Letters to the Editor

PSYCHIATRIC CARE OF THE ADOLESCENT

SIR,—Your leading article (March 30, p. 676) stresses the need for a coordinated approach by medical and non-medical services dealing with adolescents, but surely a prerequisite for this is an adequate psychiatric service for this group. Psychiatric services which are non-existent, or exist in token form only, can scarcely be coordinated with any other sort of service. As you say the provision of more psychiatric beds for adolescents had been the aim of Ministry of Health policy for a long time, but before they could be of much value there must be many more training posts for psychiatrists who wish to work in this specialty.

The training needs of the psychiatrist who is to deal with adolescents are very special. He must have training in general psychiatry and also in child psychiatry, and of course he should have spent a period working in inpatient and outpatient adolescent units. The greatest need is probably for many more posts in the senior-registrar grade. Even in this region, where a child-psychiatry unit has lately been opened and an adolescent unit is due to be opened, the level of trainee posts so far allowed by the Ministry of Health has been hopelessly inadequate.

Although hospital building is not usually a particularly rapid process, training staff can take even longer. Even if training posts were created now, it would take a decade or more to produce a reasonable supply of psychiatrists expert in adolescent psychiatry. It is no use the Ministry of Health recommending twenty or twenty-five beds per million of the population unless it at once provides for appropriate psychiatric training posts. At present the beds, even if provided, would stand empty for lack of staff.

The Charles Burns Clinic,
Queensbridge Road,
Birmingham 13. PHILIP BARKER.

SIR,—My colleagues and I lend our emphatic approval to the call for clear thinking and rigorous methodology made in your leading article. That it is incredibly easy to set out on this task already armed with unproven assumptions you demonstrated yourself. You fail to question the clinically prevalent belief that " adolescent emotional stress is often masked deliberately, or through ignorance, by parent or institution until the youngster has grown out of the age-group ". If this were so, the amount of treated morbidity in the community would be less among adolescents than among adults. Our own data [1 2] on the incidence of treated illness suggests that rates are almost identical for adolescents and adults. While symptoms *may* be masked in adolesence more readily than in adulthood, we cannot be certain until it is methodologically possible to conduct a field survey. Again, you believe that adolescent emotional stress " is often directed into the deviant and antisocial channels and disappears in the epidemiological mists of juvenile delinquency ". But does it? This too is untested.

I believe that a major advance in our understanding of adolescence can come only from a field survey. For this it is necessary that we make a careful study of the phenomenology of normal adolescence before attempting to measure psychiatric morbidity.

M.R.C. Unit for Research on the
Epidemiology of Psychiatric Illness,
Edinburgh University Department of Psychiatry,
Royal Edinburgh Hospital, Edinburgh 10. A. S. HENDERSON.

WHEN SHOULD RANDOMISATION BEGIN?

SIR,—The series of articles in the issue of March 9 on the anticoagulant effect of purified fraction of Malayan pit viper venom may be a milestone in the development of successful therapy for patients with thromboembolic disease, but it also raises a critical question as to the scientific and ethical requirements of new-drug trials in man. How early in the development of new drugs should the process of randomisation be introduced into the therapeutic trial? I am firmly convinced that the first patient to receive a new agent should be randomised. It is too late in the case of ' Arvin ' for such an approach, and the purpose of this letter is to urge that all further trials of the drug be properly controlled. The two reports of experiences in patients and your leading article all suggest that the therapy has promise and deserves further trial. From the scientific standpoint these conclusions would be on much firmer grounds if the results in the initial patients could be compared with randomly assigned controls. Even though the numbers would obviously be far too few for any definitive conclusions about comparative efficacy, the proper comparison would allow a more scientific conclusion about the need for a further trial.

There are far more potent ethical reasons for randomising from the beginning patients treated by a new drug. When the first patient with a thromboembolic problem received arvin, there was absolutely no knowledge of its relative efficacy or toxicity. If the drug eventually turns out to be less effective or more toxic than heparin, that patient would have been lucky to have landed in the control group. If the converse eventually is true then the initial patients assigned to arvin by chance would be the lucky ones. Randomisation is most ethical when there is no knowledge about relative efficacy and toxicity, and this state exists in its purest form at the time the first patient is to be treated.

The standard argument against early randomisation is that an improper trial would result if the drug has not previously been explored in selected patients to determine the proper dose and to decide whether or not a randomised trial is ethical. Is it proper for patients to be selected arbitrarily for earliest trials of a new agent when it is even more likely at that time that they might do better if they received standard therapy?

Finally, it is apparent that most existing treatments have been either accepted or rejected without a proper therapeutic trial because conclusions were reached as a result of uncontrolled studies which, for assumed ethical reasons, could not be challenged by proper studies.

The conclusion is inescapable that randomisation should begin with the first patient. In the case of arvin it is fervently hoped that investigators will not wait until they have developed fixed opinions about its efficacy and toxicity before submitting it to a proper trial.

Department of Medicine,
Tufts University School of Medicine,
Lemuel Shattuck Hospital,
Boston, Massachusetts 02130. THOMAS C. CHALMERS.

MEDICAL STUDENTS AND GENERAL PRACTICE

SIR,—There has been much lately in your correspondence columns on this subject, and in The Student Speaks Mr. Heller and Mrs. Heller (April 6, p. 745) give an interesting account of a voluntary attachment scheme. However, I feel it opportune to give a student's opinion on the scheme here at Newcastle, which was explained by Dr. Smith and Dr. Walker (Jan. 20, p. 146).

I lately undertook this five-week course in family and community medicine, which is an integral part of the clinical curriculum. To my surprise, considering my previous prejudice against this branch of medicine, I found very little to criticise. The course is an essential part of my first year of clinical medicine, for it immediately made me realise that a patient is part of an environment and not just the occupant of a hospital bed. The study of the community services, and experience of the duties carried out, apart from being of interest, gave insight into what can be done in cases for whom more than just medical care is required. Frequent seminars held during the course, which were generally informal, were undoubtedly

1. Henderson, A. S., McCulloch, J. W., Philip, A. E. *Br. med. J.* 1967, i, 83.
2. Henderson, A. S. *Psychiat. Enfant* (in the press).