to indicate,[1] [2] that the problem of the extrapyramidal disorders is the same no matter what the pathogenesis.

Dr. Purdon Martin declares that the basal ganglia control the centre of gravity. To the psychiatrist these ganglia are the centre of gravity.

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DANGER OF AIR EMBOLISM IN HIGH-PRESSURE BLOOD-TRANSFUSIONS

SIR,—Dr. Bewes [3] has eliminated a cause of air embolism but in doing so has defeated the purpose of the drip-counting chamber. The counting chamber often fills during the ordinary course of intravenous therapy, and as with pressure transfusion the air displaced goes into the patient. Having read the article by Dr. Bewes, I carried out experiments extending his technique.

As a result of these experiments, first using water and then blood, may I suggest the inclusion of a second counting chamber 6-8 in. below the first. When expelling air from the giving-set, the second or lower chamber is filled but the first counting chamber is left almost empty.

During transfusion the second chamber acts as an air trap for the air which is displaced from the upper counting chamber.

This method prevents air from entering the patient and yet retains the function of the upper counting chamber in that the flow of fluid can be observed under conditions of high pressure mechanically exerted, free gravity flow, or controlled " drip " method.

For encouragement and the supply of blood, my thanks are due to the Regional Blood Transfusion Centre, Newcastle upon Tyne.

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WHAT MAKES THE PATIENT BETTER?

SIR,—Dr. Meares' article (June 10) and the subsequent correspondence point to the frequency with which rapid and often lasting improvement takes place without anyone understanding how the change comes about. The word " suggestion " is often used to describe the process but this takes us no further in explaining it.

We hear often enough how suggestion works, meaning the way in which it is applied by the therapist, but we hear little of what goes on in the patient. We need an explanatory model for the consideration of these processes, and in my view this is provided by the object relation theory of personality. Elsewhere [4] I have put forward the idea that during treatment the patient introjects something of the therapist's personality. This is the same process by which we grow when, as infants, we absorb and incorporate representations of parts of the personalities of our parents. These representations are based partly on the reality of their personalities and partly on the fantasies which we project on to their persons before absorbing them back into ourselves.

In treatment a patient may take from the therapist something the therapist actually has, or he may project what he needs on to the therapist and then absorb it back as material out of which he makes his own cure.

An analogy of the difference between these two processes is the difference between love and infatuation. Love is the development of two personalities in contact with each other. Infatuation is the process whereby an individual becomes attached to a fantasy that he imposes upon another individual. Cures based on fantasy perception about the therapist may disappear as suddenly as an infatuation.

Quick cures can also occur when rational medical procedures are being used. They happen when what is supplied to the patient, either in the therapist's personality or in the process used, exactly suits the patient's need. Thus, in medical practice, quick cures can accompany rational or irrational procedure, and so can they in paramedical treatments and spiritual healing.

The underlying process is the same in all these cases—namely, the incorporation of " good objects " which exist in, or are projected on to, the person held responsible for the cure.

The question remains whether we should deliberately seek these quick cures. I hold that we should be cautious in this matter because what applies to the therapeutic process could apply equally to a pathogenic process, or " sudden worsenings ".[5] When we try to force a cure on to patients by methods which invoke deceptions of the patients, or of ourselves, we are using unconscious processes with unforeseeable results.

As doctors, we should aim at using rational processes; but the irrational processes are proper subjects for our study.

London, N.W.3. J. H. KAHN.

ACTION OF CHORIONIC GONADOTROPHIN IN THE OBESE

SIR,—Simeons [6] suggested a suitable method of preoperative and postoperative treatment for the obese patient, and I adopted his methods in a series of 100 patients.

68 patients completed forty consecutive days of treatment and the other 32 patients twenty-one days. The average weight-loss was 28 lb. after forty days' treatment and 17 lb. after twenty-one days. Of these 100 patients, 20 were surgical cases: 18 required surgery either during or after their course of treatment, and 2 required a course of treatment postoperatively.

