the large bowel and found that they did not give rise to malignancies.[7] At Baragwanath Hospital, colonoscopy studies (over 100 a year) confirm absence of polyps; the colons even of elderly black patients have the same appearance and elasticity as those of young white patients.[8]

Conceivably, any population subsisting on a diet high in foods containing fibre could be similarly protected. In the early 1800s rural Scots ate oat porridge three times a day, seven days a week, with a thick vegetable soup at night.[9] In England, rural farm workers consumed a huge amount of bread, several times our present consumption,[10] but virtually all were active physically. Perhaps their gastrointestinal tracts resembled those of rural Africans in their lesser proneness to disease. Present dietary guidelines, however vehemently urged, will never cause the gastrointestinal tract to revert to its pattern in former times.

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Waiting lists out, booking systems in

SIR,—Miss Linda Beecham describes a "revolutionary" new system for booking patients in for operations. I was appointed consultant surgeon in West Berkshire in 1977 with outpatient clinics at Battle Hospital, Reading, and Newbury District Hospital. All patients seen at Battle Hospital have their operations there; most patients seen at Newbury Hospital can have their operations there, but those with more major problems are admitted to Battle Hospital.

From the date of my appointment I ran a diary system at both hospitals, every patient needing surgery being given a date for admission and operation. I still continue this practice at Newbury Hospital. At Battle Hospital, however, in August 1989 a management decision resulted in 18 beds and three operating lists being taken away from the two consultant firms on which I work. I was forced to start a waiting list. During the past 18 months, from having no patients on the waiting list at Battle Hospital I now have 97, 25 of whom have been waiting for more than six months.

Even if the beds and operating sessions that were taken away were returned there are now too many patients on the waiting list for the diary system to be reintroduced. Proposals such as those suggested by South Western Regional Health Authority are excellent in theory but fail to take into account those patients already on the waiting list. There are two prerequisites before waiting lists can be abolished: firstly, an initiative has to be taken to create over a defined period extra beds, operating sessions, and staff to work off the existing waiting list; and, secondly, adequate facilities (beds, operating time, and staff) must be made available to maintain a booking system. I doubt whether the political will and the finance will ever be made available to achieve these two prerequisites.

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DRAMS scheme

SIR,—We wish to clarify the Health Education Authority's position about the DRAMS (drinking reasonably and moderately with self control) scheme, which was developed in Scotland by the Scottish Health Education Group (now the Health Education Board for Scotland).[1]

The Health Education Authority is the statutory body charged with health education and health promotion in England. It has agreed to introduce the DRAMS pack to general practitioners and others together with a range of materials, such as the COD (cut down on your drinking) pack, which we and others are currently developing for those working in primary health care. These materials address the issue of sensible drinking in a variety of ways.

Our intention is to acquaint general practitioners, trainers, and other staff with this range of materials and the different approaches through a series of introductory workshops. We hope that this will encourage general practitioners and regional advisers to make informed choices about alcohol training and support materials appropriate to their needs and the needs of their patients.

We are confident that the incentives contained in the general practice contract will help achieve the widest practicable dissemination of DRAMS, COD, and other materials beyond these initial workshops. We will be happy to supply further details of our plans to anyone who contacts us.

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Gradients of portable ramps

SIR,—We found Dr A F Travers's article on ramps and rails interesting,[1] having recently evaluated commercially available portable ramps for the Department of Health[2] and completed a separate study that aimed to establish gradients that could be negotiated by wheelchair users on two different lengths (1 m and 1·8 m) of otherwise identical portable ramps.[3]

In the light of the findings of the second study, we would query Dr Travers's recommendation that a ramp's gradient should not exceed 1 in 12 and should ideally be 1 in 20. Indeed, both the British Standards Institute and the American National Standards Institute recommend gradients of 1 in 12 or shallower,[4,5] but we found that gradients of 1 in 8 and 1 in 6 could be negotiated on both lengths of ramp by a significant number of subjects in our study. A gradient of 1 in 10 on the 1 m ramp could be negotiated with relative ease by most of the subjects, and we concluded that a short ramp with a gradient of 1 in 10 may be easier to accommodate (in terms of space) and to use than a longer ramp with the traditionally recommended gradients of 1 in 12 to 1 in 20. The short ramp required a short burst of energy, whereas the longer ramp required a slower, sustained energy expenditure. These results confirmed the findings of a study by the Disabled Living Foundation that recommended, for wheelchair users who propel themselves, a gradient of 1 in 10 on a 3 m ramp.[6]

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Brain, mind, insanity, and the law

SIR,—In his editorial on sane and insane automatism Dr P B C Fenwick repeats the canard that when a defendant is found to be suffering from insane automatism the judge must inevitably send him to a secure hospital.[1] This is not so. These defendants may be, and indeed are, sent to ordinary psychiatric hospitals, and the Home Secretary is by no means inflexible about their management. Thus in his research on the insanity defence and its consequences Mackay describes three cases in which the defendants were found to be insane, were sent to local hospitals, and were discharged within six weeks.[2] One of these was a person with epileptic automatism. This does not mean that the 1964 act is altogether satisfactory, only that it can be operated humanely, and the Criminal Procedure (Insanity and Unfitness to Plead) Bill now before parliament will definitely be an improvement as it will make the proper disposal in these cases much easier.

As an addendum, I should like to hear from Dr Fenwick when and where defendants suffering from anxiety are found to be insane. Mackay did not come across this diagnosis in any of those found insane in the years 1975-88.

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Been to Africa

SIR,—Recently a wealth of material has been published testifying to the benefits of an elective period spent practising clinical medicine in the developing world.[1-5] I agree with these sentiments, having recently returned from working as a lecturer in surgery in Nigeria. Clinical skills, operative experience, and management skills are all enhanced in a way that is not possible in the United Kingdom. Ms Alison Fiander, however, identifies a very real problem when she states that "unsupervised tropical experience is largely overlooked."[6]

Given the benefits attested to by so many, is it not time that formal links between clinical and