The abolition of pain probably involves the abolition of most other unpleasant mental processes as well, which presumably amounts to euphoria. And which of us doesn't like euphoria?—I am, etc.,

PETER MOFFITT.

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Dangers of Barbiturates

SIR,—Drs. Elizabeth Tylden and Christine F. T. Saville (4 April, p. 49) advance further excellent reasons for restricting the distribution of barbiturates on the basis of their experience with the devastating effects of addictive barbiturate abuse. That serious consideration should be given to restricting barbiturates on the grounds of their notorious frequency in suicidal self-poisoning has already been discussed in your columns.^{1,2}

Now that satisfactory and safe alternative hypnotics such as nitrazepam are available it would seem high time that prescribing of barbiturates, at any rate to outpatients, be restricted or better still abandoned.—I am, etc.,

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SIR,—It is salutary to read accounts in the press of an event about which one knows the facts, as so seldom did the event seem to occur in the way it was reported. We were disturbed to find that your leading article (28 March, p. 770) misrepresented us in fact and opinion. You state that "out of 994 cases admitted 66 denied the act of self-poisoning." In fact our paper¹ said that 66 patients *supposedly* denied the act of self-poisoning, but after scrutiny of case records to exclude miscodings, "the authors agreed that self-poisoning was denied despite evidence to the contrary on 31 admissions by 29 patients."

Automatism is "the performance of action not the consequence of conscious effort."² The question at issue is whether drugs can produce a mental state in which further self-poisoning can occur as an involuntary, mechanical act, or whether the self-poisoning act is deliberate, whatever the motive and despite unintentional consequences.

You suggest that discrepancy between the reported high incidence of automatism in Sweden and its rarity in Scotland is diagnostic fashion, when it is clearly attributable to definition of terms for identification of cases. Jansson³ defines automatism as "poisoning where the person involved gradually has consumed an overdose of hypnotics in order to get to sleep without any intention to commit suicide." This definition does not demand that the patient has amnesia for ingesting previous doses of the drug and has carried out motor acts without awareness. The fact that the person does not wish to commit suicide does not

make *self-poisoning* an accident nor a deliberate act an automatic one. The assumption quoted by you that the discrepancy in incidence between Sweden and Scotland might be due to a difference in liability to psychogenic amnesia cannot be attributed to us.

Our results were reported in order to make available facts on which opinions could be based, and to attempt to clarify confusing clinical events. Clearly we failed since your leading article maintains that "automatism seems to be a respectable version of *accidental* (our italics) self-poisoning." Accident can only be an explanation for poisoning that is unintentional. From our evidence we contend that "automatism" is a form of *deliberate* action, about which there is amnesia psychologically determined. To use the term automatism is then a paradox. It has been given a cloak of respectability by the medical profession on the basis of such meagre evidence that it has been described as "an appeal to credulity which ought not to be attempted in an intelligent society."⁴

Coroners and others have to rely on advice from medical authorities, a source of which should be your leading articles. On this occasion you have failed to give clear direction on either the usefulness or the dangers of the term for medical usage. We challenge you to produce evidence that barbiturate poisoning can occur as a result of an involuntary action due to amnesia while in a state of clouded consciousness. Only then can barbiturate automatism be retained as a malady and not discarded as a myth.—We are etc.,

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SIR,—I feel that it is important to alert general practitioners to the fact that young people who are coming to them asking for sleeping tablets may be addicts. We have had cases where in-patients in the Drug Addiction Treatment Unit at Bexley Hospital, who were being withdrawn from heroin or phsyptone, attended general practitioners' surgeries representing themselves as outpatients and obtained quite large quantities of barbiturates or Mandrax (methaqualone and diphenylhydramine), on the basis of fabricated histories. There is a need for doctors to be particularly cautious in prescribing hypnotics to people in the age group 16 to 25 years, which corresponds to that of most addicts.

Barbiturates are far from being the "soft" drug they are called, when grossly misused. They may be injected persistently, in spite of the misery of the abscesses this produces and the risk of resulting septicaemia. Chronic misuse of large doses also results in epileptic fits and other severe withdrawal symptoms in the intervals when the supply has run out. There is also danger of overdose, orally or by injection.

