patient's drinking pattern. He must admit defeat by alcohol and if he desires no future punishment he must surrender unconditionally by becoming and remaining abstinent. Any compromise is an admission of failure, not only by the patient but also by the therapist. It is a common fallacy to think that the reasons why individuals use or misuse alcohol are important. In fact they are immaterial, as they are as numerous as the frailties of man. Susceptibility to alcoholism is increased by alcohol ingestion and all alcohol drinkers are potentially vulnerable. They are temporarily protected by their tolerance or moderation, which can vary according to circumstances, the disappearance of either producing vulnerability.

The very complexity of man prevents perfection in every detail. We all have flaws in our construction. Attempts to repair these flaws by alcohol consumption prove unsuccessful as the original disability still persists even if temporarily camouflaged. The reasons why people drink do not matter; it is because they drink that alcoholism occurs. The treatment for alcoholism is abstinence. All therapists must understand, recognise, and acknowledge these facts. Only then can their energies be directed in a positive manner for the patient's benefit. He must be persuaded to accept the diagnosis and treatment. The attractions of freedom from alcoholism must be emphasised and abstinence should be portrayed not as a punishment but as a relief. The patient must desire a change from his intolerable problems, appreciate the process of recovery, and recognise the necessity to maintain this improvement. The therapist can only advise and observe; he cannot compel. Therefore he must elicit the full co-operation of the patient.

Alcohol is an evil drug. It has been destroying man since Genesis. Society suffers from alcoholism because it condones alcohol ingestion. Western civilisation regards abstinence as abnormal. Such is the power of alcohol to deceive.

NEIL PANTON

Romsey, Hants

Abuse of herbal cigarettes containing stramonium

SIR,—We wish to report the following instance of drug abuse.

On the evening of 12 October a man of 19 was seen urgently at home at 11 pm at his parents' request, having been brought home by friends who were concerned about his condition but, as it turned out, gave a cover-up story of his having been drinking. When seen by his family doctor he was overactive, extremely anxious, overtalkative, losing the thread of what he was saying, and misconstruing what was said to him and what was happening to him. He was disorientated for time and place. He could not put his shoes on and was picking at invisible spots on his trousers and sweater. He talked of four black vans coming because "someone's going to freak out" and he was frightened of "six big red men" advancing on him.

He had fixed, widely dilated pupils, a bounding pulse rate of 110/min, and a blood pressure of 100/70 mm Hg. There were no signs of any intravenous needle marks. He was admitted to hospital for overnight observation and there no other abnormal findings were noted; all his reflexes were brisk and equal. He was noted to have wet himself, but there was no history of a fit. He was still hallucinated and on hearing a generator going instantly associated it with the Van de Graaf pop group.

During the night he was restless, sleeping fitfully, and remained anxious. By 7 am his pupils had returned to normal size and were reacting normally. He was no longer hallucinated, but alarmed that he had completely lost track of 16 hours.

Later that morning he related that at 2 pm the previous day he had unrolled 18 Potter's Asthma Remedy cigarettes, made an infusion of them, and then drunk the resultant brew, which, containing stramonium, had produced the resultant clinical picture. He had had no other drugs at that time and could not recall how quickly the potion took effect. His friends, who found him at 5 pm in their room, took turns to watch over him until they became so anxious that they took him to his own home.

The idea for trying the herbal cigarettes and therefore, knowingly, stramonium had come from the August pop festival at Knebworth, when it was being recommended by word of mouth as a new type of "trip" and a substance that did not make you vomit—unlike marijuana if taken in excess.

This young man has been extremely frightened by the result. It may be that other people will try such cigarettes prepared in a similar manner.

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Barbiturate prescribing: views of accident and emergency staff

SIR,—I read with great interest the recent report by Dr B M Barraclough on "Barbiturate prescribing: psychiatrists' views" (16 October, p 927) and the letter from Professor E Wilkes on "General practitioners and barbiturates" (p 939). In July 1975 I carried out a one-month prospective survey in 62 London casualty departments of all patients attending with drug-related problems. During this period there were 1641 episodes of drug overdose in patients over the age of 15 years, and barbiturates were used in 381 incidents (22%). They were the commonest drugs used by male patients (28%). Moreover, 54% of drug-dependent individuals used barbiturates in a drug overdose.

These figures clearly show that the staff of casualty departments bear front-line responsibility for dealing with the more serious consequences of drug-related problems. Their views on barbiturates and other drugs are of potential interest and value. A 14-page questionnaire exploring the attitudes of accident and emergency staff to patients with drug-related problems and recommendations

Barbiturate prescribing: views of casualty department

	Ambulance personnel (n = 212) %	Nursing staff (n = 668) %	Doctors (n = 188) %	Non-medical casualty staff (n = 153) %	Total response (n = 1231) %
There should be a voluntary ban on the prescription of barbiturates by doctors	64	60	56	59	60
	15	19	34	13	20
	21	21	10	28	20
Regular publicity campaigns should be organised to encourage people to hand back surplus drugs	95	93	87	93	93
	3	3	6	5	4
	2	4	7	2	3
Drug education should start with young people while they are still at school	89	85	79	86	85
	6	6	11	7	7
	5	9	10	7	8
All prescribing of narcotics (heroin, methadone, etc) for addicts should stop	59	38	33	41	50
	23	32	47	23	36
	18	30	20	36	14

for their care was distributed to the staff of 60 casualty departments in Greater London and to ambulance personnel. A total of 1231 questionnaires (90% of those sent out) were completed. The data obtained are currently undergoing analysis, but I present here the responses to four questions which I think are relevant to the issues raised by Dr Barraclough and Professor Wilkes. The table below shows the responses of the emergency staff subdivided into different disciplines.

