that alcoholic beverages are commodities included in the retail price index around which so many pay claims revolve; and no present-day chancellor of the Exchequer is likely to risk pushing this up by the public health measure of increasing taxation on alcohol. Political pressure and action is required to have alcohol (and tobacco) removed from the retail price index, so that price control can be used to attempt to control abuse of alcohol.

G A C BINNIE

Berwick-upon-Tweed,
Northumberland

SIR,—In reference to Professor R E Kendall's article (10 February, p 367), can anyone tell me what is the difference between social drinking, drunkenness, alcohol problem, addiction to alcohol, dependence on alcohol, habituation to alcohol and alcoholism? And which, if any, are political problems?

LÉON SHIRLAW

Romford, Essex

SIR,—Returning from overseas, it has concerned me to find that at so many functions now one is offered only alcoholic drinks—the glass of sherry pushed into one's hand or the tray offering only a choice of alcoholic beverages. To opt for a soft drink requires not only mental courage but often considerable perseverance also, with obvious implications especially for the young or the "dried-out" alcoholic.

As a small practical suggestion towards action on alcohol, may I suggest that we in the profession (both as individuals and in running functions) should take a lead by always ensuring that soft drinks are offered alongside the hard.

D A ROCHE

Droitwich, Worcs

SIR,—In the publicity given by your journal (10 February, p 367) and in other news media to the problem of escalating alcoholism and drink-related problems in the UK among the various suggestions for alleviating the problem is the proposal that licensing magistrates have a role to play.

It may not be widely known that powers of licensing committees have been curtailed in recent years in connection with those certificates which allow extensions to the permitted hours. A special hours certificate allows sale of liquor until 3 pm and again until 2 am (3 am in Inner London) where a music and dancing licence is held, where substantial food is served, and where the building is structurally adapted. If the conditions are met the justices must grant the certificate—they have no discretion. The Licensing (Amendment) Act 1976 brought even ordinary bars within the scope of the certificate. This certificate, once granted, does not require renewal at the annual Brewster Sessions, as does an ordinary licence, nor does a transfer to a new licensee need to be made by the local court. A supper hour certificate allowing extended hours in a licensed restaurant must be granted if the conditions are met.

Increasingly one suspects that the main purpose of licensed clubs which obtain a special hours certificate is to provide drinking facilities outside permitted hours. These clubs

are proliferating, and in this borough, where there were 2442 convictions for drunkenness in 1978, crime and excessive drinking are frequently related. Violent incidents in a public house, of which there are many, are not considered by the police to be exceptional or to be grounds for objecting to renewal of the licence.

Licensing Committees still exercise control over the issuing of new licences but in many respects their powers have been so eroded by permissive legislation that they are unable to make what should be an effective contribution to the problem of easy accessibility to alcohol.

GWEN D MOLLOY

London NW6

Fatal accidents on non-gritted roads

SIR,—You ask that doctors should notify any deaths resulting from the current industrial troubles in the NHS (10 February, p 364). But it is not only NHS industrial action that may cause death and suffering. I have in this intensive care unit a man with severe multiple injuries following a road traffic accident. His 6-year-old daughter was killed outright at the accident but her 7-year-old friend, who was also a passenger in the car, took several days to die. The cause of the accident was braking while journeying downhill on ice and so skidding into another car. The road had not been gritted as a result of the industrial action. Contact with other intensive care units, when the telephone calls are not censored by the unions, has revealed many similar cases—that is, severely and often fatally injured victims of road traffic accidents resulting from unsafe roads. Despite traffic being reduced to a minimum because of the lorry drivers' strike, the number of damaged vehicles has also never been higher,¹ and with this must be a high number of fatalities.

The Health and Safety Executive is deliberately ignoring this gross disobedience of safety instructions by the work force—it is not even going to investigate it.² This is bizarre behaviour for a body devoted to safety. While any one of these accidents could have occurred even with gritting, yet the totality must include a number of deaths, probably a substantial number, directly resulting from the industrial action. The alternative hypothesis is that gritting does not reduce accidents. The silence from the Department of Transport over this matter is noteworthy, verging on a conspiracy—a conspiracy of silence. Could all those involved in the current disputes please pause while the dead are counted?

P J TOMLIN

Intensive Care Unit,
Queen Elizabeth Hospital,
Birmingham¹ *Observer*, 11 January 1979.² *Birmingham Post*, 2 February 1979.

McMaster revisited

SIR,—Professor G J Fraenkel's analysis of the McMaster programme (14 October, p 1072) is misleading and riddled with errors. His preoccupation with the administration and theory of the school's approach neglects the impact of the student body and individual initiative in creating the McMaster learning experience.

