I wonder just how many of us anticipated this in 1967 when we debated the so-called reform of the Abortion Laws at the A.R.M. in Bristol. I know I was shouted down when I dared to foretell such events. Unfortunately, Government intervention in medical ethics has come home to roost—with dire consequences.

Quite apart from any Government investigation into the effects of the Abortion Act, it is high time the medical profession took stock of the situation and its involvement in the present situation. We are up against not only a serious ethical problem, but also one of demand and work load. If Britain is continually flooded with prospective abortees from the continent as well as our own, gynaecological problems, other than unwanted pregnancies irresponsibly acquired, are going to be neglected, to the detriment and increase of morbidity in this field of medicine. Morally our profession is in danger, its integrity at stake. Our traditional ethics are in conflict with the law of the land, and unless we make an effort to restore this problem we shall become debased and dishonoured.

Those of us who are atheists or agnostics probably see no major problem, apart from the work-load problem. But those of us who profess a Christian faith—and most of us do—cannot in all conscience condone the present state of affairs. Whether we be Catholic, Anglican, or Non-conformist, we are bound by the Commandments, and from this we cannot escape. "Thou shalt not kill" is the law of God, which no professed Christian can deny. The act of abortion is the taking of a human life and the breaking of this Commandment. However hard we try to evade this by philosophical arguments we cannot alter the fact. It is one of the basic truths. There are times, admittedly, when as individuals we feel we must advise termination of pregnancy in the interests of the health of our patients, but at such times we should with true humility and compassion search our conscience, with a full awareness of the sacrifice we may be making, not only of ourselves, but of our patients.

The advocates of sexual freedom and easy abortion consider themselves progressive and enlightened, as did the protagonists of the reform of our abortion laws. But did any of them consider the moral burden they place on those who have to advise and perform the operation? Have they witnessed the unavoidable guilt and emotional conflict in so many women who have had abortions? The answer is obviously "no," or otherwise they would temper their so-called enlightenment with more wisdom and logic.

I am not alone in this protest. Many of us feel this, especially in general practice, where perhaps we are more closely involved with the problems and emotions engendered. And where the law of the land is in conflict with the law of God we must stand up and say so, with courage and conviction.—I am, etc.,

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Homoeopathy

SIR,—I am most grateful to Mr. J. M. Potter (15 May, p. 401) for raising the question of controlled trials for homoeopathy. It is a matter too little understood outside homoeopathic circles, and one which merits explanation in the wider form.

The short answer is that we would welcome such trials. Unfortunately, the nature

of homoeopathic treatment does not lend itself easily to that method of testing. The homoeopathic approach is to treat the patient as a whole, rather than the disease. So different patients may be treated with different medicines for a malady which non-homoeopaths would generally regard—and treat—as the same in all of them.

A controlled trial, therefore, involves not merely the testing of a single medicine against a specific disease, but of a variety of treatments applied according to the diverse responses that the disease in question produces in different types of individuals. And in any trial this makes for a formidable number of statistical permutations. Indeed, so formidable as to require far more money, patients, and research resources than we possess. So we have been obliged to let each doctor finally judge the results of homoeopathy from his own experience of using it. It is a method to which, I suggest, in the end all doctors subscribe, anyway, modern research and trial methods notwithstanding. But even though we see the doctor's own knowledge and experience in the use of medicines as his ultimate recourse, we should be only too happy to co-operate in controlled trials for homoeopathy.

For doctors who wish to learn more directly about the practice and efficacy of current homoeopathic medicine, the Faculty of Homoeopathy runs postgraduate courses at the Royal London Homoeopathic Hospital, where the consultant physicians are always ready to help registered medical practitioners towards a basic understanding of our different approach to treatment of the patient.—I am, etc.,

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Falls in Acid Output

SIR,—I take it that one of the points of the paper by Dr. H. G. Desai and others on spontaneous and persisting decrease in maximal acid output (8 May, p. 313) is that spontaneous falls in acid output may mistakenly be attributed to the action of drugs, especially when they are given over long periods. They cite Hunt and Wales¹ as attributing a decrease in acid output to an anticholinergic.

We reported two findings. Firstly, that giving poldine continuously for six months reduced gastric secretion by half. After two months on dummy tablets secretion of acid returned to the original level. This we do attribute to poldine. Secondly, that gastric secretion of acid two years after the last dose of poldine was one-third less than it was before taking poldine. Concerning this second phenomenon we wrote "We do not regard this long term reduction of secretion as being a direct effect of poldine but as a manifestation of the course of the disorder."

In our patients the secretion of acid was very stable for over four years, the mean outputs of acid component, at six monthly intervals, being 49, 51, 48, 49, 51, 50, 53, 51, 53 with poldine compared with 91 and 87 without poldine. However, we were aware of the phenomenon documented by Dr. Desai and colleagues as one of us had described a similar fall in secretion of acid in two medical students on relief of stress."

I would agree with Dr. Desai and col-

leagues that such decreases in secretion may explain prolonged remissions in patients with duodenal ulcer. Poldine seems to be one way of making life comfortable for patients until these spontaneous falls occur.—I am, etc.,

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¹ Hunt, J. N., and Wales, R. C., *British Medical Journal*, 1966, 2, 13.

² Hunt, J. N., *Journal of Physiology*, 1951, 113, 169.

³ Hunt, J. N., and Price, T. M. L., *Practitioner*, 1967, 198, 156.

Care of Chronic Psychotics

SIR,—Your leading article on "Care of Chronic Psychotics" (15 May, p. 351) is both succinct and timely. In these days when psychiatrists are increasingly recognizing that multidisciplinary teams with individually defined roles (and not they themselves alone) are responsible for the treatment of the mentally ill, I would like to make a few general points which might help to bring the predicted run-down of beds to a reality.

(1). Objectives should be clearly defined and understood by all disciplines working in a hospital and at all levels. Psychiatrists, psychologists, nurses, social workers, occupational therapists, and professional administrators are all involved with many others. Effective communication for both planning and executive phases will therefore have to be established.

(2). It is essential that the staff of the hospital as a whole becomes community orientated. This may require a considerable relearning experience for many whose orientation has been to think first of moving patients to long-stay beds to make room for new admissions.

(3). Admission and discharge policies should always be closely vetted to avoid unnecessary delay in starting treatment after admission and unnecessary delay in discharge at completion of treatment. In this way, "throughput" will increase and pressure on beds be reduced, thus obviating moves to long-stay beds for administrative reasons.

(4). Certain officers in psychiatric hospitals still have their salaries fixed to the number of beds, despite representations by influential bodies to change this archaic practice. I understand that reassurances have been given, but would it not be much more realistic to fix salaries to population served?

Finally, one point about rehabilitation of long-stay patients. The criterion for discharge of these patients should be that they go to a situation in the community which is at least equal to the one which they had in hospital. If this is not so, I share the view expressed in the article that many will find their way into prison, or at least become a greater liability in some other way.—I am, etc.,

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SIR,—In your leading article entitled "Care of Chronic Psychotics" (15 May, p. 351) you quote Kathleen Jones's statement that "Only in Britain, has 'progress' taken the form of denying that the mental hospital has a useful function and planning for its abolition."¹ However, if this is the British view I would