of questionnaire from time to time to ascertain what type of articles members would be interested in.

I should like to make clear that I am not questioning either the frequency of appearance of the *Journal* or its quality; in both these respects, as in others, the *Journal* seems to me to be greatly improved since I first came into psychiatry in the late '50's. My complaint centres rather on the *type* of articles, which seem to me to cater to a somewhat narrower interest than might be the case. As a sort of caricature, I can express what I mean by saying that I think it would do very well as a high quality and somewhat specialized "Journal of Experimental Psychiatry"; as such I would respect it but probably not read it much.

To look at it another way, what is left out? I think I could summarize my views by saying that a very large percentage of the articles could as well be written about white rats. One misses the feeling of human emotions and relationships being talked about. I note that in your Editorial of May 1964 you conclude by saying "First and foremost this Journal is an organ for the communication of information which can be subject to test, confirmation and refutation". I take it that this is an expression basically of a philosophy of science associated with the name of Karl Popper, which after a good deal of reflection I have found myself unable to accept. It seems to me that much of our work is not capable of validation, quantification, falsification, etc., and that if one restricts oneself to what *is* capable of such treatment, one has to leave aside much of what is most alive, important, and specifically human. Perhaps it is significant that I can recall only one article on existential psychiatry (an unsympathetic one, I felt); and certainly anyone whose reading in psychiatry was restricted to the *British Journal of Psychiatry* might well be excused for not knowing that such a person as Dr. Laing exists. The same could be said about such distinguished figures as Drs. Balint and Winnicott.

The above two paragraphs represent of course my own opinion and predilections; it may well be however that many members of the Association share my views; others might wish to see more on the subjects of child psychiatry, forensic psychiatry, family therapy or other topics. It is for this reason that I suggest that it might be a good idea to canvass the opinions of members of the Association.

R. E. MACKIE.

The Ross Clinic,
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[*Editorial Note:* The above has been condensed, by the elimination of extraneous matter, from two letters received from Dr. Mackie.]

DEAR DR. MACKIE,

Thank you for your letter, which I have discussed with Dr. Walk.

I think you have the wrong idea that we are turning down papers when they come from a field of work which we regard with disfavour. This is not so. We have published nothing from Balint, Winnicott, Laing, etc., because we have not been offered anything. I am sure they have their own preferred media of communication which put them in touch with the audiences they want to reach. Dr. Walk thinks that what you are really suggesting is that we should not be merely passive recipients (as we largely are), but should go out to get articles. If we did this on a large scale, it would certainly get us into trouble on the score of not being impartial.

However, we could certainly do a little in that way, just as we do ask for occasional critical reviews. Would you care to offer a paper, e.g. a discussion on a field which you think the *Journal* is grossly neglecting? I can't guarantee to accept it unseen, but it would be very sympathetically received.

ELIOT SLATER.

R.M.P.A.,
London, W.1.

ATTEMPTED SUICIDE AND THE NATIONAL HEALTH SERVICE

DEAR SIR,

The National Health Service seems to have been under critical scrutiny of late. I have read the paper

which appeared in the March, 1967, number of the *Journal*, on "The Ecology of Suicidal Behaviour" by Mr. J. W. McCulloch, Mr. A. E. Philip and Professor G. M. Carstairs, and noted sympathetically their view of a relation betweeen the ready availability of drugs and the sharp increase in attempted suicides in recent years. I was especially struck by their phrase "the ready availability of drugs under the National Health Service has undoubtedly contributed".

The very large increase in deliberate self-poisoning in Edinburgh (Kessel, 1965) has been more than matched in Western Australia (Oswald, 1966). It is true that the prescription of barbiturates doubled in England and Wales between 1953 and 1959 (Ministry of Health, 1961), but prescription rates in 1962 (Ministry of Health, 1964) suggested that the rise had levelled off. The 1962 figures were of under 16 million general practitioner prescriptions for barbiturates in England and Wales in 1962. Assuming an average of 45 tablets per prescription (Brooke and Glatt, 1964), and that 36 million people were over 17 years of age, we arrive at a figure of about 20 tablets per adult head per annum, and even if hospital prescribing were added we might reckon on an average of under 25. This in a country with a lot of old people, who use more hypnotics (McGhie and Russell, 1962), but with a National Health Service. In the State of Western Australia, which has a more youthful age structure but no National Health Service, figures recently supplied by the pharmaceutical companies to my colleague Dr. G. Milner reveal a distribution in 1966 of approximately 40 barbiturate tablets per head per annum by persons over the age of 17 years. Incidentally, an average of 12 Librium (chlordiazepoxide) capsules were also sold.

Barbiturate prescribing rose to about 1·5 grams per head per annum in England and Wales in 1959 (Ministry of Health, 1961), but this was still well below the 1948 figure for the U.S.A. output per head (Isbell *et al.*, 1950). With this in mind, one can now read that the average U.S. family increased its expenditure on all prescribed drugs by 6·5 per cent. a year between 1959 and 1965, but that "from 1952 to 1963, the retail sales of sedatives and tranquillizers increased 535 per cent." or 44 per cent. a year (Department of Health, Education and Welfare, 1967). No National Health Service contributed to that rise.

Alternatives to a National Health Service usually mean a voluntary insurance scheme which pays for agreed classes of drugs. The merit of the Service is that it can help restrict unnecessary prescribing, since the patient has one particular doctor, who can if he chooses advise against sedatives without feeling that he will immediately forgo all financial interest in the patient or that the latter will at once go to the doctor in the next street. It is not easy to get comparable figures for drug use and abuse in different countries, but such as they are they would not appear to indict the N.H.S.

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PHYSICAL HEALTH AND PSYCHIATRIC DISORDER IN NIGERIA

DEAR SIR,

I wish to clarify one or two points raised by Dr. Kiev in his review of my "Physical Health and Psychiatric Disorder in Nigeria" (*Journal*, August, 1967, p. 936).

He writes "In a more critical vein one wonders why so arbitrary a category as functional illnesses was used in the presence of demonstrable physical disease where a diagnosis of symptomatic psychosis might have been made." I took some pains to point out in my paper that my patients were carrying several parasites and were in imperfect health, like almost all rural Yoruba, but that they were not suffering from physical illness of such a degree that a diagnosis of symptomatic psychosis could be made. In fact I had carefully excluded such sick people from my study, as I pointed out. He says further: "One might also question the feasibility of making a diagnosis on the basis of response to treatment, for as yet treatments in psychiatry are non-specific as compared to treatments in medicine." As to this, I am well aware of the limitations of present-day psychiatry; but if response to treatment is an imperfect method of indicating the cause of a disease it is still a lot more realistic and precise than much of the highly theoretical speculation we are asked to consider seriously when making a psychiatric diagnosis.