SIR,—Your leading article "Compulsive Gambler" (13 April, p. 69) raises some debatable points, and also denotes a remarkable change of viewpoint since the article on "Pathological Gambling" three years ago.[1] The article seems to imply that it is possible to determine with certainty which aspects of behaviour are controllable and which are not. If a patient complains that he cannot stop gambling surely it is passing judgement to thereupon assume that "what he means is that he does not want to stop—the attractions are too great." The same could be said of the pathological drinker or the exhibitionist. The same used to be said of nocturnal enuresis, which was attributed to laziness, or of attempted suicide, which was considered to be immoral and cowardly.

Many forms of psychiatric illness present as behavioural disturbance—epilepsy, melancholia, schizophrenia, to name but three. If we disregard an important complaint such as the inability to control one's gambling then we shall be poor doctors and may miss important diagnoses, such as depression, hypomania, or personality disorder. Even your article mentions the possibility of brain damage or disease as a cause of excessive gambling (it notably omits psychological illness). In addition, techniques of treating patients in whom it presents as the predominant symptom are now being successfully developed.[2-4] The "attractions" of a destructive form of behaviour which leads to social rejection and degradation, financial ruin, and marital disharmony can be overestimated. Your leader writer overestimates them to the point of saying that "a gambler does not hurt himself." Surely the individuals best able to determine this are the patient himself and his close associates. Most psychiatrists would agree that "antisocial behaviour must not be confused with mental illness," but a patient complaining of an irresistible urge which is destroying him socially and financially is complaining of a psychological symptom, and will not be helped by being informed that "he lacks a sense of responsibility . . . to society." Many a psychotic patient lacks such a sense of responsibility, but that does not detract from his illness; it may even add to it, and be a justification for compulsory detention in a hospital.

Three years ago your leading article[1] noted that "the varieties of the gambling syndrome still await proper description." That this is sadly still true is a reflection on medical inadequacy and is not a reason to dispose of a distressing symptom complex as beyond the psychiatric pale. Severe illnesses such as chronic alcoholism, also a pathological extension of normal behaviour, were once totally undefined, but the sufferers were no less ill for that. Chronic alcoholism is still frequently an intractable disease, but its recognition as a clinical entity has enabled it to be subjected to medical investigation, and consequently we are one step nearer helping this group of ill people. Why cannot pathological gambling also be viewed in this light?

I suspect that the strictly clinical terrain of psychiatry we are exhorted not to exceed cannot be defined, but I am sure that it is not limited to brain damage and psychotic illness, as implied in your article. I do not believe, either, that it is simply limited to patients who present themselves at hospital clinics. I have recently been involved in a survey of epileptic prisoners in which 56% of receptions simply stated that they had never attended a hospital; many of the hospital-non-attenders are severe epileptics, some are late-onset epileptics, and some say they have never consulted a doctor before being admitted to prison. In my spare time I give psychiatric supervision to a prisoners' after-care club. This club collects the most fascinating and yet appalling range of mental illnesses. Superficially, most of its members can be derided as dead-beats or layabouts, but beneath this façade lurks a whole range of mental illness—schizophrenia, depression, personality disorder, epilepsy, chronic alcoholism, etc. Many of them will not see a doctor except in the privacy of the club and refuse to attend hospital outpatients on account of a host of paranoid fears, and are thus quite unable to partake of their entitlements under the National Health Service, and so continue in their misery. Are these men too "outside the pale of psychiatry" and beyond the boundaries of psychiatry's "strictly clinical terrain"?

I entirely agree that "the doctor's primary duty is to diagnose and treat his patients, not to enforce society's rules," but I submit, Sir, that medicine must be concerned with *all* persons distressed in body and mind, no matter how unusual or even antisocial their symptoms may be.—I am, etc.,

Institute of Psychiatry, University of London, London S.E.5. JOHN GUNN.

REFERENCES

1 *Brit. med. J.*, 1965, **1**, 809.
2 Barker, J. C., and Miller, M., *Lancet*, 1966, **1**, 491.
3 Barker, J. C., and Miller, M., *Brit. med. J.*, 1966, **2**, 115.
4 Goorney, A. B., *Brit. J. Psychiat.*, 1968, **114**, 329.

SIR,—Your leading article (13 April, p. 69) dissects the term "compulsive" for this type of gambler but betrays almost total ignorance of the abnormal degree of gambling impulse that may be observed. It also makes some very questionable assertions—for example, that "the gambler enjoys every bit of his 'compulsion,'" that "his motivation is no different from that of the ordinary gambler or the man who likes betting," and, most absurd of all, that "the gambler does not hurt himself as the compulsive patient does."

Since a branch of Gamblers Anonymous opened in London in July 1964,[1 2] I have had the privilege of continual observation of the scores of excessive, uncontrolled, "compulsive," call them what you will, gamblers who have come to its meetings. I think anyone who listens as I have done to the well-nigh incredible experiences related by these wretched gamblers would conclude that they suffer from an overmastering urge to gamble that is different not only quantitatively but qualitatively also from that of the average punter or better. Gamblers Anonymous now has five branches in the London area, two in Glasgow, one each in Edinburgh, Belfast, Dublin, Newcastle, Sheffield, and Manchester. Many gamblers have come, and we reckon that about one in six attends regularly and gets help; the others at any rate know where to come again when all else fails.

