Correspondence

Letters to the Editor should not exceed 500 words.

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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.,

W. I. C. MORRIS,
Professor of Obstetrics and Gynaecology,
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-

normality, defined as: Loss or severe impairment of the capacity for self-care and self-preservation, or the occurrence of socially unacceptable behaviour, as a result of adverse intellectual or emotional change.

Four symptoms of advanced physical disease—stroke, multiple falls, inability to walk, and incontinence—were looked for in these patients. Two or more were present in 52% of the mentally normal and in 69% of the mentally abnormal. Both groups of patients were treated in the same wards by the same staff. Three months after admission 19% of the normal and 41% of the abnormal patients had died. The higher mortality of the mentally abnormal group might have been due to faulty management of their psychological symptoms or to the association of their mental symptoms with advanced physical disease. The latter explanation seems more likely. This is supported by the findings of Dr. Mezey and his colleagues; and though Kidd¹ in his original study rejected this explanation he did not provide figures comparing the mortality of mentally normal and mentally abnormal patients with physical disease treated in the same unit. I have not attempted to distinguish between physical-mental and mental-physical cases as defined by Kidd; my experience, however, lends no support to the view that "misplacement" is a significant factor in the high mortality of patients with mental symptoms admitted to a geriatric unit.

In the area covered by the study of Mezey and his colleagues many more old people were admitted to the geriatric than to the psychiatric unit. Similarly in this area I was able to estimate roughly that for every patient aged 65 or over admitted to the psychiatric service four entered the geriatric unit, and two of these had significant mental abnormality. Thus two-thirds of mentally abnormal old people requiring hospitalization in this area are treated in the geriatric unit.

Historically, our hospitals developed separate facilities and separate staff-training for the physically and mentally ill, and were then embarrassed by the arrival of a population of old people in whom physical and mental symptoms frequently coexisted. It is no solution to divide patients into arbitrary categories; to define some as "misplaced"; and to suggest the establishment of a third type of hospital unit to deal with them. A more obvious solution is to provide facilities for the diagnosis and treatment of physical and mental symptoms at the point of admission. This already happens in geriatric assessment units, though of course their staffs would benefit from more formal training in the management of psychological disease in the elderly. The special jointly staffed psychogeriatric unit advocated by Kay and colleagues,² located in teaching centres, could provide this training as well as teaching medical students and nurses and conducting research. But the service needs of the country as a whole would, in my opinion, best be met by the admission in the first instance to the geriatric assessment unit of all physically ill old people, whether or not they have mental symptoms. It would be difficult and uneconomical for many psychiatric hospitals to duplicate the complex diagnostic and treatment facilities of the modern geriatric admission unit. Psychiatrists would continue to deal with the com-

paratively few mentally ill old people whose physical health is normal (these comprised some 8% of the patients in the series of Dr. Mezey and his colleagues). Psychiatrists could also help greatly by their regular attendance at case conferences and seminars in their local geriatric units, to whose staffs they could communicate their specialized knowledge and insight. Such a scheme could lead to a situation where the medical care of the elderly depends on the principle that mental and physical diseases occur together and should be treated together.—I am, etc.,

BERNARD ISAACS.

Glasgow Royal Infirmary.

REFERENCES

- ¹ Kidd, C. B., *Brit. med. J.*, 1962, 2, 1491.
- ² Kay, D. W. K., Roth, M., and Hall, M. R. P., *Brit. med. J.*, 1966, 2, 967.

Old People in Hospital

SIR,—I hope that the somewhat detached tone of your comments on the outcome of the *Sans Everything* controversy (20 July, p. 135) is not an accurate reflection of the degree to which doctors feel themselves involved in the matter.

