families. There was also no clear relationship between the area of injury and the frequency or severity of psychological after-effects.

Thus, although I would accept that premorbid vulnerability may indeed be an important predictor of psychological outcome following a frightening event, the overwhelming majority of victims in my study who developed post-traumatic stress did not have a past psychiatric history.

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Listeria and psychiatric syndromes

SIR: In view of the recent publicity given to the almost forgotten listeria monocytogenes, it might interest psychiatrists to know that outwith the British Isles this bacterium has been incriminated as the causative agent in a wide variety of psychiatric syndromes. Although abortion most readily springs to mind in association with listeria, studies have shown that the syndrome most commonly occurring in man is the meningeal encephalitic form (Seeliger, 1958; Colmant, 1961). As would be expected, psychiatric syndromes are described in cases where the condition has become subacute and chronic.

In the German literature, Lang (1955*a*) described five children who had raised listeria titres in the course of recurrent bouts of disturbed behaviour with screaming and temper tantrums, all of which disappeared after adequate treatment with antibiotics. Lang (1955*b*) also claimed to have found a high incidence of raised listeria titres among a group of 300 children from the Bonn area suffering from different types of brain damage. Seeliger (1958) described a patient who in the course of a recognised listeriosis infection developed a manic illness which lapsed into a chronic depressive state and eventually led to suicide. In the Russian literature, Timofeyeva *et al* (1953) described three cases presenting with predominantly schizophrenic symptoms. Recurrent bouts of temperature together with a raised listeria titre strongly suggested that listeria was responsible for the psychiatric symptoms.

So far listeria seems to have made little "headway" in Britain, and hopefully this will continue to be the case. However, Colmant (1961) warned that although listeriosis is an illness resembling tuberculosis and syphilis in its complexity, its diagnosis depends on the familiarity of the doctor with the illness. Listeria fell from grace and general interest after it was found not to be the cause of infectious mononucleosis in man, following its original discovery in 1924 in Cambridge by Murray *et al* as a monocytosis producing bacteria in laboratory rabbits. However, given its known predeliction for soft cheeses, perhaps it now merits shortlisting as a possible causative agent in psychotic gourmets.

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The Melbourne Maudsleys

SIR: Readers of Henry Maudsley's autobiography in the *Journal* (December 1988, **153**, 736–740) may be interested in some further family history. Maudsley paid a visit to Australia in 1903, apparently to see "the best of cricket in its best home". I wonder, however, whether the visit offered an opportunity to meet his nephew, also Henry Maudsley (1859–1944) and his great-nephew, Henry Fitzgerald Maudsley (1891–1962). Both Australian members of the Maudsley family were prominent physicians, with the younger Henry being a key figure in the development of Australian psychiatry.

Henry Maudsley (1859–1944), like his uncle, was born in Yorkshire, near Settle. He obtained his MB BS at the University of London in 1881. Again like his uncle, some 30 years previously, he was a medical officer at University College Hospital. He migrated to Australia and settled in Melbourne in 1888. In 1903 he joined the staff of the Melbourne Hospital and was Lecturer in Medicine in the University of Melbourne. He became a leading consultant physician and, unlike his uncle, was knighted (Obituary, 1944).

A short biography of his son, Henry ('Hal') Fitzgerald Maudsley, has recently been published

(Sinclair, 1988). He graduated in medicine at the University of Melbourne in 1915 and received his MD in 1920. He then worked in London and obtained the DPM in 1921, after spending some time at the Bethlem Hospital. He also obtained the MRCP in 1922 and FRCP in 1937. In 1938 he became a foundation Fellow of the Royal Australasian College of Physicians. He was awarded the Military Cross in the First World War for exceptional bravery.

Maudsley returned to Melbourne in 1923 where, in the words of one of his contemporaries, he "screwed a modest shingle on his father's residence in Collins Street [the local equivalent of Harley Street] and proceeded to divest the suckling infant of psychiatry of its swaddling clothes and present its dimpled features to a somewhat incredulous profession" (Ellery, 1956). He was a pioneer in launching psychiatry beyond the medical backwater of the asylum, extending its boundaries beyond the certification and custodial care of the insane. Through considerable effort and by his ability to command the respect of medical colleagues and of his larger society, he demonstrated psychiatry's place as properly within medicine and showed that it was humane, and relevant to those with mental disorders far short of gross insanity. In 1923, the year of the official opening of the Maudsley Hospital in Denmark Hill, he established the first psychiatric unit in a teaching hospital in Victoria – an out-patient clinic at the Melbourne Hospital. There he developed general hospital psychiatry along modern lines.

It is generally agreed that Maudsley conceived the idea for, and initiated the first meeting of, the Australasian Association of Psychiatrists in 1946 (Williams, 1963). The Association was at first based in Melbourne, in fact often meeting in his rooms in Collins Street. He was uniquely honoured by being elected President twice. Furthermore, through this initiative he became, in effect, the founder of the Royal Australian and New Zealand College of Psychiatrists which arose in 1964 from the Australasian Association of Psychiatrists in a manner forseen by him. He has been honoured for this contribution by having the headquarters of the College (Maudsley House) named after him.

Consistent with his awareness of the social implications of psychiatry, he was in 1931 one of the founding fathers, and later President, of the Victorian Council of Mental Hygiene, an organisation which brought together representatives from disciplines and bodies relevant to the problems of mental illness, both state and voluntary.

Maudsley was also an exceptional sportsman as well as a prominent figure in Australian society, becoming, like his father before him, President of the Melbourne Club.

It appears that Maudsley did not have the same philosophical bent as his great-uncle, and he wrote relatively little (Maudsley, 1929, 1948, 1950, 1957). Indeed, he provides a rather strong contrast. His contributions were those of an optimistic vision of what psychiatry could become (as the papers cited clearly reveal), an ability to inspire others, and of action. He anticipated the major directions psychiatry was to take in the succeeding half century and acted as a major catalyst in their unfolding.

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The opiate prescribing debate

SIR: At a recent conference organised by the College and the Department of Health, I heard eloquent pleas for a return to the British system of opiate prescribing, the change being justified because of the need to contain HIV infection. It was also suggested that there was so much illicit opiate available that there would be no danger of medical prescription creating more addicts. I think it would be useful if there was wider debate about this, in particular to see if there is any scientific evidence to justify what seems a purely emotive response. There is little consensus which would justify giving alcohol to alcoholics, but there seems to be no scientific information which would allow us to prove or refute the proposition that the nature of drug addiction problems are different.

Medical thinking is rarely scientific and unclouded by emotion, as is shown by the problems of