All the patients were ambulant and continued to work full-time over the treatment period. They were given 125 units of chorionic gonadotrophin daily by deep intragluteal injection, and maintained on a 500-calorie, fat-free diet containing 200 g. of protein. None of the patients felt hungry or weak or had difficulty in coping with his normal daily activities. The best results were achieved when the patient cooperated fully, but even those who dieted irregularly lost weight more readily than with any other treatment tried. For the first time many previously refractory to other regimens lost weight. The symptoms commonly associated with obesity—lassitude, breathlessness on exertion, " rheumatic " aches and pains, and headaches—all subsided a few days after starting treatment.

From the surgical point of view it was noteworthy that in no case did the skin sag or become flaccid despite the rapid loss of 25–40 lb. The loss of subcutaneous fat so usual in other forms of weight-reduction did not occur. After operation the skin always healed by first intention, and this was particularly important and gratifying after reduction mammaplasty and abdominal lipectomy. In 2 patients acute appendicitis developed during the treatment, which was nevertheless continued throughout their stay in hospital. There was no difficulty in inducing or maintaining anæsthesia; and after an uneventful postoperative recovery both were discharged from hospital within ten days. 5 other patients had operations during their therapy. None had any ill-effects and they recommenced therapy immediately after the operation.

3 patients with radiologically demonstrable diaphragmatic herniæ, causing severe symptoms, were all trouble-free within a few days of starting treatment and remained so throughout the course. They required no further treatment.

A diabetic had previously been treated with insulin for five months and then maintained on daily chlorpropamide (' Diabinese ') 500 mg. and a 1200-calorie diet. She lost 45 lb.

1. Boardman, R. H., Fullerton, A. G. *J. ment. Sci.* 1960, **106**, 1468.
2. Boardman, R. H., Fullerton, A. G. *Acta neurol. belg.* 1961, **61**, 78.
3. *Lancet*, 1961, i, 429.
4. Kahn, J. H. *Ment. Hyg., N.Y.* 1960, **44**, 568.
5. Scott, W. C. M. *Lancet*, July 15, 1961, p. 151.
6. Simeons, A. T. W. *ibid.* 1954, ii, 946.

in two courses of treatment, and her urine is now sugar-free without any other form of medication. Her " before and after " glucose tolerance curves were as follows:

	Blood-sugar (mg. per 100 ml.)		Urine-sugar		Acetone
	Before	After	Before	After	
Fasting specimen	205	104	++++	Absent	Nil
½ hour		176		,,	,,
1 hour	488	214	++++	+	,,
1½ hours ..		238		++	,,
2 hours	500	171	++++	++++	,,

This patient has not increased in weight during the past four months since her treatment finished, and only requires to restrict her eating habits to a dietary level which does not permit weight to increase. She is allowed a free choice of food.

I think this series substantiates Dr. Simeons' original work and illustrates particularly the advantages in planned abdominal and plastic surgery; the method is rapid, effective, and safe, and causes no hardship to the patient. A number of patients who would otherwise be unfit for operation, or, at best, a bad risk, may be safely operated upon. Patients treated preoperatively will avoid the cardiovascular and respiratory embarrassments of the obese.

London, W.1. PHILLIP LEBON.

PSYCHOLOGICAL TRAINING FOR FUTURE MIDWIVES

SIR,—The implication of your annotation of July 15 seems to be that the psychological training of midwives is not now controversial, and that the views expressed in your recent review of the midwifery services were conservative.

That the teaching of insight into the parturient woman's psychodynamics can do " nothing but good ", as Dr. Shîla Ransom thinks, is at variance with the findings, for example, in child guidance, where insight in the hands of ancillary workers with strong ambivalent feelings towards children can be used, even if unconsciously, as a weapon. In the labour ward the risks of destructively aggressive manipulation of insight are greater, the patient more vulnerable, and psychiatric supervision less. " Insight " that a mother who cannot breast-feed does not really love her baby, and that a woman in prolonged labour is having difficulty in accepting motherhood, is more damaging, because of the guilt aroused, than unnecessary pain and indignity inflicted, for example, by squeezing engorged breasts or slapping the face of an " hysterical " patient.