The *Findings and Recommendations*¹ which the Minister of Health presented to Parliament comments on overcrowding and shortage of nursing staff. Overcrowding occurs because doctors admit more patients than the hospital has room for. Shortage of nurses implies that doctors admit more patients than the nurses can properly look after. The inquiries also comment on the need for improved communications between doctors and nursing staff. Five of the seven hospitals named have between 1,288 and 2,258 beds—an average of 1,708. This piece of information is not stated in the reports but is the only finding of interest resulting from publicly naming the hospitals concerned, which I otherwise think unjustifiable. Revans has shown how large hospitals tend to have communication difficulties and low morale, so this finding is not surprising.² Doctors faced with an elderly patient living in unhealthy conditions in the community have to decide whether to admit her to an institution where she will increase the overcrowding and impose an extra burden on inadequate nursing staff—thus increasing the risk of allegations against them (not against the doctors) of cruelty or negligence; or on the other hand to leave her where she is to deteriorate and die in her familiar, if objectively squalid, surroundings.

Perhaps it is easier for the doctor to admit, and pretend that he is being compassionate to the patient (if cruel to his nursing staff), than to refuse to admit, on the realistic grounds that the community is failing to provide adequate facilities. But let us not pretend that we think that *Sans Everything* (even if exaggerated) was an unjustified publication, and that anyway it is no responsibility of the doctors.—I am, etc.,

JAMES R. MATHERS.

Birmingham.

REFERENCE

- ¹ *Findings and Recommendations Following Enquiries into Allegations Concerning the Care of Elderly Patients in Certain Hospitals*, Cmnd. 3687, 1968. H.M.S.O., London.
- ² Revans, R. W., *Standards for Morale*, 1964. London.

Intraperitoneal Transfusion in Anaemia

SIR,—We should be grateful to Dr. J. M. Fowler and others ("Intraperitoneal blood transfusion in African adults with hookworm anaemia") (27 July, p. 220) for providing such a clear demonstration of the potential usefulness of intraperitoneal transfusion in tropical practice. Their extension of the technique to the treatment of adults should prove to be of great value, particularly "in rural hospitals where . . . a simple, safe and effective method is obviously needed." Their implication that the therapeutic value of such transfusions in children has already been established is, however, open to question. No controlled clinical trial to compare it with the conventional intravenous route has yet been made.

Last year in a rural West African mission hospital both the intravenous and intraperitoneal method were being used in children under 5 years of age in whom malaria, severe pyogenic infections, and protein-calorie malnutrition were the main cause of anaemia; hookworm was rare. No attempt was made at pairing or random allocation between the two methods, and in general the most seriously ill children received intravenous blood. But even when this was taken into account the results of intraperitoneal transfusions were disappointing by comparison. In 57 such transfusions there were 17 deaths (30%), while among 48 cases where intravenous blood was given initially (18 of these subsequently had some intraperitoneal blood as well) there were only seven deaths (15%). In three cases of the first group it seemed likely that the intraperitoneal transfusion itself was a contributory cause of death. Only 38% of the group having intraperitoneal blood showed a satisfactory rise in haemoglobin concentration (at least 5 g./100 ml. in four weeks), while 62% of the intravenous transfusions produced a similar rise.

We concluded that in these severe anaemias in young children, where cardiac failure was not often a presenting feature, intraperitoneal transfusions did not seem to be a satisfactory alternative. Nevertheless, we thought they were worth a clinical trial in childhood cases of chronic, compensated anaemia.

We had another striking finding that is corroborated by the results of Dr. Fowler and colleagues. This was the wide variation between patients in the response of the haemoglobin concentration to intraperitoneal transfusion. While a few showed a dramatic rise of as much as 2 g./100 ml. per day, others showed little or no change, and the difference could not be correlated with the cause, the severity, or the chronicity of the anaemia.—I am, etc.,

J. M. PATRICK.

Department of Physiology,
The University,
Dundee.

Electric Convulsion Therapy

SIR,—Your leading article (25 May, p. 448) on electric convulsion therapy was most welcome as an attempt to explain one of the most successful and least understood therapies in medicine. Unfortunately it has not so far stimulated the discussion it deserved.

Your leading article discusses the effects of E.C.T. at the biochemical level and dismisses any theory that its efficacy could be due to factors at the conscious or behavioural level. The statement that E.C.T. is not a "punishment" is misleading. Though it does not