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Correspondence

THE SEEBOHM REPORT

DEAR SIR,

Although shamefully ignorant of the Seebohm report, I found Dr. R. S. Ferguson's comments upon it (*Journal*, July 1970, pp. 126–7), particularly those regarding changes in establishment policy both interesting and misleading. Perhaps sociologists sometimes become too preoccupied with their own paradigms to concern themselves with history.

He makes the point that Chadwick and his public health measures were rejected in 1854 but accepted in 1889 because he, like Seebohm, 'were non-medical men and they proposed changes in paramedical aspects of social life which were unpopular. The whirligig of time may indicate the latter as it did the former. But Miss Turner and her extra-medicine friends will have to keep up the pressure'.

Possibly, but before ascribing Chadwick's nearly posthumous vindication to 'the pressure of extra-medicine friends', Dr. Ferguson should have at least mentioned some other factors. Chadwick, like Semmelweiss before him, was vindicated by the rise of bacteriology deriving from the discoveries of Pasteur, Lister, Koch and scores of others. Their new evidence made the usual resistance to what Miriam Siegler (2, 3) and I have called the Public Health Model of Medicine much less easy to sustain regarding the treatment of water supplies and general sanitation. In 1854 there was no bacteriology; in that year the *Times* was echoing the conventional wisdom when it stated: 'We prefer to take our chance with cholera and the rest, than to be bullied into health.' The public supported the *Times* common sense view. However, things looked very different by 1889, for in 1883 Robert Koch discovered vibrio comma, and by then every schoolboy was beginning to know about those deadly microscopic bugs which caused cholera and other fatal diseases. Quite properly the establishment felt that it had to do something to recompense the maligned and the ill treated Chadwick, not because of the 'pressure of extra-medicine friends', but because of the rise of a new and formidable branch of medical science. Whether comparable changes within medicine and its allied disciplines will effect Seebohm's recommendations, whatever they may be, remains to be seen, but if Dr. Ferguson's parallel with Chadwick holds, they are at least likely to do so.

Many but fortunately not all sociologists are more alert to the effects of society upon medicine but seem ignorant or uninterested in the other side of this equation. This may have led Dr. Ferguson to overestimate the medical and social importance of Goffman's facile, witty, amusing and slightly perverse book *Asylums*. Siegler (4) and I have shown in our as yet unpublished 'Goffman's Model of Mental Illness', that this lively and sharply observant man describes mental hospitals in terms of what we have called in an earlier paper 'The Conspiratorial Model'. While this may be entertaining and possibly has some value as an intellectual exercise, it is about as useful as a butchery or sadistic model of surgery for increasing our understanding of that art and science. A naïve person could easily perceive an operating theatre as a place of torture, sacrifice or murder. It is only within medicine that such practices have been licensed for, if recent anthropological findings are correct, about 50,000 years (5). Goffman's model is wonderfully clever, but if there are mentally ill people in his total institutions his analogy can be quickly destroyed. This does not mean that his satiric vision may not have its place, for, due to the appalling lack of social cohesion produced by grave mental illnesses such as schizophrenia, our patients are peculiarly open to exploitation, neglect and even dehumanization. It is a difficult and exacting art to treat and care for the mentally ill, as Sommer (6) and I noted some years ago; a mental hospital does not resemble a prison, a school, a religious retreat, or a concentration camp; it is as far as most patients are concerned, especially the chronic and very ill ones a 'no-society'—like nothing else on earth. It is a place where the normal social glue, usually so resistant even to the gravest tyranny, simply fails to hold fast!

There is nothing new about this discovery. Sir Francis Galton (1) noted it from his railway carriage while passing Hanwell Asylum during the 1880s. He wrote:

> 'There is yet a third peculiarity of the insane which is almost universal, that of gloomy segregation.'

This remarkable phenomenon which is as widespread today as in Galton's time, should be of interest to sociologists, especially if they can accept the fact, distressing as they find it, that current sociological notions have as yet been of little help in describing

mental hospitals, let alone changing them for the benefit of their patients.

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5. SMITH, P. (1970). Radio Broadcast (Interview with Dr. Phillip Smith, Canadian Archaeologist) Canadian Broadcasting Corp., Program 519.' International Science Report, Broadcasting Foundation of America.
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TRAINING OF PSYCHIATRISTS

DEAR SIR,

While congratulating Dr. Russell and Professor Walton on editing the B.J.P. Special Publication (No. 5.) on the 'Training of the Psychiatrist', it is a pity that some of the cogent points in the discussion have unfortunately been left out. For instance, on page 33 (right hand top column) the purpose of mentioning that most psychiatric hospitals in this country are staffed in the junior posts by doctors from overseas, who are here only temporarily was to indicate that the training programme should at least in part be arranged to cater for the General Practitioner who initially sees the large majority of patients with psychiatric illness and who could gainfully be employed as a clinical assistant in the hospital if he were trained appropriately. However, this important climax of the point I made was left out.

Again on page 95 (bottom right hand column) the purpose of organizing the teaching programme for the part I and part II D.P.M. at the hospital was to include this in the advertisement for junior posts in the journals, and as a result to recruit the most suitable doctors since many more applied for the post than if the teaching programme did not exist. This important conclusion to the argument has also been omitted.

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MIGRAINE AND SCHIZOPHRENIA

DEAR SIR,

I have recently learned that one of my patients, a girl who suffered a severe hebephrenic breakdown (which came into full remission with very intensive physical treatment) at the age of 16, had previously suffered from what sounds to have been typical attacks of migraine, with severe headache, vomiting and prostration in early childhood, and during early adolescence she seems to have had a mild and self-limited bout of anorexia nervosa, with refusal to eat and secondary amenorrhoea. This case is of particular interest for several reasons, one being the psychopathological similarity between anorexia nervosa and schizophrenia. Another interesting point is that serotonin metabolism is thought to be involved in both migraine and schizophrenia, but attacks of migraine are rare in proven schizophrenics; this patient has not had migraine since she developed schizophrenia. One possibility that comes to mind is that migraine may act as a 'schizophrenic equivalent', and of course short-lived perceptual disturbances are quite common in migraine. Again, some people consider that migraine is related to epilepsy, and it can be quite difficult to differentiate temporal-lobe epilepsy from schizophrenia.

A further point of interest is that we found that our remitted female schizophrenics became more stable mentally and less likely to behave promiscuously when they were started on a balanced oral contraceptive, such as Ovulen. I have found that migraine also tends to remit on balanced oral contraceptives, the remaining attacks tending to occur at the end of the withdrawal period,—often the day when the next course is due to start, i.e. when the serum hormone concentration is at its lowest.

These purely clinical observations suggest some fascinating possibilities for further biochemical research, and I wonder if any of your readers can throw any light on them, or know of similar cases of their own.

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ERRATUM

CONCURRENCE OF TURNER'S SYNDROME AND ANOREXIA NERVOSA

It is regretted that the name of Dr. F. M. M. Mai of the University of Rochester School of Medicine and Dentistry, 260 Crittenden Boulevard, Rochester 20, New York, was omitted as a co-signatory of the letter published under the above heading on page 237 of the *Journal,* August 1970.