drum or in some way inferior in its thinking to that of the 'hard science' of hospital-based medicine, often seems to lead to attempts to erect an alternative edifice of research emphasizing, say, epidemiology or statistics. This talks the same language and carries some academic respectability. There is, of course, need for such work, and indeed for continuing expansion in the other discernible directions of modern general practice, training and postgraduate education. But we now have glimpses of a new sort of medicine, and if we have the vision to begin weaving together those threads that are appearing, they will provide the material for a new tapestry of medicine which will illuminate our practice in ways that we can, at present, only dimly, but with mounting optimism, anticipate.

EDWARD MORRIS

Shongwe Hospital
Private Bag X30
Shongwe Mission PO
1331 South Africa

Reference

1. Sacks O. *Awakening*. London: Pan Books, 1982.

Sir,

Having been slightly dismayed by Dr A. S. Dixon's recent article (June *Journal*, p.358) I feel I must make the following four points in reply:

1. Dr Dixon describes as a 'moot point' the degree of acceptance among linguists of Edward Sapir's hypothesis concerning the influence exerted on a society or culture by its language. I think he would find, in fact, that the vast majority of linguists are rather less favourably inclined towards this view than he suggests.
2. The main argument against Sapir's theory of language providing a grid through which its speakers see the world is that while it is indeed the case that different cultures make different distinctions in their languages, according to what is considered important in their respective societies, such differences in categorization do not prevent the implicit recognition of distinctions which are *not* made. The fact that some languages do not distinguish between blue and green in their colour terminology does not mean that their speakers see the sky and grass as being the same colour. The influence of society on language, however—the converse relationship—is much more widely accepted; it is surely as a result of his environment, rather than his state of mind, that the well-quoted Eskimo has so many words for snow.
3. I would also dispute rather strongly Dr Dixon's description of language as 'conservative'. There are innumerable examples of language changing quite readily to fit the changing needs of its speakers: the kinship terminology of Russian, for instance, changed quite drastically after the revolution to reflect the development of a different kind of family unit, and certain terms quite quickly became obsolete as new ones were found to be necessary.
4. Dr Dixon's view, then, that it is language which 'encourages the depersonalization of illness and the placing of disease beyond the patient's control' is surely rather a cop-out. He does, however, admit that it might be necessary, when trying to improve the current situation, to break through 'social and ideological rather than (the) linguistic or conceptual barriers'. Would it not therefore be more beneficial to that society to spend time trying to change its views of control of illness and shared responsibility between doctor and patient, rather than attempting to provide the medical profession with a language which will undoubtedly develop anyway in response to the changing needs of its speakers?

JUDITH HALLIWELL
Secretary to Stuart Fellow

Royal College of
General Practitioners.

Sir,

'Is the underlying grammatical construction of our language the reason . . . why we seem to have trouble with apparently vague processes and influences as represented by the psychological and social factors in our lives?'

The question certainly needed to be asked. We are surely indebted to Dr A. S. Dixon for tackling the subject with such erudition and scholarship (June *Journal*, p. 358).

Even the answer is provided. 'In natural languages . . . vocabulary, inflection and modes of sentence structure . . . do not make it impossible to express certain things, they (may) merely make it more difficult to express them.' Why then does Dr Dixon in his conclusion state three difficulties indicating that his answer to the initial question is an unqualified yes? His article itself contains two pointers to why this may be.

We in the medical profession do not use words fundamental to the philosophy of medicine with thought and consistency. For example in the first enumerated difficulty in his conclusion Dr Dixon implies that we might be more successful if we did not automatically consider diseases as 'its'. But surely the whole advantage of inventing (not discovering) any disease is that we then have a hard mental tool to use in healing people who are ill. Diseases are similar to Newton's Laws of Motion. As such they are as concrete as any abstract notions can be. It would appear diseases are invented specifically to be 'its'. I believe it would be clearer to argue that we should not consider all illnesses to be 'its'.

Let me return to a phrase from the article's fundamental question, namely 'apparently vague processes and influences'. Consider Dr Dixon's example of 'it rains'. This phrase did not prevent meteorologists from making great strides in the understanding of weather systems. Apparently vague meteorological processes and influences of 10 years ago are now elegant hypothesis shaped by Occam's razor.

In short, that our patients' illnesses seem vague is not due to any inherent defect in the English language but to our lack of knowledge. We in primary care would wait futilely for a grammatical revolution. What we need are our equivalents of the weathermen's sputniks and Kray II computers.

M. B. TAYLOR

40 Market Street
Heywood OL10 4LY

Treatment of Heroin Addiction

Sir,

I read with interest the account of clonidine withdrawal in general practice by Joliffe and Melville (June *Journal*, p. 368). I agree that the prevalence of the problem, the inadequacy of the present clinic system and the imperative to encourage a sense of self achievement and responsibility by the patient, all lend support to a community primary care approach to the problem.

I have been treating heroin addicts with clonidine withdrawal for the past nine months. My treatment practice differs from that of Joliffe and Melville in that I do not insist on a fixed dose of clonidine. I explain the action of clonidine in as technically complete terms as is possible and allow the patient to titrate symptoms of withdrawal against over-sedation and drowsiness. Ideally, I ask the patient to keep a record of all

symptoms and tablets and drugs taken. After all, the drug abuser is an expert at controlling his body using pharmacologically active substances.