I have seen scores of chronic wrecks, some from my own profession, helped to stop gambling. Their lives and those of their despairing wives and families have been transformed by the dynamic self-help group therapy of Gamblers Anonymous.

British doctors should know that the chronic gambler and his family usually conceal the shameful secret, just like that of an alcoholic in the family. They should also know that Gamblers Anonymous is now active in Britain and Eire, and that it often succeeds where psychiatrists, priests, and prison officials have failed.

Any doctors wishing to attend a Gamblers Anonymous meeting would be welcome. They may either contact me or the headquarters of Gamblers Anonymous at 19 Abbey House, Victoria Street, London S.W.1 (01-222 4252).—I am, etc.,

London W.1. F. R. C. CASSON.

REFERENCES

1 Casson, F. R. C., *Brit. med. J.*, 1964, **2**, 1533.
2 Casson, F. R. C., *Lancet*, 1964, **2**, 133.

SIR,—It is good for psychiatrists to be reminded from time to time that it is not their business to "normalize the abnormal and non-conforming," as you put it (13 April, p. 69). Apart from the impossibility of defining what is "abnormal," the aetiology of "non-conforming" often lies in the way society is organized rather than in the individual. Society cannot be held blameless for the increasing frequency of gambling habits. With the ubiquity of football pools, bingo halls, roulette casinos, one-arm bandits, and licensed betting shops, we have a wide advertisement to encourage a "get-rich-quick mentality."

It is indeed very fortunate that the wife of Dostoevski did not think there was an indication to take him to a psychiatrist, and that leucotomy was not practised 100 years ago, otherwise we would be the poorer by the greatest novel ever written (*The Brothers Karamazov*). Whatever leucotomy may do, it does not enhance original, creative abilities. It is a pity that Dostoevski left no specific clue as to how he was cured, but it is clear that even the most intense gambling fevers sometimes clear up without the aid of a psychiatrist and without risks of mental impairment from irreversible brain destruction.—I am, etc.,

Weybridge, Surrey. I. ATKIN.

Overcrowding in Psychiatric Hospitals

SIR,—I feel that the solution to the problem of overcrowding in psychiatric hospitals suggested by Dr. C. Entwistle (13 April, p. 116) is incomplete and even misleading. He is, I suspect, preaching to the converted. Since the Mental Health Act of 1959 the psychiatric consultant has had almost complete control of the use to which the beds under his supervision are put. Throughout the country enthusiastic psychiatrists have been able to discharge rapidly an accumulation of recovered but institutionalized patients and to initiate a programme of vigorous treatment in their admission wards, which has reduced the rate at which new

long-stay patients are acquired. But this process is ultimately self-limiting, and we are now facing the more difficult problem of discharging the aged and the more severely disabled younger patients. It is easy enough to reduce the number of beds still further by adopting rigid criteria for the retention of such patients in hospital. Many of them would indeed be better off outside hospital, provided that they received sufficient support and aftercare. Can we honestly say that they will get it ?

In the All Saints' Group we are attempting to offer a wide and flexible range of facilities, including day care, hostel accommodation, industrial rehabilitation, and domiciliary visiting by doctors, social workers, and nurses. We try to review patients regularly at every stage of their programme of resocialization inside and outside hospital. Consequently the number of inpatients continues to decline at much the same rate as that described by Dr. Entwistle. We could have achieved the same result without such intensive efforts in community care simply by insisting that these patients were now the responsibility of the already overburdened local authorities and general practitioners. But this would be an unrealistic policy.

There is increasing (and probably justifiable) disquiet over the numbers of mentally and emotionally handicapped individuals at large in the community without adequate supervision, and it is unfortunate that the financial resources allocated to the psychiatric hospitals are determined largely by the number of inpatients. In fact the comprehensive service which we envisage requires considerably more able and numerous staff than would be needed if the same patients were allowed to remain indefinitely in hospital. To focus attention on bed occupancy without discussing the responsibility of the psychiatrist to the patient in the community is likely to give the false impression that our psychiatric services do not need to be extended. They do. But the additional investment must be channelled into hospital-based services which enable the mentally handicapped to enjoy a reasonably effective and tolerable existence among their fellow citizens.—I am, etc.,

All Saints' Hospital, Birmingham 18. MARTIN DAVIES.

Intramuscular Injections and Gas Gangrene

SIR,—The report of a fatal case of gas gangrene associated with intramuscular injections by Drs. P. W. Harvey and G. V. Purnell (23 March, p. 744), together with your leading article (p. 721) on this subject and the comments of Drs. T. H. Bewley, O. Ben-Arie, and V. Marks (p. 730), raise some important issues regarding the potential dangers of imperfect asepsis on which we would like to comment.

