BRITISH MEDICAL JOURNAL

SATURDAY 13 SEPTEMBER 1969

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL MEMORANDA

MIDDLE ARTICLES

BOOK REVIEWS

NEWS AND NOTES

CURRENT PRACTICE

CORRESPONDENCE

OBITUARY NOTICES

SUPPLEMENT

No. 5671 British Medical Journal, 1969, Volume 3, 605–664 Weekly. Price 5s.

BRITISH MEDICAL ASSOCIATION, TAVISTOCK SQUARE, LONDON W.C.1 TEL: 01-387 4499

Correspondence

Letters to the Editor should not exceed 500 words.

Poisoning and Psychiatrists

SIR,—I think the psychiatrist's role in the management of acute poisoning cases requires much more study and thought than Dr. Henry Matthew and others (30 August, p. 489) or the Hill Report[1] appear to have given it. Psychiatrists are not so plentiful in Britain, nor ever likely to be so, that they can examine all these cases, except at the cost of dropping some of their other work.

Dr. Matthew and his colleagues want a regular daily psychiatric service, psychiatrists "attentive to the need for emergency assessment," and every night of the week from "6 p.m. to 9 a.m. an emergency roster staffed by senior registrars." To provide weekday cover at Edinburgh Royal Infirmary they have a full-time psychiatric registrar plus two sessions a week of a consultant, to say nothing of help from psychiatric research fellows, for the psychiatric handling of 20 cases a week, which therefore get a minimum of two hours of psychiatric time each. On the other hand the Department of Health and Social Security has told regional boards that the psychiatric needs of poisoning cases must be met within available resources—that is, without establishing extra medical posts. Are psychiatrists, already quite fully occupied, to cancel their inpatient or other outpatient commitments at short notice and give poisoning cases top priority?

What is the purpose of this psychiatric examination? I suggest it is to separate out the small minority of cases who would or will go on to successful suicide from a small group of other conditions which are currently treatable. We have to bear in mind that the vast majority of self-poisoners have no intention of killing themselves and never will kill themselves. They include girls who take a few tablets after a tiff with a boy friend, young people estranged from their families and wanting to make it up, and people protesting against family pressures or housing difficulties or emphasizing a point in a marital row. We must also remember that depression is a normal mood in some circumstances, and does not always need treatment. Dr. Matthew and his colleagues themselves admit the very great importance of social problems, and the presence of depression of any sort in only one-third of their cases. They arranged inpatient psychiatric treatment for only about one case in five, and over half their cases had no further psychiatric treatment at all. It is also significant (and wasteful) that nearly half the patients to whom they gave outpatient appointments failed to turn up.

It is poor use of a psychiatrist's time to spend hours discovering untreatable cases, or cases where the treatment is social work. I wonder whether a more realistic use of time might be as follows? Each poisoning case would have completed by the medical houseman a short history questionary designed to record any previous psychiatric treatment the patient had had, and to reveal the symptoms of manic-depressive (endogenous) depression if present. Each case would also be seen by a social worker, who would carry straight on with any necessary social work. The social history and the houseman's questionary would be forwarded to the psychiatrist, who would then decide whether to visit, give an outpatient appointment or other follow-up, or admit straight away. Admission would be primarily for the cases of endogenous depression (5% of self-poisonings?).

I would like Dr. Matthew and his colleagues to make two further studies for us, a work study and a clinical trial. Could they analyse their 1968 cases and see how many of them were treated by social work, and how many by consultant as opposed to registrar (and what kinds of cases in each category?)? How often was the emergency roster called on, at what time of night, and for what kind of case—so that we can judge how necessary such a roster is? Would they be prepared to put their recommendations for the use of psychiatric manpower to a test? Suppose for a time they allocated their cases randomly to two groups, both of which received social work, but only one had the full psychiatric work-up, while the other received some kind of screening such as I have suggested. The two groups would then be followed up to compare readmissions, actual suicides, new referrals elsewhere, appearances in court, time lost from work, and so on over the following six or twelve months.

They have the clinical material and the facilities to work out a really practical management scheme for the country as a whole. Will they do it?—I am, etc.,

St. John's Hospital, Stone, Aylesbury, Bucks. J. L. CRAMMER.

REFERENCE

[1] *Hospital Treatment of Acute Poisoning. Report of the Joint Sub-Committee of the Standing Medical Advisory Committees, Ministry of Health, Scottish Home and Health Department.* H.M.S.O., London, 1968.

Insulin: Credit for its Isolation

SIR,—In your leading article (23 August, p. 430) you refer to the "isolation" of insulin. It is satisfactory to note that this term has replaced the expression "discovery of insulin" which seemed to imply a disregard for the large volume of antecedent research of which the isolation of insulin was the culmination. Banting and Best are generally credited as the first to have succeeded in isolating the anti-diabetic hormone, but this is perhaps open to question. Recently I drew attention[1] to the work of the Rumanian physiologist Paulesco, work which appears to be virtually unknown.

Paulesco (1869–1931), an able and experienced experimentalist, prepared pancreatic extracts which effectively lowered the blood