An important additional factor that I have utilized is to use recent graduates of the withdrawal regime to lend support and encouragement to those withdrawing. This has proved helpful in combatting the depression which seems universal by the fifth day of the regime. How much of this is due to the clonidine, how much to lack of opiate 'buzz' and how much to pre-existing personality problems is not clear. Support from the group with or without subsequent antidepressant therapy seemed very helpful with this problem. The development of a self-help group linked to the local drugs council is being explored at present.

The need for hypnotics is universal. I tried to avoid giving tranquillizers during the day, most especially lorazepam which in my opinion, because of its buccal absorption, is itself a drug of addiction more than other benzodiazepines. I used diazepam or, perhaps better, flurazepam at night.

The regime is adjusted to the individual needs of the patients. Older patients seem to withdraw more severely, independent of quantity or duration of opiate abuse. Withdrawal symptoms seem to be greatest at the times of the day that abuse had previously taken place.

For certain patients, it is difficult to stop use of other drugs of abuse. Amphetamine has a definite adverse psychological and pharmacological effect. Cannabis has a heterogenous effect, exacerbating withdrawal symptoms in some and having little effect in others. Alcohol has a synergistic effect. In general the patients learn from their mistakes and this results, sometimes after a long time, in a sustained change in behaviour.

The regime can be modified to yield withdrawal courses of different degrees of intensity:

—*The most intense;* as a universal opiate antagonist, naloxone can speed up the process considerably but results in more intense withdrawal symptoms necessitating more clonidine. The naloxone can be used after seven days by those who are impatient to be off all medication.

—*The usual course of clonidine alone;* most patients were taking the maximum dose of 12 0.1mg clonidine tablets by the third day with a gradual withdrawal after this. On average it seems to take about three weeks to tail off the clonidine.

—*Use of dihydrocodeine;* either, in the case of one patient, at the beginning (as he had evidence of noninfectious hepatitis) to reduce the severity of the process, or after about a week of clonidine to allow a reduction of the clonidine dose. There is no doubt that after about one week, most patients get fed up with the large dose of clonidine. It is relatively easy to reduce and then eliminate the residual small dose of dihydrocodeine.

Permutations of these regimes can be tailored to the needs of different patients.

Treatment of opiate addicts is multifactorial and can be problematic. Attention to social, emotional, financial and employment factors are all very important. The results of this combination of clonidine withdrawal, self help group support and treatment within the context of general practice may indicate relatively good results. Out of the 14 treated so far, 10 are doing well at present, four are not doing so well (in that they are using opiates) but of these four only two actually made the effort to withdraw in the first place. One of the failures who did withdraw successfully is trying again at present.

Treatment of heroin addiction with noncontrolled drugs is within the province of the general practitioner.

MICHAEL ROSS
Princes Park Health Centre
Bentley Road
Liverpool L8 0SY

Reference

1. Riordan CE, Kleber HD. Rapid opiate detoxification with clonidine and naloxone. *Lancet* 1980; **1:** 1079-1080.

Sir,

I was surprised to read this paper (June *Journal,* p. 368). I had assumed that the supervision of withdrawal from opiates was not unusual for a general practitioner. In response to the author's request I report another case.

A 26 year old unemployed heavy plant driver came to me in December 1982 asking for help in 'kicking the habit'. He had abused many drugs for a number of years, but had found himself dependent on heroin for about three months. He was well motivated to stop and this was helped by the fact that his girlfriend had left him and refused to return until he was drug free. I felt an immediate rapport with him and I believed him.

I referred him to the Regional Drug Dependency Unit (DDU) but was told that there was a two month waiting list for an outpatient appointment and a longer wait for inpatient treatment. This was unsatisfactory. With the shaky background of a student attachment to a DDU for two weeks, I decided to help him withdraw. I notified the Home Office and started to prescribe methadone tablets. We were very open about our expectations of each other and I saw him at least twice a week.

My plan was to withdraw him over several weeks. He progressed well but had several relapses relating to police enquiries about previous motoring offences. He stopped completely on several occasions for a few days at a time. We gained much insight into the nature of drug addiction. After four months of this, when I was beginning to despair, he suddenly found he could manage without drugs.

He remained drug free for three months. He then came back to me apologetically and handed over his syringes, having started again only a week previously. This time I withdrew him rapidly with diconal as he disliked methadone. I gave in to this request with reservations in view of recent publicity about diconal. Within a week he was drug free and 3 weeks later he has not started again.

I claim no special skills in dealing with drug abuse. I believe I was fortunate to have a patient with whom I had a good relationship and who was well motivated. I do not believe that I was abused or that he was obtaining drugs elsewhere. The lack of immediate specialized treatment spurred me to continue with my efforts alone. I believe opiate addiction can be treated by general practitioners.

PETER J. M. DAVIS
87 Radford Road
Leamington Spa
Warwickshire.

Medical Students and the College

Sir,

As an incentive to recruitment to College membership I would like to suggest that we have some form of student membership, then students would go on to join the College when qualified.

The British Medical Association have this arrangement. Associate members of the BMA are medical students who become full members when they qualify.

E. M. ROSSER
Member,
South London Faculty Board

6 Drummond Road
London SE16 4BU.