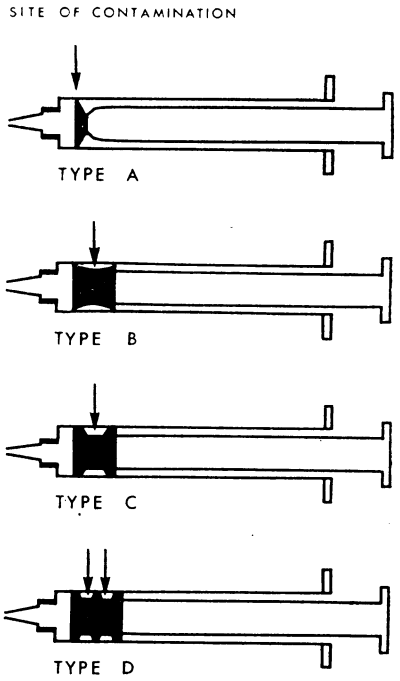
The danger of injecting adrenaline in the gluteal region is very properly emphasized in your leading article. In our book, *A Review of Sterilization and Disinfection*, p. 191,[1] we reviewed the infectious complications which may result from a simple injection given by qualified or unqualified persons, and went so far as to state, " There is little justification for the intramuscular injection of adrenaline in oil and its use should be discontinued." The case reported in your pages involved another long-acting form of the drug, the manufacture of which has now been discontinued. The risk of infection following self-administered injections, particularly among drug addicts whose standards of cleanliness are low, was also stressed by us in relation to tetanus and re-emphasized by Dr. Bewley and colleagues in respect to serum hepatitis. Recently we investigated the possible causes of a case of gas gangrene in a young woman who died following intramuscular injection into the buttock of 2 ml. of iron polymaltose containing 100 mg. of elemental iron. It is obvious, therefore, that deep intramuscular injections in this site of slowly absorbed vasoconstrictive or other irritant preparations carries a serious risk of gas gangrene.

While the most likely source of *Clostridium welchii* in these cases was undoubtedly the skin of the patient in the anal region, all the episodes investigated reveal some breach in aseptic technique, such as reliance on 5 minutes' boiling for the sterilization of syringes and needles or their storage in methylated spirits or 70% alcohol containing chloroxylenol. As it is now becoming obvious that these methods are inconsistent with professional standards of asepsis, an increasing reliance is being placed on commercially sterilized disposable syringes and needles, the use of which could become almost universal. In anticipation of this shift in practice, it seems appropriate to make a short comment on the sterilization of these articles. Many manufacturers use an ethylene oxide process for bulk sterilization, and the question immediately arises whether this method can be fully relied on for all the types of disposable syringe that are offered to the medical profession. In a recent study[2] we have demonstrated that certain types of syringes cannot be sterilized with an adequate margin of safety, even under optimal conditions of gas sterilization. From the Figure and accompanying Table it will be readily seen which types of syringe are likely to fail in ethylene oxide sterilization.

The gross failure of type D and the marginal failure of type C syringes even at low levels of contamination can be attributed to the inability of the gas to penetrate across the contact points between plunger and barrel. Accordingly, little reliance can be placed on ethylene oxide sterilization of certain types of disposable syringes, particularly those with wide double or triple contact plungers as illustrated above.

While we do not suggest that *Cl. welchii* is likely to be found in the gas-inaccessible sites of disposable syringes, it would nevertheless seem proper to legislate against the acceptance of ethylene oxide sterilization for those of the type C or D design. These should be processed by ionizing radiation at a dose of 2.5 Mrad from a cobalt-60 source.

We entirely agree with your statement that certain types of injection should never be made into the gluteal region and that the danger can be lessened by injecting elsewhere. We hope that this message has not passed unnoticed by nurses and physicians who administer adrenaline or colloidal iron preparations by injection. When the buttock is used as a site for intramuscular injection of other preparations, particularly non-inhibitory agents such as gammaglobulin, extreme care must be taken to avoid the carriage of transient flora of bowel origin along the needle track. It must be recognized that there is no skin disinfectant which will destroy spores rapidly, so the operator must rely on their mechanical removal from the injection site. Such skin preparations as tincture of iodine or 0.5% chlorhexidine in 70% alcohol will effectively destroy vegetative contaminants



Failure of Ethylene Oxide in Sterilization of Disposable Syringes

Syringe Design	No. Syringes Sterile after Treatment. Spore Contamination Load (*B. subtilis* var. *niger*)						Ethylene Oxide Acceptability
	10^3		10^4		10^6		
	No.	%	No.	%	No.	%	
A Single contact plunger (high density polyethylene) ..	Not done	—	Not done	—	40/40	100	Acceptable
B Double contact plunger (thin edge rubber)	40/40	100	54/55	98	145/150	96·5	Acceptable
C Double contact plunger (thick edge rubber)	60/65	92·5	63/102	61·7	110/231	47·5	Unacceptable
D Triple contact plunger (thick edge rubber), glass barrel	6/25	24	Not done	—	1/15	6·7	Unacceptable

1,000 mg. ethylene oxide /l. for 12 hours at 30° C., relative humidity 38%. (After Rubbo and Gardner, 1968. Results for type D not previously reported.)