The problem of drug diversion is common in methadone clinics. In many services it is accepted and not judged to require a major response. Some units, however, judge things differently and make patients collect their drugs on a daily basis. In Nottingham we take a tolerant stance. Patients who fail to keep appointments and provide urine specimens have their prescription gradually reduced while those known to divert their drugs have a quicker and more final reduction.

Methadone has a vital role in involving drug misusers in treatment, in controlling craving and, hence, reducing criminality[2]. Prescription of substitute opiates alone cannot eradicate illicit heroin use but works when used in conjunction with psychosocial therapies.

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Breast feeding retention rates and supplementary feeds

Fashion in therapeutics (October 1993 *JRSM*, p 609) is nowhere more apparent than in obstetrics.

Breast feeding is widely acknowledged to be of great importance in infant well being. The notion that supplementing feeds is detrimental to the establishment of successful breast feeding has been accepted[1]. Our own figures suggest that this should be re-evaluated.

In Meningie, a small town in South Australia, two doctors working from one hospital provide medical care to a population of 4500 Caucasian and aboriginal people in an area of 1600 km^2. In hospital, 'top-up' feeds of dextrose or cow's milk formula are given to babies at every feed until the mother's milk is fully established around 3 days post partum. Records of 100 consecutive deliveries were reviewed for subsequent breast feeding rates. At 3 months, 67% of all patients were fully breast feeding. The rate in the sub-group of 88 who expressly intended to breast feed, was 76%. These figures were compared with those obtained from a 1992 statewide survey of 1277 mothers conducted by the Child Adolescent and Family Health Service (CAFHS) which is strongly against supplementary feeding. In the CAFHS survey the full breast feeding rate at 3 months was significantly different to ours ($P<0.003$), being only 52%.

There are many caveats. The populations overlap but may not be directly comparable. When these are allowed for, there still appears a benefit from 'top-up' feeds in increasing breast feeding rates. It may be that an empty breast has already been maximally stimulated and that a frustrated mother and an overtired, hungry baby, do not make for contented, successful breast feeding.

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Call selection of the helicopter emergency medical service

I read with interest the paper by Coats and Newton (April 1994 *JRSM*, pp 208-10). They present a well-balanced review of the complexities involved in the process of call selection for a medical helicopter system. Unfortunately, the authors' data do not support their inference (viz. 'telephone triage by an experienced paramedic enables the appropriate utilization of a helicopter to be significantly improved'). Whilst I do not dispute that improvement may have occurred during the study period, reference to Figure 1 in their paper clearly shows that this phenomenon had begun *6 months before* the creation of the Special Incident Desk. Evidently, some other factor was wholly or partly responsible for the apparent improvement in performance. More critical review of the system's operational data in the light of that fact might prove valuable.

I would further suggest that the primary dispatch model used by the London Ambulance Service (LAS) is sub-optimal in terms of system design. Secondary dispatch (i.e. after request by on scene ground crew) offers the following theoretical advantages:

(i) a rapid initial response by the nearest land ambulance
(ii) assessment of the patient followed by a *measured* and *informed* decision as to whether helicopter transport is necessary; this can improve overall cost effectiveness by reducing the overtriage rate (which approached 340% in 1991 for the system under discussion)
(iii) the minimum on scene time - the helicopter response interval can be used to stabilize and 'package' the patient
(iv) rapid transit from the scene to an appropriate destination hospital

The above model hinges on the ability of land-based paramedics to assess and recognize critical injuries. Whilst recognizing that training every LAS paramedic to such a level represents a daunting task, such an approach might lead to a more unified and comprehensive system of trauma care than the model that the LAS have chosen to adopt.

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The origin of the Society's motto

I hope the short article by Dr Theodore James (May 1994 *JRSM*, p 255) will not be taken to throw any new light on this matter. Martial's 'valere' in the motto is of course the right idea for the Society: strength, vigour, health. For some reason Dr James traces Martial's thought back to 'living well' in Plato's *Crito*, although only a few words later on in that dialogue, Socrates said that to live well means the same thing as to live honourably or rightly; and 'living well' in his particular circumstances meant allowing the state to execute him. There is not a tenuous trail leading back from the Society's motto to Plato's *Crito*: there is no trail at all.

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The author replies

Dr Forrester's acute observation is correct, as far as it goes. However, immediately preceding, in 47 D, Socrates, in his dialogue with Crito, begins a direct comparison first with the body for which 'living well' is benefited by health and injured by disease. Then, when he has obtained Crito's agreement, Socrates compares this *physical* state with the *philosophical* attitude that living well and living rightly are the same.

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