the above small survey, which I hope to supplement, is that at least half the fatal accidents occurring after 10 p.m. in this area in 1953 were due to intoxication in motorists, cyclists, or pedestrians.

None of the above fatalities will be recorded in the official statistics as having any connexion with alcohol, the verdicts being "accidental death" (with a note of the chief injury), even in those cases where the driver was almost certainly drunk. Unless a driver is examined at once and is very obviously drunk, no conviction of intoxication can usually be obtained. In night accidents he seldom is seen at once. The certificate which is sent by the coroner to the registrar of deaths is based on anatomy and according to the chief injury—for example, fracture of skull—and there is no place for "conditions contributing to the death" such as is provided in the ordinary G.P.'s death certificate. The Ministry of Transport's Report also does not get to the root of the matter. It lists over 30 "contributory factors" to "drivers" accidents, but these so-called factors really are the manœuvres or mistakes which lead to the accident, such as "cutting in" or "speeding," the real "contributory factor" at the back of many of them being slight intoxication. In fact, official statistics support the pretence that a drinking driver is only a small danger.

No test for carelessness has ever been devised, other than by numbering the mistakes or accidents resulting, and by this test there is conclusive evidence that slight intoxication makes a man "accident-prone," and that the accident rate rises proportionately to the alcohol in his tissues. For this reason I think that chemical tests as well as clinical tests should be authorized as a routine in the examination of intoxicated persons.—I am, etc.,

Leicester. N. I. Spriggs.

References

[1] *Road Accidents, 1952*, p. 56, H.M.S.O., London.
[2] *The Recognition of Intoxication*, 1954, B.M.A., London.

Difficulties of Child Adoption

Sir,—I know two patients, a childless married couple aged 49 and 48, who have for the last four years been trying to adopt a girl of about 5 years old from anywhere. After strenuous efforts by myself and their solicitor, they have just been bitterly disappointed for the last time. They have given up in despair because the societies say they have no children available. This I cannot believe, judging from the agonizing letters which we receive from these societies through the post.

I can only attribute the shortage of children to the ridiculously jealous restrictions hedged around the children by the societies, and to an unfounded suspicion of those kindly disposed couples who wish to adopt, and of the medical profession, who often try to bring a child into a home in order to preserve the happiness of that home. The societies will reply "Aha! a child must be required for its own sake, and not in order to bolster up an unhappy home." But why? I should have thought that an otherwise unwanted child which could make an unhappy couple happy would more than justify its existence, and be far better off doing this than merely being an inmate of a home.

My object in asking you to print this letter is to find out if other general practitioners have had similar experiences, or if my problem is an isolated one.—I am, etc.,

North Walsham. P. M. Fea.

Cricket

Sir,—The B.M.A. *v.* Law Society Cricket Match takes place on Sunday, May 29, at Hurlingham Club, London, at 11.30 a.m. I have been asked by Council to make the necessary arrangements on behalf of the Association, so will any members who are active cricketers and who wish to have their names considered please get in touch with me as soon as possible, stating their "potentialities"?—I am, etc.,

The Little House,
Broadwater Down,
Tunbridge Wells. R. Prosper Liston.

POINTS FROM LETTERS

Postcards for In-patients

Dr. R. Douglas Howat (London, S.E.24) writes: One of my friends, who has been an invalid, has made out a scheme which, in my opinion, will save money and also undue anxiety, besides easing the calls made upon the overworked members of hospital staffs. The suggestion is that all hospitals should offer their in-patients printed prepaid postcards which they can send to their next of kin. Briefly, such cards would have a list of questions requiring only a "yes" or "no," or, where it is not possible for the patient to do this, a plus or minus sign can be substituted for "yes" and "no." The following questions are suggested: (1) Do you feel better? (2) Are you sleeping better? (3) Do you require any cash? (4) Do you require any cigarettes? Fruit? Chocolates? (5) Do you require any underclothes? (here specify type required); etc. A space would be left at the foot of the card for any additional wants by the patient, also a space for comments by the doctor, sister, or staff nurse. . . . Consider also the enormous saving of unnecessary telephone calls such a system would ensure, also the saving of unnecessary anxiety both on the part of the patient and the relative. Such cards would, of course, require to be of three types—namely, for men, women, and children.

"Topical"

Surgeon-Commander C. J. Robarts (B.F.P.O. 51) writes: Is the use of this word in relation to analgesia of the urethra really necessary? Most laymen and at least one doctor understand "topical" to mean "in the news." If your correspondent Dr. B. G. Forrest (*Journal*, March 12, p. 665) used the word "surface," his meaning would be almost as clear to the learned and far clearer to the unlettered.

Night Cramps

Dr. H. Angell Lane (Battle, Sussex) writes: Dr. H. R. Odlum's letter (*Journal*, April 2, p. 848) suggests one unusual cause of night cramps, which I observed in my own case. I suffered practically every night for four years from severe cramps, chiefly in the calf muscles. This was during the war. No treatment suggested was of any value. I was 75 years of age and to keep going in my job I took daily amphetamine. I discontinued this in 1946. I also discontinued the cramps. They return only after I take amphetamine again for two or more consecutive days.

Infected Clothing

Dr. G. C. Pether (Hitchin) writes: When I have a cold my germ-laden handkerchiefs go into one pocket and then another. It is true that the tailors do provide what is known as a handkerchief pocket, but this receptacle, in an inconvenient position and badly designed, cannot hold many handkerchiefs when I have a streaming cold. They wander uneasily from place to place and, presumably, infect my clothes in the process. Would it not be sound to have at least two of our larger pockets lined with a washable material and designed to hold our handkerchiefs and nothing else? They could be wiped out with disinfectants, and presumably our germs would not wander along our waistcoats, braces, and other fittings. Has any work been done to discover what pathogens, if any, are put away with our winter clothes in the spring, to emerge, after a good rest, eager for the fray in the autumn? It would be reassuring to know that this cannot happen. If it can, then some sterilization of the clothes before storage would seem wise.

Tetanus Immunization

Dr. D. N. Everingham (Guildford, N.S.W., Australia) writes: Your annotation (*Journal*, January 29, p. 278) suggests that active immunization may be preferable in combined vaccines or in armed forces, in view of the risks of horse serum. The main risk of giving serum routinely is that there is less protection, in the event of delayed sporulation, than from toxoid. In any case most patients will have several gravel grazes, punctures by thorns, and contaminated cuts for every major injury which takes them to a doctor, and often they will be more at risk from these than from the "major" injury. This is confirmed by two simple facts: (1) most patients who ask for an anti-tetanus injection have clean or well-opened wounds, or slightly contaminated wounds well flushed by bleeding, or (in this country) dog bites, cuts of a thumb web or other interdigital cleft, or open laceration by a rusty nail (all of which are thought to be tetanus risks); (2) most people to whom anti-tetanus injection is given do not come for that purpose. Therefore I consider I am giving longer, more comprehensive protection by giving toxoid routinely, and recommending a return for a booster on each occasion of a soil-contaminated injury until three injections are given, then a booster for such injuries at three- to five-year intervals.

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