BRITISH MEDICAL JOURNAL

SATURDAY 2 FEBRUARY 1985

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NO 6465 BRITISH MEDICAL JOURNAL 1985 VOLUME 290 337-412
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 290 (6465) 337-412 (1985)

CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

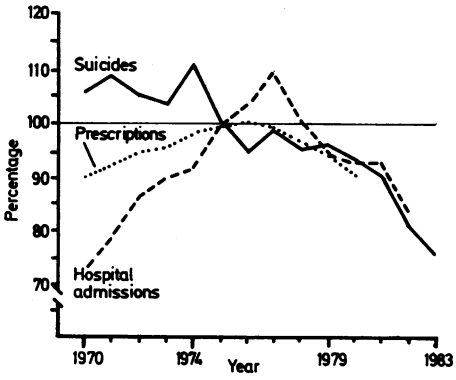
Self poisoning in 1984: a prediction that didn't come true

SIR,—In 1977, observing the trends in admissions for self poisoning, Jones predicted that if they continued every acute medical bed then existing would be filled with a self poisoner by 1984. His calculations were correct but the trends did not continue. As the figure shows, they peaked in 1977 and have fallen steadily almost every year since, along with the number of fatal suicidal poisonings. So have the numbers of fatal accidental and undetermined poisonings from solids and liquids (although they are not shown in the figure).

This sharp fall in the incidence of overdoses is without peacetime precedent. There may be more than one explanation, but we suggest that the most important and likely cause is that since 1976 the annual number of prescriptions for hypnotics and tranquillisers has also fallen steadily (see figure). Inevitably these drugs, so popular for overdoses, are preferentially prescribed for precisely the sort of patients and households among whom self poisoning is most common. If, for whatever reason, their availability is reduced fewer people will be able to take overdoses of them. That they will not necessarily use other drugs or methods is apparent from the decline in completed suicide by all methods since 1981, following a reduction in the rate of increase since 1979, despite high unemployment.[2]

We suggest a parallel with the progressive removal of carbon monoxide from domestic gas and the subsequent disappearance of coal gas poisoning, which caused such a sharp decline in the British suicide rate from 1963 to 1975. These findings add to the evidence that self poisoning, like alcohol abuse, is influenced much more by external factors which are sometimes controllable, such as availability, than by internal, pathological ones such as "depressive illness," and that successful and attempted suicides are not "separate but overlapping" groups but form a continuum. (Similarly, it is difficult to believe that the US suicide rate would still be nearly twice the British one—half of it by shooting—if firearms were not so easily available there.)

We will risk a new prediction for 1994: that changes in the indices of self poisoning will continue to reflect changes in the availability of prescribed sedatives and other psychoactive drugs. These figures and our explanation of them challenge some fashionable theories about the nature and prevention of suicidal behaviour. We believe they should also cause both doctors and patients to question even more seriously the elevation of human unhappiness to the status of a disease requiring medication, which has been such a feature of the past 25 years.



Hospital admissions for adverse effects of medicinal agents, suicide by solid or liquid substances, and numbers of prescriptions for hypnotics and tranquillisers, all expressed as percentage of 1975 level. Sources: OPCS mortality statistics, Hospital Inpatient Inquiry, Health and Personal Social Services Statistics for England.

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1 Jones DIR. Self poisoning with drugs: the past 20 years in Sheffield. *Br Med J* 1977;i:28-9.
2 Office of Population Censuses and Surveys. *Annual reports*. London: HMSO.

Why do our hospitals not make more use of the concept of a trauma team?

SIR,—I commend Mr J D Spencer on the organisation of a trauma team to facilitate the rapid resuscitation of patients with multiple injuries (12 January, p 136). In our own district the methods adopted to improve the care of the injured differ from Mr Spencer's but have also proved effective.

An internal survey conducted in 1977 showed alarming deficiencies in the standard of care of patients with multiple injuries. Critically ill patients often remained in the