after infarction.¹⁵ Hypoxaemia may also increase the risk of severe arrhythmia. Rawles and Kenmure,¹⁶ however, failed to show benefit from administering oxygen after infarction. They excluded all patients with evidence of heart failure, lung disease, and breathlessness, so their findings can be applied only to uncomplicated cases.

Conclusion

It seems reasonable to believe that if pneumoconiosis is severe enough to produce chronic hypoxaemia, pulmonary hypertension, or a large reduction in the pulmonary capillary bed it is likely to reduce the chances of survival. In contrast, the views put forward by the Department are, in my opinion, irrational and based on entirely faulty deductions. In a field in which there is little firm evidence, it is important that what is available is interpreted sensibly. If the arguments used by the Department are faulty there is no mechanism now available to recompense the widows in the three cases cited⁴⁻⁶ without resort to High Court actions. There are probably many more such cases that did not get beyond the insurance officer or the local tribunal.

I thank Dr D C Banks for critical comments.

References

- ¹ Cochrane, A L, Carpenter, R G, and Moore, F, *British Journal of Preventative and Social Medicine*, 1959, **13**, 128.
- ² Davies, D, *British Medical Journal*, 1974, **2**, 652.
- ³ Lindars, D C, *et al*, *Journal of Pathology*, 1972, **108**, 249.
- ⁴ Nonkin, P M, Dick, M M, and Baum, G L, *Archives of Internal Medicine*, 1964, **113**, 42.
- ⁵ Sanders, W L, *Thorax*, 1970, **25**, 233.
- ⁶ *Commissioner's File*, CI 357/1975. London, DHSS, 1975.
- ⁷ Department of Health and Social Security, *Index and Digest of Commissioner's Decisions*, No R(1) 5/74. London, HMSO, 1974.
- ⁸ *Commissioner's File*, CI 74/1974. London, DHSS, 1974.
- ⁹ Caplin, M, and Festenstein, F, *British Medical Journal*, 1975, **3**, 678.
- ¹⁰ Tibblin, G, Wilhelmsen, L, and Werkö, L, *American Journal of Cardiology*, 1975, **35**, 514.
- ¹¹ Friedman, G D, Klatsky, A L, and Siegelaub, A B, *New England Journal of Medicine*, 1976, **294**, 1071.
- ¹² Zoll, P M, Wessler, S, and Schlesinger, M J, *Circulation*, 1951, **4**, 797.
- ¹³ Oram, S, *Clinical Heart Disease*, p 607. London, Heinemann, 1971.
- ¹⁴ Radványi, P, Maroko, P R, and Braunwald, E, *American Journal of Cardiology*, 1975, **35**, 795.
- ¹⁵ Madias, J E, Madias, N E, and Hood, W B, *Circulation*, 1976, **53**, 411.
- ¹⁶ Rawles, J M, and Kenmure, A C F, *British Medical Journal*, 1976, **1**, 1121.

Clinical Topics

Barbiturate prescribing: psychiatrists' views*

B M BARRACLOUGH

British Medical Journal, 1976, **2**, 927-928

Summary

When questioned by post most of a one-in-five sample of consultant psychiatrists replied that they did not favour the use of barbiturates as hypnotics or as sedatives.

Introduction

It is wise that doctors should monitor their use of drugs and modify their prescribing when the best interests of patients indicate that this is necessary. Like many drugs, barbiturates may be a threat to health because of side effects and abuse; the large amount of barbiturate prescribed and its association with suicide make it a drug of special concern.

When used as a hypnotic, barbiturates produce abnormal sleep rhythms that may persist for weeks after withdrawal.¹ Hangover effects the next day reduce performance.² The elderly patient may become confused.³ When used for daytime sedation rapid dependence may result, and the patient seeks to improve his mood further by increasing the dose, sometimes to a dangerous extent. In any case, the price is impaired intellectual and motor performance, sometimes to a dangerous extent. Paradoxical excitement may also occur.⁴ Barbiturate withdrawal

*Results of a survey conducted under the direction of the Research Committee of the Royal College of Psychiatrists.