Professor Fraenkel's information is often badly confused—educational prescriptions are not based on phase I investigations. Lectures are not "illegal events," and are openly incorporated into the programme if deemed necessary. His contention that "compared with more conventional schools, real contact with patients and real life medicine is scarce before phase IV" is especially puzzling. Phase I students eagerly seek and find patient contact. The clinical skills course (beginning in phase I) often includes real patients. Parallel electives (beginning in phase II) frequently involve "real life medicine." For example, the popular "community physician elective," taken by 76% of this year's class, allows students to develop interviewing techniques, clinical skills, and problem solving during regular visits to a local general practice.

A successful "experiment in medical education" deserves a more accurate and thorough examination than Professor Fraenkel's cursory sketch.

W D MORTON
Phase II studentMcMaster University Medical School,
Hamilton, Ontario

* *We sent a copy of this letter to Professor Fraenkel, whose reply is printed below.—ED, *BMJ*.

SIR,—I am grateful for the opportunity to comment on Mr Morton's letter. I do not believe that it is profitable to argue about matters of opinion and the point of view of a Phase II student is necessarily different from that of someone who has spent his life in medical education in a considerable number of English-speaking countries. My views are based on a stay of five months at McMaster with daily discussions with many students and members of the staff. Successive drafts of the manuscript were distributed to and discussed with a large number of members of the staff and all errors of fact which they pointed out have been corrected.

The extent of patient contact is a matter of opinion and it is possible that I have a wider basis of comparison than Mr Morton. It seems to me that his statement "The clinical skills course often includes real patients" by implication proves the very point I am trying to make. Most courses in clinical skills with which I am familiar include real patients all the time.

G J FRAENKEL

School of Medicine,
Flinders University of South Australia,
Bedford Park, South Australia

Automatic blood-gas analysers

SIR,—Having some years' experience with blood-gas analysers, and more recent experience with the Radiometer (Copenhagen) ABL2, I would like to comment on the article by Dr P Rubin and colleagues (20 January, p 156).

The authors quote a four-hour warm-up period, yet the manufacturers quote a two-hour period and I have found less than two hours usually necessary. Aberrant Po_2 results were found by the authors but we have had no such problems when samples are entered correctly. ABL2 users are offered a free course on maintenance and trouble-shooting, and we have found that after this course the calibration checks, flashing lights, and digital voltmeter facility were adequate for diagnosis of simple

faults, including membrane dysfunction. We have not had to call out the service engineer for such faults or resort to the coded printout which is meant for the use of the engineers.

We have found that for analysis of syringe samples medical staff require about 15 minutes' tuition, during which the need for heparinisation is emphasised. To date no problems have occurred due to air bubbles or clotting in the machine but I would agree with the authors that basic maintenance must be performed by a skilled technician.

From my own experience the ABL2 deserves more credit than it received in this assessment and I can only assume that the demonstration model was unfortunately faulty.

PATRICIA M TWEEDDALE

Respiratory Laboratory,
Northern General Hospital,
Edinburgh

Priorities in road accidents

SIR,—Please allow me the following comments on your leading article (3 February, p 287) "Priorities in road accidents."

Firstly, improving driver efficiency does not, surprisingly, feature among your priorities to minimise road accidents. We all know of drivers who are regularly involved in minor accidents and who repeatedly skid on wet and icy roads every winter. Even the insurance industry recognises the concept of the "high-risk driver." Yet little, if any, effort seems to be directed towards achieving improvement in this risk factor. The Department of Transport driving test examines only the very basics of driving skills required for public highways. Given the ever-mounting volume of traffic, a now-so-familiar arctic winter, and the current trend towards ungritted, icy roads, it is all the more important to encourage motorists to seek improvement in their driving skill. The police in various areas organise—and they ought to if they do not—further instruction for qualified drivers. The Institute of Advanced Motorists honours those who pass its test by admitting them to the membership of the institute and by awarding a certificate. There are also skid-pans in various areas, to which, I understand, the public is allowed access. Surely such measures, if used on a large scale, can only contribute to vastly improved driver performance and, consequently, road safety. These or similar measures, undertaken voluntarily, could be sold to the public in return for a worthwhile discount in insurance premium. Drivers in higher-risk groups (such as the young) could qualify for a higher discount, thus maintaining all-round motivation. Such discounts could last, say, for five years, to be renewed after a "requalification" test. The insurance companies could advertise these concessions in their yearly notice of renewal.

Secondly, driving efficiency improves with experience and hence it is not unreasonable to suggest a top speed limit of, say, 50 mph (80 kpm) for newly qualified (and even penalised) drivers for a specified period.

Thirdly, while, in general, motorists show respect and regard for their fellow road users, certain categories are accorded special courtesy—for example, the ambulance and fire brigade. A notice of "disabled driver" earns instant consideration from the driver following. Impatient drivers might be more thoughtful of the slow mover in front if he displayed, for instance, a "senior citizen" sign.

