Hysteria
Jon Stone and his fellow authors (December 2005 J RSM) rightly draw attention to the undue influence on a general medical readership of Eliot Slater’s 1965 paper on hysteria. However, it is perhaps misleading to describe it as ‘a blessing for psychiatrists’. In fact, a sensible psychiatric response which was highly influential on subsequent psychiatric practice was Aubrey Lewis’s classic paper ‘The survival of hysteria’, which pips Stone et al. to the post by 30 years; and which surely must be read alongside Slater. Besides writing a general homily on the subject, Lewis reported a series of 98 patients who had received diagnosis of hysteria at the Maudsley Hospital, with follow-up from 7–12 years, but with somewhat different findings to Slater (‘... in very few did this raise the question of an altered diagnosis’). Of course, Lewis’s series came from a psychiatric hospital and Slater’s from a neurological one, causing him to state of his results, ‘That they are not similar to the findings on patients diagnosed at a neurological hospital is not surprising’. Indeed it is not. The implication that did not escape those of us for whom both Slater and Lewis were required reading in our psychiatric training, was that psychiatric diagnoses made in psychiatric settings may be more robust than psychiatric diagnoses made in neurological settings. The paper ends with one of Lewis’s celebrated aphorisms ‘... a tough old word like hysteria dies very hard. It tends to outlive its obituarists’. Unfortunately, it seems the same cannot be said for Lewis’s huge contribution.

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REFERENCES
2 Lewis A. The survival of hysteria. Psychol Med 1975;5:9–12

Huntington disease
Apropos Ben Harper (December 2005 J RSM) on Huntington disease: George Huntington (not George S Huntington, an eminent American anatomist), observed what he called ‘hereditary chorea’ in Pomeroy, Ohio, but in East Hampton, New York, where he grew up the son and grandson of physicians. As a newly qualified physician, he moved to Pomeroy to begin a medical practice. It was in nearby Middleport that he gave his paper On Chorea in 1872. This history is well known.

It has also long been recognized that he was not the first to describe this disorder in adults, namely chorea accompanied by cognitive decline and emotional disturbance, leading inexorably to death. While most earlier writers acknowledged the hereditary transmission of this illness, they did so within the conventional mid-nineteenth century paradigm of inheritance. That is, they accepted that the disease might skip a generation before it appeared again. Huntington evoked a radically different pattern. In his description, an individual who did not develop the disease during a normal life span could not transmit it to subsequent generations. Once it failed to appear, it would not reappear. It was this insight—based on the observations of his father and grandfather and the East Hampton families—that distinguished his account from those of his predecessors, and which later investigators acknowledged as an accurate representation of the Mendelian dominant inheritance pattern of the disease.

Far from being ambitious, Huntington was remarkably modest. Though his paper had gained wide recognition by the 1890s, he remained a small-town family physician. Ironically, it was partly through the influence of the Canadian turned Oxford University professor William Osler that the malady came to be known by the ‘American’ name of Huntington’s chorea and later Huntington disease.

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REFERENCES

Walking the walk
Phil Hadridge suggested in his article (December 2005 J RSM) that, if the culture of patient safety is to improve in the health service, we should take a leaf out of the oil industry where safety since the Piper Alpha Disaster has been paramount. He suggests leaders in the health service should ‘walk the walk’ like in the oil industry and check fire procedures and exits at each meeting.

He is missing the point by a mile. He is walking the wrong walk, and I am not surprised that he has met with incredulity when he has suggested it.

Fire is a fundamental issue in the oil industry. Fire is the safety issue in the oil industry.

He is, however, quite right to ask what is our Piper Alpha? MRSA perhaps? Leadership needs to walk the right
walk if they are to improve patient safety. In a culture where the patient comes first, worrying about your own skin in a fire comes across as counter intuitive when most of the health professionals would be looking at saving their patients first before running for the fire exit.

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I am afraid Phil Hadridge needs to remove the inverted commas from ‘ridiculous’ in his recent contribution (December 2005 J RSM1). Should doctors have to be given a detailed briefing about their immediate environment every time they meet somewhere? It is exceedingly unlikely that, by checking the fire escapes in a room, a doctor would significantly reduce the risk of a catastrophe, and it certainly would not make patients any safer. So as a direct action it is ridiculous.

Would such an action set a good example? Well, of course, I would like to be seen as rational and flexible: however, checking the fire exits everywhere would give the opposite impression. If you want to change behaviour, first convince people that what you want is sensible and correct.