It is clear that the majority of the staff support a voluntary restriction on the prescription of barbiturates, and most believe that publicity campaigns and early drug education are important.

A HAMID GHODSE

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Road safety: BMA comments

SIR,—As road safety is primarily a traffic engineering matter may a pioneer member of that empirical science make a few comments on the BMA comments (23 October, p 1000)?

The first pioneer of it was Bennett, then county surveyor of Oxfordshire—I was his chief assistant—who before the war showed that there is seldom a single "cause" of an accident but that there are almost always several features in it, and that if one of these had been changed it would not have happened. He argued that the term "cause" should be dropped and "factor" used instead. It is wrong to say that there is a sole "cause" of an accident and it is regrettable that the Road Research Laboratory and the BMA should still use that misleading term.

I would not quarrel with the statement that "human factors" contribute to 95% of accidents, though I would put the figure at almost 100%, but it is essential to realise that it is not always driver error. It may even be wholly on the part of others. Of three fatalities in which I have recently been consulted in connection with litigation, two were wholly due to wrong design of cambers laid down in Ministry manuals and on which a driver could not possibly be expected to know the error. One did not go to court at all and in the other the Ministry paid substantial damages to the widow of the dead driver. In the third case the Ministry was at least as much to blame as the driver and settled out of court for a 40% share of the damages, which I, as expert witness, did not think enough. If you are going to study the human factors you will have to study the whole of the adult population and it would be more useful to start with the legislature and judiciary.

The BMA comment seems to disparage accident "rates," but it is impossible to make proper comparisons unless we use them. Obviously we cannot compare, say, Malta, the UK, and the USA directly without allowing for populations, etc;

neither can be compared the UK in 1946, when there were 3 million motors, and in 1974, when there were 17 million. We must have some comparative rate, and if this is improving we are entitled to claim that we are making progress. The large number of deaths is at least partly due to the enormous number of motors. It is also remarkable that your profession, who are in the best position to know, should neglect the large saving in lives made by the motor in enabling you to get to your patients more quickly and to get them to hospital promptly, in enabling the fire brigade to reach fires early, and so on.

This mistake has been made twice, if not three times, with tragic results. Between 1946 and 1956 the number of deaths rose slightly, although the "Smeed rate"—which allows for the population and number of motors—and the deaths per 100 million vehicle-kilometres both fell markedly. The rise in deaths, slight though it was, was blamed wholly on the drivers, though the number of motors had risen from 3 million to 6½ million. An Act increasing penalties was passed, the trend of the deaths rose sharply, and both rates rose. This was again blamed on the drivers and another Act, much increasing penalties, was passed in 1962. The deaths then rocketed upwards to the highest they have ever been, almost 8000, the rise being as much as 1100 in one year. When they fell again in 1967 the fall was claimed for the alcohol regulations in spite of many other measures taken at the same time which would reduce the deaths. The rises were ignored. The deaths then rose again and nearly reached the "Marples" summit. The probability is that all three Acts increased the deaths.

I agree with you about the recording of accidents and strongly condemn the popular use—once again even by the RRL—of the word "casualty" for minor bruises and cuts. Worse still is the use of the word "maim" for these, though I think I heard—at 77 my hearing is not 100%—a prominent member of your Association do it on TV recently.

Unfortunately, however, it does not seem possible to get the full information about the human factors. I have tried it. You must remember that the object of accident investigation at present is to find out if a driver—and a driver only—can be prosecuted, and once that has been decided the armour-plated door clangs to and nothing more can be done. I even tried to find out whether drivers concerned were local and knew the road—important information—in my studies. The chief constable refused to ask this question on the grounds that it might produce prejudice. I could not argue with him. God knows there is enough prejudice already. I think you will find that to get the information needed would need the total reform of the law, though this is badly overdue. You must, however, remember that we engineers know how to stop the accidents. We have done it many times. I have done it. What we need is the money.

J J LEEMING
Former County Surveyor of Dorset

Buckfast, Devon

Clinical integration

SIR,—Your leading article (23 October, p 964) does not mention the vast financial saving to the NHS which would result from co-ordination of hospital and general practitioner services. The present arrangement of large outpatient follow-up clinics in hospital duplicates much of the GP's work and is wasteful of scarce NHS resources. The four common disorders of dyspepsia, stroke, hypertension, and diabetes which you mention are far better cared for in

general practice; I do not think that reliable readings of blood pressure and blood sugar can be obtained in the hospital outpatient clinic. However, the problem of long-term follow-up and chasing up of defaulters is one which has not yet been solved in general practice and is an area which could well benefit from hospital experience.

