BRITISH MEDICAL JOURNAL

SATURDAY 25 MAY 1968

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No. 5603 Brit. med. J., 1968, Vol. 2, 443–504 Weekly. Price 5s.
BRITISH MEDICAL ASSOCIATION, TAVISTOCK SQUARE, LONDON W.C.1 TEL: 01 – 387 4499

Correspondence

Letters to the Editor should not exceed 500 words.

Integrity of the Profession

SIR,—When the General Medical Council decided to revise its rulings on abortion to conform with the current will of Parliament there vanished almost overnight one of the great safeguards for the integrity of the medical profession. An ethical vacuum has now been created, which cannot be filled entirely by each of us adopting our own particular brand of ethics. A profession is most vulnerable, not from its external critics, but from the permissive minority within its own ranks. Medicine is no exception, and without some authoritative body which can clearly enunciate ethical principles freely accepted by the profession as a voluntary discipline, then we will face intolerable pressures ahead.

Has not the time come for the British Medical Association, together with the Royal Colleges, to set up a body to provide general guidance to the profession, Parliament, and the public on ethical issues, especially those relating to the value of human life ? If such guidance had been available two years ago, and had been acted upon, we might have been spared some of the anomalies of the Abortion Act which are now causing such a conflict of loyalties. A body of this kind, if endowed with sufficient authority, could also play a vital part in protecting the medical profession from being manipulated by politicians, who may be subject to divers pressures, and who in any case do not have the ultimate responsibility for putting their legislation into practice.

With the abysmal lack of moral leadership in Britain today more and more people are turning to their doctors for the kind of wise counselling which they can no longer obtain from other sources. This may be a key to our future role in society. Could it be that the medical profession, and the B.M.A. in particular, by giving a fearless lead in ethical and social issues, may provide a stabilizing factor for the whole nation in the days which lie ahead ?—We are, etc.,

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Heroin Dependence in Britain and the U.S.A.

SIR,—I feel that comment is required on the comparison of the mortality of British and New York City addicts made by Drs. T. H. Bewley, O. Ben-Arie, and I. P. James in their article entitled "Morbidity and Mortality from Heroin Dependence" (23 March, p. 725).

The comparison is a doubtful one, because both the numerator of deaths and the denominator of size of the New York City addict population are uncertain, and in any case not comparable to the Home Office index and the years-at-risk calculations used for the British addicts. These are different sums and give different answers. The authors use as a basis for their statement of the New York City rate Helpern and Rho[1] and Louria *et al.*[2] Unfortunately they neglect the far sounder study of Duvall, Locke, and Brill,[3] which used patients from the New York City area who had been discharged from the Lexington, Kentucky, narcotics hospital. They found a mortality rate of about 2 per 100 per year, a rate equal to that found by the authors among British addicts.

The reasons for the discrepancy between the first two studies and Duvall *et al.* are several. Firstly, in terms of the numerator the 350 deaths (380 in actuality) given for addicts in 1964 in this city were identified addicts only. This number has risen year by year through the 1950s and early 1960s, and then jumped from the 1964-through-1966 level to more than 500 in 1967. During this period the Office of Medical Examiner has become increasingly interested in the subject, and also, coincidentally, has introduced administrative changes centralizing much of the authority and functions of the borough medical examiners in the Manhattan office of the Chief Medical Examiner. This has resulted in an increase in identified addict deaths and a concomitant shift from an original Manhattan concentration of these deaths (75%) to one representing more deaths from the other boroughs (Manhattan now constitutes 45% of the total). Secondly, with regard to the denominator, the population of addicts in this city is much larger than the number of persons on the Narcotics Registry, but is more in the order of 50,000—a qualified calculation from Dr. F. Kavaler.[4]

The rate given for British addicts' mortality is based on a calculation of years at risk derived from entry to the index or register. However, it is absurd to assume that in Britain people become addicts solely at a point at which they are registered. There must be a preceding period of trial and increasing drug dependence. Therefore the registered addicts are a subgroup of the entire narcotic-using population (proportion unknown), selected because of greater drug dependence, longer usage, etc. This population of heavy users is not comparable to addicts in this city, who enter the Narcotics Registry files on the basis of reports from hospital, the police, and social agencies. To further strengthen this point the causes of death for these two groups are dissimilar. In New York City over 70% die of so-called "overdose"—in reality an unexplained syndrome of sudden collapse after intravenous injection, with the major finding at necropsy being pulmonary oedema.[5] This is apparently not seen in the British addicts, and they in turn suffer from proportionately more violent death, and deaths due to septic complications. Since it has been noted above that the overall mortality rate may be equivalent in the two populations if deaths due to "overdose" are eliminated from consideration the registered British addicts would then appear to have a far higher rate.

The registered British addicts may well be in poorer physical shape and have more severe illnesses than their New York City counterparts. This does seem to be the case