This is a problem among heroin users who run out of their daily maintenance supply, and also of other young people who are addicts to soft drugs only.—I am, etc.,

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Purification of Ampicillin

SIR,—May we congratulate Dr. E. T. Knudsen and others on their success in reducing the incidence of rashes by "purifying" ampicillin (21 February, p. 469). Ampicillin causes other, more serious reactions as well as rashes, and it is to be expected that these will also be diminished by "purification."

The responsible "impurity," according to them, is a penicilloyl protein similar to that found in 6-APA, as reported by Batchelor *et al.*¹ and by one of us.² In subsequent investigations of ampicillin, we have not always been able to detect a protein impurity, meaning by that an impurity with unexpected amino acids, but we have detected and described³⁻⁵ peptide polymers composed mainly of subunits of intact or degraded ampicillin molecules which yield, after acid hydrolysis, phenyl glycine, valine, alanine, and dimethyl-cysteine; that is, those amino acids which could be liberated by internal reaction or breakdown of the intact or decyclized ampicillin molecule. Various polymers can therefore be formed, but one such, with a molecular weight of about 5,000, has immunogenic and allergic potency in experimental animals, and we are wondering if this is part of the "protein impurity" reported by Dr. Knudsen and colleagues.—We are, etc.,

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Epileptics on Phenytoin

SIR,—Dr. F. B. Gibberd and others commented (17 January, p. 147) on the wide variation in serum levels of phenytoin between epileptics prescribed the same dose. They presented evidence that irregular taking of tablets is one important source of this variation. We are studying patients who have had a myocardial infarction and in whom the possible usefulness of phenytoin as a long-term anti-arrhythmic is being evaluated. Using Wallace's method,¹ which measures a specific benzophenone derivative of phenytoin, and using whole blood, we have observed similar wide variations. So far our findings differ from those

of Dr. Gibberd and his colleagues in that blood levels in our patients are significantly higher in those prescribed 100 mg. q.i.d. than in those prescribed 100 mg. t.d.s.

Another source of variation in our patients is suggested by the fact that the mean blood levels of patients prescribed phenytoin alone tend to be higher than those of patients prescribed one or more additional drugs. The mean blood levels estimated as the specific benzophenone derivative are $6.9 \pm 4.5 \mu\text{g./ml.}$ (27 observations) in the former, and $5.2 \pm 2.6 \mu\text{g./ml.}$ (112 observations) in the latter. The difference between means is highly significant ($p < 0.05$).

The additional drugs are most often digoxin, diuretics, anticoagulants, and psychotropic drugs. We have been unable to associate any single one of these with particularly high or low blood levels. When patients are rated on their own estimates of how often they omit a dose of phenytoin, their replies accord with the notion that prescription of additional drugs is associated with more frequent omission of a phenytoin dose than when phenytoin is the only drug prescribed. While at this stage the possibility is not excluded that we are observing the effect of specific drug interactions, it is likely that multiplicity of prescriptions contributes to omission of doses and hence to the variability of blood phenytoin levels.—We are, etc.,

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REFERENCE

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Epidural Analgesia in Labour

SIR,—During the last five years epidural analgesia has been increasingly used in the obstetric departments of this teaching hospital group. Several interesting facts have emerged. Two are of particular interest and are reported here as a graph.

The graph shows all numbers expressed as a percentage of the total number of deliveries per annum. The number of women delivered under epidural analgesia is a steeply rising line.

Though the majority of women given epidural analgesia have an operative delivery, the rising epidural rate has had no effect on the total rate of instrumental delivery. This suggests that common medical indications for epidural analgesia tend to select women who anyway would have required operative help. It is our experience that as the indications widen, and as more "normal" labours are included, so the number of normal deliveries under epidural analgesia increases. We are watching this rising trend with interest. The later figures show that as the epidural rate approaches 30% so the incidence of non-operative deliveries approaches 40%.

