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.

ELIZABETH A HARRISON
D H MORGAN

Psychiatric Department,
West Norfolk and King's Lynn
General Hospital,
King's Lynn, Norfolk

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

Addiction Research Unit,
Institute of Psychiatry, London SE5

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;