medical officer (S.A.M.O.) has management functions in relation to policy decisions made by the regional hospital board.[24] It seems desirable, therefore, that the community physician, like the S.A.M.O. and M.O.H. should have not merely advisory functions but managerial ones also.

CONCLUSIONS

We have discussed the evolution of the concept of the community physician, and have suggested, in general terms, the roles which he might play in the National Health Service of the future. It should not, however, be thought that his presence alone would transform the Service into a near-perfect agency for the delivery of medical care. Rather, we contend that, just as specialists in administrative medicine have been able to help their clinical colleagues in the process of rationalising and delivering such care, the community physician, once freed from the constraints of a tripartite Health Service structure, would be in an even better position to do so.

If the concept is accepted, there is urgent need for an authoritative spelling out of the job description and career prospects for the community physician, as these have implications for the recruitment, training, and deployment of this small but, we believe, important specialty. And we welcome especially the declaration, in the 1970 green-paper, that the scope and nature of the work of the community physician in a reorganised National Health Service is to be studied in detail.

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Occasional Survey

HOSPITAL ADMISSIONS DUE TO LYSERGIC-ACID DIETHYLAMIDE

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L.S.D. was introduced into British psychiatry in the 1950s, and had a temporary vogue as part of a psychotherapeutic approach. Many psychiatrists were discouraged by their experience of serious incidents, including severe depression and occasional psychosis. This experience led most psychiatrists concerned to adhere to more traditional forms of treatment and the use of other adjuncts to psychotherapy.

If L.S.D. can produce serious side-effects, even in skilled hands and with careful supervision, it is not surprising that people taking this substance without adequate precautions should experience serious symptoms.

It is often difficult to be sure that L.S.D. caused any particular psychotic response unless the patient can give a clear history. Nevertheless during the years 1966 and 1967, in 73 cases of patients admitted to hospital with a diagnosis of drug addiction L.S.D. was mentioned as the drug, or one of the drugs, leading to admission. 7 of these patients had more than one admission. 67 case-papers were obtained and an assessment made of the part played by L.S.D. as a cause of admission. The following five categories were found:

1. *Acute psychotic reactions.*—26 patients were admitted to hospital as a direct result of acute psychotic reactions. In most cases the patient was acutely disturbed and in many was found wandering in a confused and hallucinated state. For example, patient A was a single man of 24 with a long history of psychopathic traits, including truancy, emotional disturbance, and minor criminal offences. He came from a broken home and had formed no consistent relationship with any relative or parent surrogate. He left a provincial town and came to London where he claimed to be living by using his wits. He had used L.S.D. on several occasions without difficulty. Early one evening he took what he assumed was his usual dose and three hours later was found in a public square shouting that wild animals were wandering in the streets. He assaulted a policeman who went to help him, and was eventually admitted to hospital via the mental welfare officer. His symptoms subsided in twenty-four hours, and urine tests showed no evidence of any other drugs. He appeared to have made a full recovery and discharged himself after three days.

2. *Suicide attempts under the influence of L.S.D.*—2 patients attempted suicide shortly after taking the drug. Mr. B, aged 18, was a single man living with a group of adolescents in London. He was the only child of strict parents and had left home at the age of 17 to get away from parental domination. He had drifted from job to job; had experimented with cannabis and other drugs. On the night in question he bought some L.S.D. from a friend and took it in his room at the same time as his friends took a similar dose. He said that, whereas his friends seemed to become quiet and preoccupied, he felt increasingly fearful until he panicked and ran out of house. He wandered in the streets for an unknown time and became increasingly depressed.

He felt that his whole life was in ruins. He made a half-hearted attempt to jump in front of a car, and was then shortly afterwards restrained from a more deliberate attempt, which led to minor injuries, by a passer-by, who had seen the first incident. He continued to express determined suicidal ideas in the casualty department, and although he slept under sedation he was still morbidly depressed when a psychiatric assessment was made next day. His depression persisted through his four nights' stay in a psychiatric hospital, but was not severe enough to warrant his detention when he insisted on taking his discharge.

3. *Aggressive outbursts.*—2 patients were admitted as the result of aggressive outbursts whilst under the influence of the drug, and a 3rd ran out of the house where she was staying after becoming increasingly excited because she was afraid she would attack her relatives. Patient C was a professional man in his 40s. He had taken L.S.D. several times without ill-effects; but on the occasion in question he became increasingly agitated and began to feel that he was in some danger. He felt he could not trust the friend he was with and made an excuse to leave the house. He was found lurking with a hammer in his hand by a night watchman, whom he attacked, luckily causing no serious injury. He was taken to a police station and was admitted to hospital the next day. By the time he was admitted acute symptoms had subsided, and, apart from some perplexity and feelings of unreality, no psychiatric symptoms were elicited. He had limited insight and said that at the time he had believed the night watchman had been sent by unknown persons to kill him, and he had acted in self-defence.