Integration should also involve the social services. A great deal of the work in general practice would be done better by a social worker attached to the practice as a member of the primary health care team. Pooling of information and resources would again make an enormous financial saving.

GEORGE STRUBE

Crawley, Sussex

Survival at sea

SIR,—May I draw attention to an error in your leading article on this subject (30 October, p 1026)? The first step in improving naval lifesaving equipment after the second world war was the inflatable lifejacket, not the liferaft.¹

May I also comment on the statement that the survivor's need is for water rather than food, except in extreme cold? Lest it be inferred that water is not important in cold climates it should be noted that many seafarers in antarctic seas have reported to the contrary—for example, Sir Ernest Shackleton, "Thirst took possession of us. . . . Lack of water is always the most severe privation that men can be condemned to endure,"² Commander F A Worsley, RN, "All hands were suffering from the sensation of thirst. . . . Our raging thirst prevented us from eating,"³ and more latterly Dr David Lewis, "Chronic thirst remained a constant preoccupation. Two fingernails came off today."⁴ Wartime survivors in arctic seas likewise reported their craving need for water; one stated, "No one ate very much, nor complained of being hungry, but we all craved for a drink."⁵

E C B LEE

Bath

¹ Holt, W J, *Transactions of the Institution of Naval Architects*, 1955, **95**, 332.

² Shackleton, E H, *South*. London, Heinemann, 1919.

³ Worsley, F A, *Shackleton's Boat Journey*. London, Hodder and Stoughton, 1940.

⁴ Lewis, D, *Ice Bird*. London, Collins, 1975.

⁵ Lee, E C B, and Lee, K, *Exposure at Sea*. Proceedings, Studies Section, International Radio Medical Centre, Rome 1968.

Diets for diabetics: no added sucrose

SIR,—My recent letter (23 October, p 1011) contained a mistake about the sucrose content of Professor J W Anderson's diabetes diet. The sugars in the US diet average 20-25% energy and in the diet of the American Diabetes Association are about 20%. Dr Anderson had reported that the proportion of "oligosaccharides"—that is, sugars—in his diet was 20%.¹ A colleague pointed out that I should not regard these as sucrose, but by then it was too late to prevent publication of my letter. I wrote to Dr Anderson in Kentucky for more details of his diet, previously not published. He replied very kindly and promptly (27 October) that "our diets contain about 25% of total carbohydrate as simple sugar." (From previous letters and articles I had misinterpreted this to signify "simply sucrose"). But

the letter continued "no added sucrose . . . less than 20 g per day". I also noted that fat had with safety been increased from 9% to 15%, thus increasing palatability. There are each day 13 servings of wholemeal bread and five servings of starchy vegetables. After two weeks' hospital treatment over 20 diabetics have been able to discontinue sulphonylurea; also those receiving 15-25 U of insulin each day have been able to discontinue it, but not those requiring more.

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¹ Kiehm, T G, Anderson, J W, and Ward, K, *American Journal of Clinical Nutrition*, 1976, **29**, 895.

Hypotension during angiotensin blockade with saralasin

SIR,—Sodium depletion has been commonly recommended to identify angiotensinogenic hypertension with the competitive angiotensin antagonist saralasin.¹ However, the decrease of blood pressure obtained after saralasin infusion in a severely sodium-depleted state may give more information about the extent to which the renin-angiotensin system was stimulated than about the true angiotensin-dependent nature of the hypertension itself. Moreover, saralasin infusion in a severely sodium-depleted subject may lead to a dangerous fall of blood pressure, as was demonstrated by Dr R Beckerhoff and his colleagues (9 October, p 849). In addition to their findings we would like to report our experience with saralasin infusions in a hypertensive patient before and after six days' treatment with chlorthalidone 100 mg daily.

The patient was a 43-year-old man with a blood pressure of 175/120 mm Hg. Renal arteriography showed a severe proximal stenosis of the left renal artery. The patient received no medication. After three hours of recumbency saralasin was infused at increasing rates (0.5, 5, and 10 ng/kg/min) while the patient was on moderate sodium intake (urinary sodium excretion 93 mmol(mEq)/24 h). Blood pressures were recorded automatically by an Arteriosonde. Only a small decrease of blood pressure, from 160/110 to 150/108 mm Hg, was recorded after 45 min of saralasin infusion (see figure). A short initial rise of blood pressure was noted within 5 min after the beginning of the lowest infusion rate. After six days chlorthalidone 100 mg/d, resulting in a 2.8 kg decrease of body weight, an immediate fall in blood pressure from 136/108 to 108/87 mm Hg was observed at the

Blood pressure recording during saralasin infusion before and after sodium depletion with chlorthalidone 100 mg daily for six days.