As for the ‘well it won’t hurt’ argument? Why not offer up a quick prayer, or take a vitamin tablet at the start of each meeting—easy, cheap and useless. The reasons that we are bad at patient safety are that too many problems are hard to fix, and living with unfixable problems makes it easy to ignore the fixable ones. Some of the latter are now being addressed—for example, the introduction of alcohol handwash dispensers everywhere, and a new culture which makes it easy to roll up sleeves and discard ties, jackets and white coats, has greatly increased the frequency of handwashing. If management are serious about patient safety, they should make this their priority rather than finance and DH targets. If adequate bed area cleansing were regarded as more important than meeting the 4-hour A&E target, and bed occupancy rates fixed at safe levels, I have little doubt that nosocomial infection rates would fall. There is also little doubt that patient waiting times would increase and mangers would be sacked (or relocated). The NHS seems to be concentrating on quantity of treatment whilst accepting some reduction in quality. And given resource limitations, and the fact that the vast majority of the huge number of treatments carried out daily are successful, the balance may not be far out. However, if we want to improve patient safety, management mumbo jumbo is not the answer—adequate time and space to treat patients is.

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History of brucellosis
We read with interest Dr Wyatt’s article (October 2005 J RSM1) on Zammit’s discovery that brucellosis was transmitted by goat milk. We would like to add the names of some other people who were involved in the research.

First, Dr Carruana-Secluna, who accompanied Zammit to Chadwick Lakes, carried out a great deal of work for Sir David Bruce—he prepared the agar plates and the culture media and cultured the causative organism from the spleen samples of fatal cases. He never received proper recognition for his work and Sir David Bruce did not allow him to be co-author on any publications. Secondly, Surgeon Captain M. Louis Hughes assisted Bruce in his studies and first named the disease ‘undulant fever’. He also named the organism Micrococcus melitensis, although he was wrong about the source of infection, believing it to be resident in the soil and inhaled by the human. Hughes was killed in the Boer war at the age of 32.

Sir David’s wife Lady Bruce was a trained microbiologist, and took an active part in her husband’s research, including the exquisite illustrations to his papers.2

Finally, it is worth noting that Zammit was knighted—an honour given for his work.

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1 Wyatt HV. How Themistocles Zammit found Malta fever (brucellosis) to be transmitted by the milk of goats. J R Soc Med 2005;98:451–4

Super hospitals
Neville Goodman (November 2005 J RSM1) bemoans the cancellation of a giant hospital amalgamation in the West Country after thousands of medical hours were wasted on the planning. This will teach him not to sit on too many committees. Who wants to be treated in a vast megolithic
superhospital where nobody knows anyone? Who wants to
work in some vast sprawling new hospital where nobody
knows anyone? Small can often be beautiful where hospitals
are concerned where patients and staff can be respected. Dr
Goodman should put down his committee agenda, pick up
his stethoscope and start enjoying medicine again.

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REFERENCE

Death to all clichés?
About the article by Ian Forgacs on clichés (December 2005
JRSM), may I respectfully disagree, for surely Dr Forgacs
you jest! In my years teaching medical students and house
officers (at Stanford University in California) I found that
the aphorism (which I prefer to cliche) ‘common things
happen commonly’ was very useful in pointing out to the
fledgling doctors that the first, but not the only, diagnosis
one entertains is the most common. As with your other
eamples, what I suspect you were railing about is the
tendency for many of us to speak in tongues, when we
should say what we mean, and mean what we say.

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Death to some clichés
I agree with Dr Forgacs (December 2005 JRSM) that
referring to a patient as being ‘haemodynamically stable’ is
unacceptable and the offending practitioner should be
requested to return to basics and provide actual values.
However, I admit to being fond of ‘common things
occur commonly’ and the similar ‘when you hear the sound
of hooves, don’t look for zebras’, both of which, in the
thinking individual, do not exclude the uncommon
diagnosis. I also believe that ‘irregular irregularity’ is
perfectly acceptable when describing a pulse or a magnified
abnormal volar skin appearance.

What about clichés in general? ‘See you later’ annoys
when, as is often the case, the speaker is unlikely to see you
again. The simile cliche’ bald as a coot’ may sometimes be
accurate but it is a rude expression ready for burial.
‘Quality of life’ is expanding its meaning as it becomes
overused, and its use should be restricted.

Other clichés are no doubt ‘in the pipeline’. Unoriginal
and trite they may be, but many still deserve ‘tender loving
care’ (Henry VI Part ii Act 3 Sc.2).

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Semmelweis and his thesis
Was the pedestal off which Irvine Loudon (December 2005
JRSM) so neatly knocked poor Semmelweis really reserved
for the most famous name in the history of obstetrics? Does
not Caesar still stand, passive and immovable, on that one?

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REFERENCE

CORRECTION
Shafqat S. The long shadow of cerebral localization. J R Soc
Med 2005;98:549
In line three of this paper we referred to ‘the late Raymond
Adams’. We are delighted to learn that Dr Raymond D
Adams is alive and well and still reads the JRSM.

Letters to the Editor
Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk].
Letters should be no longer than 300 words and preference will be given to letters
responding to articles published in the JRSM. Our aim is to publish letters quickly. Not
all correspondence will be acknowledged.