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Correspondence

Letters to the Editor should not exceed 500 words.

Heroin Without Prescription

SIR,—With the cessation of unauthorized prescribing of heroin it was hoped that the drug would not be available to those who are not prescribed it, and also that it would halt recruitment of newcomers to the habit. Our experience, based on Crawley, suggests that these hopes are not being fulfilled.

Those of us authorized to prescribe heroin in this area do not as a rule prescribe heroin on an outpatient basis, unless we have repeatedly failed in our attempts to get the patient off heroin on outpatient, daypatient, and inpatient treatment basis. In our opinion observation after inpatient admission is absolutely necessary to enable us to determine if the patient needs to be on heroin at all, and, if so, how much. In the present state of our knowledge we do not think that there are other reliable alternatives to this.

Our view is that maintenance of a patient on heroin, except in exceptional cases, is a very poor substitute to persuading the patient to come off heroin and rehabilitating him, and this we try to do.

One is aware that some clinicians will find our approach too inflexible. They may argue that (*a*) this attitude may encourage illicit trafficking, but to date there is little evidence to support its existence or the probability of its happening. And, even if it did exist, surely this is a problem primarily for the law enforcement agencies. (*b*) A sizable proportion of patients do not want to come off heroin. We have come across patients who on the face of it claim an unwillingness to come off heroin, but on further discussion we have found that these patients are not unwilling to come off heroin but are very afraid of facing an existence without heroin and feel hopeless about ever feeling "normal" without heroin or of achieving a heroin-free state. But this is not the same as not willing to come off heroin.

Thus, given that the patient can be persuaded to accept treatment, which involves heroin-free state, his incentive to come off heroin is very undermined if the drug is available to him, especially without needing a prescription, and it is this latter situation which is causing us concern.

Dr. de Alarcon and myself, both licensed to prescribe heroin, do not prescribe heroin for any of our patients. There is no evidence to suggest illicit trafficking as a commercial venture. And yet many of our patients can and do get heroin without prescription. Where does it come from? Evidence so far suggests that they buy the drugs mostly from "friends" or "blokes" who are receiving the drug on prescriptions elsewhere. What is even more disconcerting is that two boys have been initiated into the use of heroin within the last three months. The supplies, we learn, can be bought from "Piccadilly" or from "blokes" who will visit Crawley and oblige the needy. One wonders if a situation similar to this obtains in any other peripheral town. What, one may ask, is the source of this heroin? Is our prescribing perhaps too generous?—I am, etc.,

Horsham. N. H. RATHOD.

Requests for Abortion

SIR,—Even before the passage of the Abortion Act, 1967, I had begun to see in my gynaecological outpatient department an increase in the number of patients who were seeking to have their pregnancies terminated. This number is still increasing and results in considerable embarrassment to the outpatient department of a teaching hospital. The time spent in the consideration of each abortion case detracts from the time which can be spent with other patients. It is right that medical students should be taught on both types of patient, but a patient ill with gynaecological disease is now receiving a standard of attention less than is desirable. The effect on the inpatient service is also significant, and the demoralization of nursing staff has been referred to in a very well-balanced article by a contributor to the *Nursing Times* (12 July 1968).

I believe it will be necessary to apply some restriction to the numbers dealt with, beginning in the outpatient department. It is hard to see how this can be achieved in a manner compatible with the compassionate ethics of the profession. I am aware that the cases referred to me by my general-practitioner colleagues represent but a fraction of those who approach their family practitioners, and I am not anxious to embarrass my general-practitioner colleagues unnecessarily. It appears to me that action which might be taken would be along the following lines:

(*a*) To see only patients who are referred to me personally and by name.

(*b*) To see not more than four new patients for consideration of termination of pregnancy at any single outpatient session.

(*c*) To inform the general practitioner by return of post if I have no appointment for his patient in the course of the succeeding 10 days, so that he can refer the patient elsewhere.

I recognize that measures of this kind may be very difficult for practitioners to accept, even in a large city where there are other gynaecologists who do not claim exemption from the consideration of such cases on grounds of conscience. I shall therefore be most interested to discover whether any reasonable alternative measures can be suggested.—I am, etc.,

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St. Mary's Hospitals
Manchester.

Elderly in the Wrong Unit

SIR,—The findings of the excellent study by Dr. A. G. Mezey and others (6 July, p. 16) are confirmed by the following data on 464 patients who were referred to the department of geriatric medicine of Glasgow Royal Infirmary. All were visited at home by the consultant geriatric physician. 271 (64%) were accepted for admission to the geriatric service (and thus the term "misplaced" cannot be meaningfully applied to them); 17 (3%) were referred to the psychiatric unit; and other arrangements were made for the remainder. All patients accepted for the geriatric service were physically ill, and 48% of them had in addition obvious mental ab-