Perhaps the immature and the barren are in too provocative a situation in the delivery room—" always the bridesmaid and never the blooming bride ". It is here that a great deal of psychiatric help can be given to midwives, whose conscious aim, after all, undoubtedly is to be loving, to accept their own feelings of jealousy and their supporting part in the drama revolving around the mother.

Apart from doubts of the value of deep psychodynamics to midwives, one wonders when the many hours necessary for casework relating to the patient's own childhood could be spared, and whether the obstetrician would be willing to forgo direct contact with the patient in order to avoid prejudicing the resulting " transference " situation!

Controversial psychiatric material in the teaching syllabus itself includes the list of factors, such as sepsis, from which puerperal breakdowns arise, tiredness and loneliness as " easily preventable causes " (perhaps they are, rather, *symptoms* of the depression), and the statement that such breakdowns can be foreseen and prevented, and that they do not tend to recur in subsequent pregnancies.

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SIR,—Dr. Tylden believes that puerperal psychosis can be anticipated in the antenatal period and usually prevented by antenatal care. If this is true, it is of considerable importance. At least 2 in every 1000 women delivered in this country develop a severe psychosis in the puerperium, giving an annual total of 1700 or more. As Dr. Tylden says, such illnesses are often long and difficult to treat, and may cause great distress to patients' families. To prevent them would be a tremendous achievement. But Dr. Tylden has not, to my knowledge, published figures to support her views, and unfortunately my own observations make me less optimistic than she is.

Recently I have given careful psychiatric supervision to a group of 27 women picked at random from the antenatal clinic at St. Thomas's Hospital. The results suggest that being seen at regular intervals by a psychiatrist has helped to relieve certain emotional difficulties and changes of mood both in pregnancy and the puerperium. Psychosis is another matter, however, as shown in the following case, which happened to be among them.

A woman of 35 had been happily married for ten years. She had a previous breakdown at the age of 22, shortly after becoming engaged. She recovered from this and was well until the birth of her first child eight years ago. A few days after delivery a severe puerperal psychosis developed and she had to be admitted to a mental hospital.

During her recent pregnancy I saw her at every antenatal visit. Because of her history we paid particular attention to all her problems, and she was also helped with housing and social difficulties. In fact, all possible steps to help her were taken. But, even so, she had a severe psychotic episode five days after delivery and had to be transferred to a mental hospital.

I have also recently studied 47 women with a history of puerperal psychosis, and compared them with the normal group. The outstanding differences are that 52% of them have broken down earlier in life (excluding previous pregnancies), and 49% gave a history of breakdown in a close relative. The comparable figures for the normal group are 4% and 17%.

I think these figures suggest that, although psychological factors are important, genetic and constitutional factors play a very large part. In the present state of our knowledge Dr. Tylden's claims, unless she can support them with reliable evidence, seem to be rather presumptuous.

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PROFESSIONAL SECRECY AND THE LAW

SIR,—I strongly support the views of Dr. Keating (June 24).

It is interesting to note a case in which a doctor's objection against revealing his patient's secrets was upheld in a hearing at the Mayor's and City of London court.[1] [2] A patient, Mr. X, contracted pulmonary tuberculosis from another tuberculosis patient, Mr. Y, both working as telephone operators in the same firm. Mr. X sued the firm for compensation claiming that his disease was the result of using the same telephone that was used by Mr. Y. The doctor treating Mr. Y was subpœnaed by the court to produce the records of the condition and treatment of Mr. Y. The doctor made a protest both on the general ground that the evidence required of him was obtained by him in confidence as a medical practitioner and on the special ground of a statutory obligation to secrecy. Article 10 of the Public Health (Tuberculosis) Regulations of 1930 states: " Every notification and every document relating to a person notified under these regulations shall be regarded by the medical officer of health and by every person who has access thereto as confidential." Under section 1 (3) of the Public Health Act, 1896, as the witness reminded the court, refusal to obey the regulations would expose him to a penalty of £100. The judge relieved the doctor from giving the evidence.

1. *Lancet*, 1934, ii, 835.
2. Modi, J. P. Medical Jurispudence and Toxicology; p. 17. Bombay, 1952.