4. *Multi-drug use.*—In 26 cases it was impossible to be certain whether or not L.S.D. played the major part in leading to admission to hospital. In these cases L.S.D. had been taken together with cannabis, amphetamines, or sedatives—sometimes together with two or three drugs. For example, a young girl gave a long history of emotionally disturbed behaviour. She was illegitimate, and at an early age had defied her mother, truanted from school, and had several spells in institutions. She came to London when 16 and lived as a prostitute. She had taken a variety of drugs and claimed to be taking amphetamine by day and a variety of sedatives, including ' Mandrax ' and ' Amytal ' at night. A friend persuaded her to take L.S.D. one evening. Some hours later she developed an acute paranoid reaction; she accused her friend of poisoning her and attacked her. There was a scene in a restaurant with much verbal and physical aggression. When the police arrived she became calmer. She was eventually taken to a casualty department where she was " washed out " because of the uncertainty of diagnosis. She spent forty-eight hours in hospital under sedation before discharging herself.

5. In 10 cases there was no apparent connection between admission and taking L.S.D. For example, Mr. D, aged 35, was a married man with high intelligence who worked as a textile designer. He had always been a shy and retiring person whose friends and contacts were mostly in the artistic and musical world. He had taken L.S.D. many times because he believed it improved his artistic sensitivity. He was admitted to hospital because of a depressive episode immediately reactive to domestic problems. During his hospital stay he obtained his notebooks and designs and was able to pick out those executed in association with his L.S.D. experiences. He insisted these were of particular merit, but the majority were unfinished and poorly executed compared with his usual style and he had been unable to sell any of them. He seemed unable to appreciate the difference between his belief that his work was improved by L.S.D. and the fact that by everyone else's standards his work deteriorated and was unusable.

DISCUSSION

Drug-taking often occurs in " epidemics ". These epidemics may be partly accounted for by availability of the drug, but also depend on fashion. There is some evidence to suggest that L.S.D. was more commonly used early in the middle '60s but became less frequently used in the past year—possibly because of adverse publicity following some bizarre incidents reported in the Press and partly because of the suspicion that L.S.D. might produce chromosomal damage. Nevertheless, L.S.D. is still in use in this country, and more cases are likely to appear in psychiatric clinics. Apart from acute reactions, there will be numerous cases where the patient merely experiences a distortion of reality, some minor anxiety, and not uncommonly feelings of unreality or confusion. Symptoms may reappear some days, or occasionally a week or two, after the original L.S.D. experience. Reading the case-records of those involved it is striking that the degree of disturbance and extent of psychiatric symptoms seemed much greater than in a similar series of patients who had taken cannabis.[1] Suicide or homicide can follow within a few hours of taking L.S.D.

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Round the World

Sweden

A SHORT STRIKE

The strike of " doctors " reported [1] in *The Times* was really one of medical students in their final year with a degree in medicine (MED. KAND.) but not yet registered, since registration requires a minimum of four months' service at the equivalent of houseman status. They are, however, allowed to take locums at a junior level in hospitals or as district M.O.s in the State health service. For these jobs they have been very well paid. On an average, they acted as locums for eleven months, and, by choosing the most lucrative posts and doing an enormous amount of overtime, it was possible for a MED. KAND. to earn 100,000 kronor (about £8000) before qualifying.

At the beginning of this year the system of payments under the Swedish N.H.S. was reorganised. Private practice using hospital facilities or those provided for district M.O.s was no longer allowed, and the total income of the State medical service was redistributed among doctors to compensate for this. During the complicated salary negotiations, the existence of the preregistration locums seems to have been overlooked both by the doctors' side and by the employers (county councils). The Association of County Councils then arbitrarily reduced their rate of pay to a level which in effect halved their income.

Those on strike (it was not 100%) returned to work after a couple of days, by which time it had become obvious that so many key posts were held by unregistered locums, especially in those areas where the shortage of doctors is most acute, that both hospital and local medical services would collapse in many places, and they did not want to be responsible for a situation which would make patients suffer. The Med. Kand. Association has now arraigned the Association of County Councils in the Industrial Court for failing to institute negotiations.

1. *Times*, March 17.