given. Allowing for differences in population, say a factor of about 3 to 1, this is still a significant difference, and it should be possible to compare the rates of manic depressive psychoses and other illnesses for which ECT is routinely used in the two countries.

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Psychopathology of nuclear war

DEAR SIRS

I am pleased that Dr Ian Deary[1] has given such close attention to my article on 'The Psychopathology of Nuclear War'[2]. He makes numerous criticisms, many of which can be answered by pointing to your editorial wish to restrict articles to 2,000 words and to my own desire to keep to medical and psychological aspects of nuclear weapons, avoiding discussion of political choices.

Dr Deary found my article confusing but I'm afraid that I must make the same complaint about his. After spending much time defending the status quo of nuclear deterrence, he ends by advocating Steven Salter's scheme for slow multilateral disarmament[3]. His acceptance of the advisability of reducing the present numbers of nuclear weapons can only support my argument that nuclear deterrence has not been the safe and stable system which people have been led to believe it is.

I know Salter's scheme and agree that it is ingenious. But why is such a clever scheme not being used now? Because there is no real will to achieve reductions in nuclear weapons; because there is insufficient appreciation of the common threat which nuclear weapons pose.

Clever schemes in themselves will not provide this realisation and this will. I agree with Einstein in his declaration that "If mankind is to survive, we are in need of a fundamentally new way of thinking." Dr Deary tries to stretch old ways of thinking about war and weapons to fit the nuclear age, and in the end it doesn't hold together. He has to agree that more weapons mean more danger, not less. He also agrees that if nuclear deterrence fails once, it fails irredeemably.

His claim that a move to a non-nuclear defence policy would not release money for improving health and welfare is not true. It is quite possible to have a defence policy based on defensive, rather than retaliatory, deterrence at less cost than the present one[4]. Such a policy, unlike a nuclear one, is usable, credible and non-provocative and also more morally acceptable.

I agree with Dr Deary that spending on conventional arms worldwide is a much greater drain on resources than nuclear spending, but this is no argument for not starting to dismantle the most dangerous end of the weapons stockpile—its nuclear tip. It should then be easier to see others, e.g. the people of the Soviet Union, as human beings, making further disarmament moves more likely. Détente and nuclear deterrence can't coexist. You cannot get to know someone you have to pretend to be willing to incinerate.

Dr Deary makes the amazing statement that nuclear deterrence, with its constant threat of genocide, is "the crystallization of system wisdom". Wisdom is the last word which should be used. I prefer Profesor Bernard Lown's description[5], at the recent Cologne conference of International Physicians for the Prevention of Nuclear War, that "Deterrence is a suspended sentence of mass murder to be executed at any moment. The idea of pointing nuclear missiles at entire nations is without precedent in moral depravity."

Dr Deary finally complains that I make no proposal. Let me propose a necessary first step away from nuclear madness. I support IPPNW's call[5] for a moratorium on nuclear testing pending completion of a Comprehensive Test Ban Treaty. This would be the real litmus test of political will. It would not require trust, because seismological arrangements of verification are available. It would restore to people hope that nuclear weapons are within human agency to control, and enhance confidence between Governments. It would be an unprecedented achievement in preventive medicine.

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Alcoholism and the Mental Health Act

DEAR SIRS

A letter from Dr Iqbal Singh (*Bulletin*, July 1986, **10**, 188) following an earlier letter of mine (*Bulletin*, February 1986, **10**, 38), in which he states that the best way of dealing with delirium tremens is to admit the person to a medical facility under Common Law, warrants a further comment.

I have some sympathy with the idea although I have not always been able to persuade my medical colleagues of the wisdom of such a move. The case over which I was in correspondence with the Medical Defence Union, however, could not be dealt with by this means. The patient, a woman in her late 30s, was already in hospital on an orthopaedic ward. On the day before I saw her, while intoxicated, she had sustained complicated fractures to her left tibia and fibula. Plaster of Paris had been applied but was not yet steady enough to bear weight. The symptoms of delirium tremens supervened and the patient attempted to run, or at least hobble quickly, out of the ward repeatedly despite the

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