In this case, it could be argued that the onset of mania had nothing to do with buspirone. However, this appears unlikely: the patient had been withdrawn a number of times from alcohol and had taken disulfiram in the past, both without adverse effects. There have been no reported interactions between buspirone and disulfiram. The temporal relationship of being on buspirone and becoming manic, would seem to preclude any role that alcohol may have had in the onset of his symptoms.

If buspirone does cause hypomania, its use in alcoholics, or drug addicts, although attractive, should be carefully monitored and the relative risk of precipitating a psychotic illness weighed against the attraction of using an anxiolytic which is reputed to be free of abuse or dependency.

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Educating the psychiatrist of the 21st century

SIR: As I read Cawley's Lecture (*Journal*, August 1990, **157**, 174–181), with its persuasive *tour d'horizon*, I found myself becoming increasingly restive. Finally, and doubtless because I live abroad, I spotted the trouble – his title was wrong. It should have been "Educating the British NHS consultant psychiatrist in the 21st century". If we hold psychiatry to be a discipline like others that transcends local administrations and national frontiers, the education of psychiatrists in general is another matter.

As psychiatrists go, the British consultant is a peculiar animal in ways that I can only outline here. He or she is employed in large hospitals and institutions, and would be classified as a hospital or a government psychiatrist in some other countries. He has concerns with 'management', and now 'audit', which are of no interest or incomprehensible to many psychiatrists elsewhere. He is one of a team of public employees that deals with the patient, and he does relatively little clinical work by himself, and even less of the kind sustained for months or years with individual cases, from their start to their finish. He may go into the outside world with his team but he does not belong to it, and therefore has scant familiarity with the main mass of psychiatric disorders, even though they are often as destructive to human welfare as the atypical fraction he meets in hospital. Indeed, as Professor Cawley puts it, he and his team "may have little direct experience of the vast majority of the clinical problems in the field in which they claim expertise".

Far from taking psychoanalysis near its centenary peacefully for granted as integral to the study of mind, culture, and society, the British consultant psychiatrist sees it still as totally controversial, if not crackpot, and of no everyday clinical relevance, while quite unaware that there are neighbouring countries (e.g. Germany) where psychoanalytic therapy is funded by the health service, widely available, and reinforced by university departments. Although seldom possessing serious knowledge of it, he can, as Professor Cawley sadly observes, be ferocious in belittling psychoanalysis, unless he belongs to a small eccentric minority who have a habit of forsaking psychiatry altogether for psychoanalytic practice amid a non-medical fraternity almost confined to London.

If we forget, as I fear Professor Cawley has done, that this animal is only one type of psychiatrist, but by no means the world over the common one, we can easily agree that it is absolutely essential for the psychiatrist in training to be schooled in "modern management techniques", in collaborative research with neuroscientists, epidemiologists, and others, and in sharing his patients with a multiform team, all of which could seem esoteric luxuries and bizarre priorities elsewhere. Also, we can then easily forget to ask the vital question whether this is the psychiatric animal that we want to go on producing at all.

However, once the question is asked, we are up against it because we seem to have no choice but to go on producing what we do. Professor Cawley looks for innovations in psychiatric training in Britain but he does not examine the obstacles to effecting any very substantial changes, let alone fundamental ones. As I have pointed out (Bourne, 1988), these obstacles are the more huge for being invisible because they are buried in the embryology of the British Psychiatry – not only in his basic medical education, in his prejudicial studies, and in his selection as a medical student in the first place, but in his schooling from

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early adolescence onwards, and in the national character in which he is bred, and the society and its administrative and political styles and structures that he takes for granted.

Yet the question surely should be asked so that we proceed by choice rather than by habit, and also because asking questions and making choices is the first step towards overcoming the hugest obstacles.

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CORRIGENDUM

Journal, November 1990, **157**, 778 (Adityanjee). The name should read "Adityanjee" only and not "Adityanjee, P. Das". The first reference should read "Adityanjee (1987)" and the second reference should read "Adityanjee, Das, P. & Chawla, H. M. (1989)".

A HUNDRED YEARS AGO

Harvelian Society. General Paralysis of the Insane

At a meeting held on March 20th, Dr Savage read a paper on General Paralysis of the Insane, which he considered to be a disease of higher civilisation. It was rare in the highlands and wilds of Great Britain and Ireland, and also in the negro of the Southern States. Dr Savage looked upon general paralysis as a premature decay frequently having a local origin. In earlier symptoms of this disease extreme difficulty was often experienced in distinguishing between causes and early symptoms, for in many cases the causes of general paralysis might often form signs of the disease. As a result of extensive observation, Dr Savage finds it more commonly met with in middle-aged married men, inhabitants of cities, flesh eaters, and drinkers of alcohol. When the onset is gradual, the finer social and muscular adaptations fail, and weakness in mind and body gradually becomes apparent. In cases which occur suddenly, the storm may assume the character of a convulsive seizure, or an attack of emotional excitement, or one of mania. Ataxy also may be the first symptom of general paralysis. In this form there will generally be muscular defects of the hands and tongue out of proportion to the progress of the ataxy, and the symptoms will be either those of exaltation or of hypochondriacal melancholia; whereas, if the insanity be that of the ordinary ataxy, it will be of the suspicious and "persecuted" type. Temporary aphasia is one of the most striking warning symptoms of this disease. In such cases the patient, without any real cause of after slight excitement or fatigue, becomes aphasic. The attacks may recur, and this aphasia is usually marked, before changes in the handwriting become apparent, though this symptom is an early one in cases of general paralysis. Then facial expression is very early affected. Syphilis plays so important a part in general paralysis that Dr Savage says: "If after a history of syphilitic cranial nerve lesion there are any signs of nervous instability, there is real reason to fear that general paralysis may be the result. Any local cranial lesions, especially such as depend upon syphilis, may originate the degeneration of general paralysis". Dr Savage observes from his notes that neuralgia, headache, sciatica, rheumatic pains, and the like, were almost universally recorded as having been noticed a year or more before general paralysis was recognised. Double sciatica is not a symptom to be overlooked, and if it is recurrent and associated with any change in habits or character, it is a warning not to be disregarded. Among the warnings of a "mental" nature, the gradual loss of power of social accommodation is one of the earliest and most marked. Memory for recent events becomes defective; loss of the power of attention and a want of persistence are very well marked. In early general paralysis stupid stealing and thoughtless indecency are the common forms of its manifestation. The early "general paralytic" easily becomes drunk, and is easily poisoned. Changes of temper and character are probably the most common of all the changes which are noticed in early general paralysis. Alternations of buoyancy and depression are of bad import. The sudden outbreak of mania is a frequent precursor of general paralysis, and this specially interesting when it assumes the form of delirious mania. Warnings of general paralysis may be present for years, and almost certainly they are present for a year at least before the symptoms induce even the sensitive specialist to scent out the disease.

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Lancet, 5 April 1890, 753.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Surrey.

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