MRC Clinical Psychiatry Unit, Graylingwell Hospital, Chichester, West Sussex PO19 4PQ, and Royal College of Psychiatrists, London SW1X 8PG

B M BARRACLOUGH, FRACP, MRCPsych, honorary consultant psychiatrist

may precipitate grand mal fits.⁵ Liver chemistry is affected by barbiturates, which alter the metabolism and hence the therapeutic effects of other drugs.⁶ Young people have suffered permanent damage to their bodies by injecting the contents of capsules or of ground-up tablets.

Alcohol and barbiturates are potentially fatal when taken together and the combination causes many deaths. There is a higher death rate from barbiturates than from alternatives.⁷ From 1965 to 1974 19 000 adult deaths, two-thirds of them suicides,⁸ resulted from barbiturate poisoning, about 0.3% of all deaths for this period (see figure).^{9 10}

Concern about the need to restrict the supply of barbiturates has resulted in attempts by the medical profession to limit prescribing by using educational measures. Probably these measures and the availability of alternatives account for the fact that general practitioner prescribing of barbiturates is

Barbiturate prescriptions and barbiturate deaths in England and Wales, 1965-74.

decreasing by 10% a year (see figure).¹¹ Hospital prescribing, for which no national statistics are available, is thought now to be small except for anaesthesia, obstetrics, and for treating epilepsy.

Deaths from barbiturate poisoning, on the other hand, increased between 1965 and 1969 in spite of a drop of one-fifth in prescriptions. But since 1970 annual numbers of barbiturate deaths have declined (see figure). Fewer prescribed barbiturates may be responsible for the recent change in the death rate, since the suicide rate has decreased only slightly over the same period.

The barbiturate poisoning death rate and suicide rate in Australia rose with the increased supply of prescribed sedative drugs beginning in 1961 and fell after official limitations on prescribing were enforced after 1967, suggesting that availability affects the death rate from suicide by drugs.¹²

The most recent efforts to educate the medical profession about barbiturates and their dangers stem from the Campaign for the Use and Restriction of Barbiturates (CURB), an independent committee of doctors set up after a recommendation of the Advisory Council on the Misuse of Drugs. Their executive committee suggested that an inquiry be conducted among psychiatrists about barbiturates. The results of this inquiry, which may have some value for further educational activities, are reported here.

Method

A questionnaire was posted to a random sample of one in five consultant psychiatrists practising adult psychiatry in England, Wales, or Scotland. The questionnaire inquired about three aspects of barbiturate prescribing: present prescribing habits, therapeutic indications, and legal restraints on prescribing. The names of the 239 psychiatrists to whom the questionnaire was sent were selected by a random method from the card index file of the membership of the Royal College of Psychiatrists, to which nearly all consultant psychiatrists belong.

Results

Two hundred and seventeen (91%) questionnaires were returned. Seventy per cent of the psychiatrists replied that they never prescribed barbiturates for new patients, either for sleeplessness or for daytime sedation. Only 2% reported using barbiturates regularly for these purposes. Over 90% recommended chronic barbiturate-takers to desist. Rather fewer, three-quarters, claimed success in persuading patients to stop taking barbiturates; most seemed to find it possible for their patients to achieve barbiturate abstinence (table I).

For some patients, however, barbiturates were considered useful (table II). Over a quarter of the psychiatrists questioned thought barbiturates were still needed for treating sleeplessness, fewer for managing the anxious patient. Since clinical trials have shown that for some people barbiturates are superior to non-barbiturate hypnotics, these observations have some relevance.¹³ Barbiturates were thought by about half those questioned to have value in managing both the patient dependent on barbiturates and the withdrawal of the drug. Two-thirds of the psychiatrists regarded barbiturates as useful for abreaction, but only a quarter favoured their use for deep narcosis and continuous sleep therapy, treatments probably seldom used now in any

TABLE II—Psychiatrists' opinions about continuing therapeutic uses for barbiturates

	Yes % (n = 217)	No %
In your opinion is there a continuing need for barbiturates for any of the following?		
Aggressive behaviour	13	87
Treatment of anxiety	14	86
Aid to desensitisation in treatment of phobias	17	83
Treatment of insomnia	28	72
Deep narcosis	29	71
Continuous sleep therapy	31	69
Management of barbiturate dependence	46	54
Treatment of barbiturate withdrawal	54	46
Abreaction	66	34

case. The control of aggressive behaviour by barbiturates was thought useful by only 12% and as an aid to the desensitisation of phobias by only 17%.

