The genetic mechanisms referred to by McGuffin *et al* may certainly explain a small percentage of cases of schizophrenia, but considerable room remains for positing an environmental influence in the aetiology of schizophrenia.

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SIR: Although many hypotheses are put forward by McGuffin *et al* to account for the 'non-genetic' causes of schizophrenia, they have possibly overlooked one significant cause of the new appearance of schizophrenia in a patient with no family history: ambiguous paternity.

Estimates of the incidence of non-paternity vary from 2.8% to 30%. Rates of non-paternity depend on the population being investigated. For instance, Macintyre & Sooman (1991) report that one study of the correlation between antibody formation in artificial insemination and blood group had to stop because it had revealed that in the population being surveyed, 30% of the children could not have been sired by their mothers' husbands.

Published data have revealed non-paternity rates of 5% on the basis of ABO and rhesus markers (Johnstone, 1957), and Bellis & Baker (1990) predict a non-paternity rate of 6.9–13.8%. Via DNA fingerprinting, Le Roux *et al* (1992) estimated that, in a population with genetic disease, the rate of children not sired by the declared father was 2.8%.

There is no reason not to expect a similar phenomenon in a psychiatric subpopulation, where the relationships may be even more unstable. However, neither standard textbooks nor a literature search revealed any reference to non-paternity when discussing the heredity of psychiatric illness. Although this phenomenon may not account for all, it can explain part of the discrepancy between the observed and expected heredity. Non-paternity warrants further investigation when studying family histories.

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Lithium prophylaxis in recurrent affective illness

SIR: Guscot & Taylor (*BJP*, May 1994, **164**, 741–746) draw attention to some of the reasons for non-compliance with lithium. I profoundly disagree with the concept of separate specialised clinics which the authors propose would lessen the gap between efficacy and efficiency. This philosophy reflects a general trend in the National Health Service away from the 'generalist' towards fragmentation of services and the deskilling of staff, leading to resentment and demoralisation.

Specialist clinics with research-orientated staff on short-term contracts may not serve the patients' need for personal doctoring: long-term relationships, based on trust and mutual respect, characterised by consultations with staff who have taken the patients through relapses, and have knowledge of the family and social network. There is a need for some specialist services, but surely affective illnesses are the bread and butter of general psychiatrists.

This leads to the conundrum of training psychiatrists. How can programmes that rotate every six months possibly serve patients with long-term illnesses? The problems lie at the root of medical education, which lays emphasis on the seductive rewards of treating acute illness using an authoritarian medical model. I propose that this is an important source of non-compliance which specialist clinics cannot even provide sticking plaster for.

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Dyskinesia and withdrawal from alcohol

SIR: Duke *et al* (*BJP*, May 1994, **164**, 630–636) found that tardive dyskinesia (TD) in schizophrenic