Finally, the drunken driver should be denied even the smaller mercies. He should not, I suggest, be allowed to offset all of his heavily loaded insurance premium against expenses, where relevant.

N HASNAIN

Glossop, Derbyshire

SIR,—Your leading article on road accident prevention (3 February, p 287) was sensible and well balanced but unfortunately omitted any mention of the cyclist.

Bicycling is, as Illich has pointed out, the ideal form of transport in cities, being energy saving, non-polluting, and—perhaps most important—a valuable aid to health. Yet in 1976 4631 people were seriously injured and 300 killed on bicycles in the UK.¹ This need not happen, and experience from the Continent indicates that cycle lanes and improved junction control¹ can be provided cheaply and easily if Government interest could be awakened. These measures are just as important as the new attitudes you discuss with regard to pedestrians; the cyclist has for too long remained the poor relation of the motorist, suffering doubly from his fumes and his aggression.

TONY WATERSTON

Department of Child Health,
Ninewells Hospital,
Dundee

¹ Hudson, M, *The Bicycle Planning Book*. Mike Hudson. London, Open Books, 1978.

SIR,—I wholeheartedly endorse the recommendation of the Blennerhassett report highlighted in your leading article (3 February, p 287). Having worked in a medical unit actively concerned with the detoxification of alcoholics, I am amazed by the number who have been driving unrestricted up to the time of admission. In several cases patients have actually driven to the hospital, having already consumed their daily quota of alcohol. Although I impress on them the need to cease driving while in this state, I cannot force them to comply. The situation is not helped by the fact that these patients have a high tolerance to alcohol and often do not realise (or profess not to realise) that their blood level exceeds the legal limit.

What therefore can be done to ensure these patients do not continue to be a danger to themselves and others while under the influence of alcohol?

R GUEST

Fazakerley Hospital,
Liverpool

SIR,—As you say in your leading article (3 February, p 287), it is indeed curious how little attention your excellent series of articles on road accidents has attracted in your own correspondence columns. About 6600 people were killed on roads in the UK in 1977—one wonders what kind of public and professional reaction there would have been had there been an equivalent mortality for, say, rail travel during the same year. The daily carnage on our roads resembles a continuing minor war yet society accepts it as inevitable.

You deserve praise for trying to make us members of the medical profession think of the problem in medical terms—as a public health problem, an avoidable cause of mortality, a problem capable of solution using conventional epidemiological models. Perhaps professional attitudes are slowly changing—our changing

point of view about seat-belt legislation being an example. But we do still have a long way to go.

JAMES BEVERIDGE

Norwich

SIR,—I arrived home after a short holiday to find your latest outburst on seat belts awaiting me (leading article 3 February, p 287). One can only admire your tenacity and zeal, misguided and wrongheaded though it be.

The resounding apathy that has greeted your series is, I feel, a measure of the importance it has for most people. Indeed, I am reluctant to spend yet more time and ninepenny stamps on the matter, but one cannot allow to go unchallenged the assertions of those who think they know best as they seek to pile yet more unnecessary laws on the citizenry. No amount of pleading a special case alters the fact that it would be an unjustifiable intrusion into the liberty and right to choose of the people, nor can your emotional rhetoric be allowed to obscure the fact that the citizens' welfare is, to a large extent, their own responsibility. This attempt to bully people into action "for their own good" must stop before it gets out of hand.

There is a gleam of hope in your acknowledgment of the need to enforce the existing sound and sensible laws on drunken and dangerous driving, although your avowed intention to educate the police has disturbing overtones. But I am confident the sturdy common sense of the constabulary will triumph. Anyway, they are too busy dealing with real crime to have the time to act as a general nursemaid.

One hopes we have seen the last, for the time being, of this more unpleasant aspect of the nanny mentality in what is fast becoming the Nanny State. Let the people decide.

J C ALLEN

Leicester

SIR,—May I suggest that the pocket would be more powerful than Parliament in inducing people to wear seat belts (leading article 3 February, p 287).

The insurance companies could, by common agreement, halve the compensation payable for road traffic accident claims in cases where a seat belt was not worn at the time of the accident. This action would have more effect on public attitudes to seat belts than any new law. We already have more than enough ineffective legislation.

C P MAYERS

Holsworthy, Devon

Road accidents and legal sanctions

SIR,—Your special correspondent's article on road accidents and legal sanctions (27 January, p 245) was timely.

Compliance with traffic laws depends on the social attitudes of road users and the effectiveness of enforcement. The 1967 "Drink-and-drive" Act failed because drivers soon realised that the risk of being caught was small. An initial fall in deaths was followed by a progressive rise, and since 1973 the proportion of drivers killed in road accidents with more than the legal limit of alcohol has always been above 30%.¹ The enforcement of the 1970 Act dealing with driver training and testing of