Some other uses, not questioned for directly, were mentioned: as a diagnostic aid for catatonic stupor, to control restlessness in the occasional patient with dementia who fails to respond to other drugs, the drying out of alcoholics, by injection for the severe and acute anxiety state, for the management of behaviour problems in mentally handicapped patients, for controlling tension and sleeplessness in patients with chronic conditions unresponsive to other drugs or for whom phenothiazines are contraindicated, and electric convulsion therapy premedication. From the accompanying comments on the questionnaires it is clear that most thought barbiturates had a definite, if limited, use in psychiatry.

Most (two-thirds of those who replied) were opposed to further legal restraints on the prescribing of barbiturates, and many expressed their opposition in forceful terms. The general tenor of comment from those who replied in this way was clear—the responsibility for rational prescribing lies with the profession, and limitations should not be imposed. But a sizeable minority of one-quarter took the opposing view, some proposing restrictions of the kind applying to heroin.

Conclusion

What conclusions may be drawn from consultant psychiatrists' replies to the questionnaire about their approach to barbiturates? They regard barbiturates with reserve as a treatment for sleeplessness or anxiety, excepting the unusual patient, but see a definite if limited place for barbiturates in the treatment of some people with mental disease.

Since psychiatrists are specialists in applied psychopharmacology their opinion about barbiturates deserves some attention. They are concerned to correct abuse of barbiturates by rational prescribing, maintaining a balanced approach so as to retain them for use in some circumstances. Legal and moral reaction against an abused drug may sometimes swing too far, denying it to those who could benefit.

I thank CURB for a grant of £100 towards the cost of the survey and Miss J Boyce for organising the data collection and analysis.

References

- Oswald, I, and Priest, R G, *British Medical Journal*, 1965, **2**, 1093.
- Drug and Therapeutics Bulletin*, 1971, **9**, 9.
- Davison, W, *Modern Geriatrics*, 1971, **1**, 142.
- Smith, G N, and Beecher, H K, *Journal of the American Medical Association*, 1959, **170**, 542.
- Isbell, H, *Archives of Neurology and Psychiatry*, 1950, **64**, 1.
- Goodman, L, and Gilman, A, *The Pharmacological Basis of Therapeutics*. London, McMillan, 1975.
- Barracrough, B, *Lancet*, 1974, **1**, 57.
- Barracrough, B, *British Journal of Psychiatry*, 1974, **124**, 526.
- General Register Office, *Pharmaceutical Journal*, 1968, **200**, 387; 1969, **202**, 177; 1969, **203**, 74; 1970, **204**, 703; 1971, **206**, 422; 1972, **208**, 530; 1973, **210**, 77; 1974, **212**, 92; and 1975, **214**, 260.
- Poisoning Deaths for 1974*. London, Office of Population Censuses and Surveys, 1976.
- Department of Health and Social Security, *Health and Personal Social Service Statistics for England, 1965-74*. London, HMSO, 1969-1974.
- Oliver, R G, and Hetzel, B S, *Medical Journal of Australia*, 1972, **2**, 919.
- Perkins, R, Hinton, J, *British Journal of Psychiatry*, 1974, **124**, 435.

TABLE I—Psychiatrists' replies on their prescribing of barbiturates

		% (n = 217)
Do you now prescribe barbiturates for new patients as a hypnotic?	Frequently	3
	Seldom	26
	Never	70
	Unknown	1
Do you now prescribe barbiturates for new patients as a sedative?	Frequently	1
	Seldom	27
	Never	69
	Unknown	3
If a patient has been taking barbiturates for more than a year do you recommend they should stop?	Usually	93
	Rarely	5
	Never	0
	Unknown	2
Are you successful in getting patients to stop taking barbiturates?	Usually	77
	Rarely	17
	Never	0
	Unknown	6