The other point of interest is that the number of general anaesthetics for operative vaginal delivery has been reduced from 4% of all deliveries (20% of forceps/ventouse deliveries) to virtually nil. General anaesthesia has recently been confirmed as an important factor in maternal mortality. The last *Confidential Report*¹ showed a rise in deaths both absolutely and relatively.

Apart from any consideration of mortality there are emotional gains. The patients' complete lack of discomfort during a forceps rotation delivery under epidural analgesia is difficult to believe until witnessed.

Our departments are currently delivering more than 400 women annually under epidural analgesia. These are blocks mostly given by junior members of the anaesthetic team. The technique used is that described by J. B. Wyman² *et al.* and the drug bupivacaine. We have seen no serious complications.—We are, etc.,

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- ¹ Arthur, H., *et al.*, *Report on Confidential Enquiries into Maternal Deaths in England and Wales, 1964-1966*. London, H.M.S.O., 1968.
² Duthie, A. M., Wyman, J. B., and Lewis, G. A., *Anaesthesia*, 1968, 23, 20.

Recruits for Venereology

SIR,—I would like to comment on Dr. W. Fowler's letter (28 March, p. 816) regarding the difficulty of recruitment to the "unattractive" specialty of venereology. The problem, which is already serious, is likely to get much worse in the next decade owing to the increasing demands made on the relatively small pool of available medical manpower by other more "attractive" disciplines. It should be emphasized here that clinics throughout the country are now seeing more patients than ever before.

To the informed, interested, and enthusiastic doctor no branch of the practice of medicine is unattractive, and to this statement venereology is no exception. Its image, however, as Dr. Fowler points out, is unattractive. To my mind there is no simple, single measure which could do so much for the status of the specialty and for the well-being of the majority of our patients as a change of name, such as that suggested

in your leading article of 21 February (p. 447).

Venereology is a bad name for a number of reasons. The most important is that a majority of our patients do not have venereal disease. It is therefore unfair to subject them to the stigma which unfortunately in many places is still firmly attached to the V.D. clinic. Many of our colleagues, especially in general practice, are disinclined to refer patients to us with disorders other than true venereal disease for this reason, even though our opinion might be welcomed. This attitude is further reinforced by the appalling premises that the clinics are still compelled to work in. To rename them departments of genito-urinary medicine or some similar title would allow busy practitioners to refer a much wider spectrum of illness without their having to offer wearisome explanations such as: "I am going to ask you to see a doctor who is a specialist in V.D., which I do not think you have, but he is very interested in your problem, etc." Such explanations only confuse the patient and increase his normal apprehension.

A change of name will not prevent the venereologist in any way from continuing to diagnose, treat, and prevent syphilis, gonorrhoea, and chancroid. It will give him patients who will not be ashamed of consulting him and in my opinion it could do something to encourage recruitment to the specialty.—I am, etc.,

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Colour in Rhodesia

SIR,—I have recently served as senior examiner in the final examination for the degree of M.B., Ch.B. Salisbury and Birmingham. The hospital over which the question of "patient-apartheid" arose in fact does not exist. When completed in a few years, however, I find it impossible to believe that the splendid teaching staff, nurses, and medical students would behave any differently from what is accepted as good manners at the Teaching Hospital, Harari. There are only African patients at Harari—a few busy hospital. I saw no trace of apartheid-nonsense during my two-week visit. Moreover the atmosphere on the hospital campus was non-racial. The swimming pool for nurses and doctors was entirely "mixed," while more formal social or professional meetings ignored the race or colour of those attending.

Who will suffer if we desert our colleagues in Rhodesia? The African, whether near Salisbury or far out in the countryside where without doctors, midwives, and nurses the ancient tale of suffering will continue to be told. Surely no one intended to punish Rhodesia by cutting off medical aid? It is some consolation that the Senate of Birmingham is pressing for funds so that we may fulfil our moral obligation to those students already in training who set out in good faith to qualify M.B., Ch.B., Salisbury and Birmingham.—I am, etc.,

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