orthopaedic surgeons already too much harassed from orthopaedics by trauma work. But what chance would such junior consultants have when they tried to compete with their seniors for a proper slice for the accident service from the always-too-small financial cake? And why should trauma be denied the more experienced advocacy of a senior man who has the respect of his colleagues for the devotion that he has shown over the years to the chosen specialty that has been his primary interest?

The third and commonest error is the belief that orthopaedic surgeons are necessarily the proper specialists always to have charge of accident services, because fractures constitute by far the greatest number of cases. Sometimes they may be; but many of the really serious, potentially lethal, and worrying cases (usually head, chest, and multiple injuries) present problems that are not essentially orthopaedic at all. They are worrying because they need a good deal more than orthopaedic expertise, and the acquisition of this—as Mr. A. E. Bremner (10 October, p. 113) recognizes, and I agree with all he says—requires more than is currently regarded (even in the new training programme approved by the royal colleges) as necessary for the training of an orthopaedic surgeon.

Since regional hospitals treat the vast majority of injured people, it would seem that the teaching hospitals are not providing the type of man who is really needed to deal with trauma—simply a traumatologist. He need not displace the orthopaedic surgeon, the neurosurgeon, anaesthetist, or any other specialist. He would be a much-needed though new type of general surgeon who would still require their real expertise. There is no shortage of good young men who would be keen to do this type of surgery, but only provided there was a proper career structure ending in consultancy and not medical assistance.

Let us have this now so that these men can start training relevantly and as soon as possible for accident work; this badly needs to be allowed to have and to develop its own show.—I am, etc.,

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Amphetamines Outmoded

SIR,—I was dismayed to read the chapter on "Amphetamines and other Stimulants" in the latest edition of *Today's Drugs*. It appeared in a very similar form in an article in 1968.[1] It is perhaps a measure of the change in informed opinion that much of it reads so strangely today.

The report of the working party of the British Medical Association was published two years ago.[2] It concluded "that amphetamines and amphetamine-like compounds should only be prescribed for those conditions for which no reasonable alternative exists. . . ." It stated that these substances appear to have no place in the modern treatment of depression. They should be avoided as far as possible in the treatment of obesity, and, if they are used, should be prescribed for a limited period only. Their use in other conditions, with the possible exception of narcolepsy, should be discontinued. It has been shown in Ipswich that it is possible to practise in a "virtually amphetamine-free community." No amphetamines are stocked by Ipswich doctors or pharmacists, and no cases of abuse have been discovered since a voluntary ban on the prescribing of amphetamines was introduced a year ago.[3,4] In the light of these opinions and of this experience several of the recommendations in the chapter in *Today's Drugs* are quite unacceptable. In particular the use of preparations such as Drinamyl, in which an amphetamine is combined with a barbiturate, must be strongly condemned. They are highly addictive. Methylamphetamine (Methedrine) should not, as the author suggests, "be given orally as an alternative to dexamphetamine," since it so easily finds its way into the "black market." Its intravenous use to produce an abreaction—even in hospitals—is debatable. The fewer ampoules of intravenous Methedrine in circulation the better. The evidence that amphetamines and related compounds are of value in the long-term treatment of obesity becomes less and less convincing, and if they are used at all those with the least effect on the central nervous system should be given, and over a short period. Many obese patients are dependent on amphetamines—and are still obese.

There is always a delay between changes in medical practice and an account of them in a textbook. If it were not for the widespread misuse of the amphetamines, especially by the young, it is very doubtful if so complete a reversal of opinion about these substances would have taken place in so short a time.

The general problem of amphetamine misuse and methods of dealing with it are described in a report by a subcommittee of the Advisory Committee on Drug Dependence under the Chairmanship of Baroness Wootton.[5] It could be read with profit by all those who may be tempted to prescribe amphetamine-like drugs.—I am, etc.,

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Ban on Amphetamines and Barbiturates

SIR,—The Ipswich doctors who have shown "that it is possible to exist in a virtually amphetamine-free community" (9 May, p. 361) have rightly been acclaimed as pioneers. Dr. F. O. Wells confirms (28 November, p. 552) that no "amphetamines of any kind are now stocked by Ipswich doctors or pharmacists," and gives the encouraging information that no cases of amphetamine abuse have been discovered over the past year. A warning note, however, should be sounded. Some pharmaceutical manufacturers have been quick to note the trend against prescribing amphetamines and are now emphasising in their promotional material the fact that their appetite suppressant is "not an amphetamine." Many such preparations have, however, properties of mood elevation and addiction and have therefore been misused in Britain and in other countries. I refer especially to phenmetrazine and diethylpropion. It is to be hoped that misuse of these non-amphetamine drugs has not emerged in Ipswich or in any other towns sufficiently enlightened to proscribe amphetamines.

Dr. Wells is also to be commended for his drive to stop the prescription of barbiturates except as anticonvulsants. He advocates either the cessation of prescribing a night sedative or, if this is not achieved, conversion to nitrazepam (Mogadon). That this drug is effective as a hypnotic has not been disputed. That it is relatively innocuous in overdose is shown by the features in 102 patients admitted to this unit with self-poisoning by this drug. None was rendered more than soundly asleep, despite the ingestion in one instance of 80 tablets. No anxiety arose during their management. There is indeed no authentic record of death from overdosage with nitrazepam. Other possible alternatives to the barbiturates such as methaqualone (with or without an antihistamine), glutethimide, chlorpromazine, and ethchlorvynol are much more toxic in overdose. Moreover at least one preparation—methaqualone—alone or with diphenhydramine can produce addiction and be misused for "kicks."

By contrast the evidence regarding dependence on nitrazepam is, to date, very slender, and I would confirm Dr. Wells's opinion that it has not so far attracted misuse by teenagers. As an effective hypnotic, safe in overdose, with absence of misuse and reasonably priced, nitrazepam has much to commend it.—I am, etc.,

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SIR,—Like Dr. F. O. Wells (28 November, p. 552) I think we could ban all barbiturates except possibly phenobarbitone. I do not think this would prove a problem where addicts are concerned, as out of an army of barbiturate addicts I have only met two that use phenobarbitone very much. The addicts say that phenobarbitone fails to give them the euphoriant effect that they