During this period I have had contact with 213 such addicts. In 144 of these treatment was temporary, or they have been lost sight of in one way or another. The remaining 69 have been under continuous observation for periods of up to five years. Thirteen are still receiving regular supplies of heroin or of heroin and cocaine. In 56 cases it has been possible to withdraw the drugs either completely or by substituting other drugs such as amidone or methylamphetamine. Twenty of them have been off narcotics for a year or less; 18 for between one and two years; 14 for between two and three years; and four for more than three years.

These 56 fell into the following age groups:

15–19	20–24	25–29	30–34	35–39	40 and over
6	22	18	4	3	3

Of those still receiving drugs a much higher proportion fall into the higher age groups:

15–19	20–24	25–29	30–34	35–39	40 and over
0	2	0	3	1	7

Of the 144 who have not been in continuous treatment information kindly given by the Home Office indicates that 29 are off narcotics. This means that of this group of 213 addicts 85 have been successfully treated. This illness is known to have a high relapse rate, but these figures suggest that continuous treatment over a period of years is more successful than is commonly believed.

Seventeen of the 213 have died from causes more or less directly attributable to their addiction—about 8% in five years. Heroin addiction is still a very rare disease; less than 800 cases are known in the U.K. These deaths, most of them young adults, are probably all preventable.

My experience has been of trying to treat these people, many of whom desperately want to get clear of their addiction. What has chiefly impressed me is the pitifully inadequate means available to help them; a mere handful of general practitioners willing to undertake their day-to-day care; a hospital system very poorly geared to undertake inpatient admission for the purpose of withdrawing the drug; no aftercare arrangements of any kind.

Of the 56 successful withdrawals, 26 were effected in mental hospitals, 22 at home with supportive attendance at the surgery, five in prison, and three in general hospitals. Latterly a larger number have been withdrawn at home, and relatively lesser numbers in mental hospitals, admission to which has become more difficult in my experience. For the addict by far the most pleasant method of withdrawal is in a general hospital. But whatever the final means, the essential work is done by constant and unremitting pressure and support by the doctor at surgery attendances week in and week out, often for several years. To take the treatment of drug addiction out of the hands of general practitioners may easily reduce the existing slender means of treatment to vanishing point. I believe that more, not less, doctors should be treating this illness, and that they should be backed up by adequate inpatient facilities, preferably in general hospitals. To achieve this, education of doctors (and also of administrators) is urgently required.—I am, etc.,

JOHN HEWETSON.

London S.E.1.

Professional Freedom Threatened

SIR,—I have now spent twenty years in general practice. During the whole of that time I have proudly shouldered both the duty and the responsibility of being permitted to carry out any medical or surgical treatment needed by any of my patients, even abortion, albeit this latter only subject to certain reasonable legal safeguards. In fact, I have not carried out a single abortion, or even felt tempted to.

Under the proposed Abortion Bill, as I see it, I am summarily to be deprived of this professional right for no fault of mine, and only a limited number of certain doctors are to be designated as having a licence to kill unborn babies. But in an emergency, it seems, my right—and duty—to do the necessary are restored to me. Aren't we back to "square one"? What constitutes an emergency?

Again, for twenty years past I have been entitled to prescribe for my patients whatever treatment I considered best, including the "heavy" narcotics. In fact, I have prescribed cocaine or heroin on only some six occasions. Under the new proposals concerning drugs, as I see it, I am summarily to be deprived of this professional right, the right to prescribe these drugs to addicts.

Our patients respect us for the professional powers vested in us. To deprive us of our rights earned by hard work and retained by a lifetime of proper professional conduct can only lead to further loss of status. If the authorities do not trust us, how can we expect our patients to? Again, once these restrictions are allowed to start, where will they end? Surely it is naive to think that once general practitioners are barred from performing abortions or prescribing certain drugs for certain patients the problem is solved. With respect to my consultant colleagues, I submit that there always have been, and always will be, a very small proportion of black sheep in all walks of life, in all professions, and in all branches of all professions.

To misquote, I may never wish to do these things, but I feel I must defend with all my might my right to do them.—I am, etc.,

Birmingham. K. E. JOLLES.

Termination of Pregnancy Bill

SIR,—The B.M.A. Council[1] was not unanimous in approving the joint B.M.A./R.C.O.G. report[2] on Mr. Steel's Bill. I for one spoke against and voted against acceptance on precisely the two grounds which Dr. P. A. T. Wood (4 February, p. 299) finds objectionable.

I too strongly object to creating the professional equivalent of a private grouse moor to be shot over only by this or that favoured sectional interest. Once this principle of restricting certain forms of treatment to certain sections of the profession is admitted, no limit can be set to its application.

With regard to registered nursing-homes, it was pointed out by a fellow member of Council that nursing-homes are registered with the local health authority for specific purposes—for example, a nursing-home might be registered for only geriatric patients and might not have facilities for surgical operations. It seemed to me that this could be overcome by specifying in the Bill "a registered nursing-home suitable for surgical operations."

On the face of it, it seems absurd for the B.M.A. always to be prating about the patient having as full a choice of medical facilities as possible, and then denying these to a woman who wishes to have an abortion in a nursing-home.

I may perhaps add that I am not a member of the Fellowship for Freedom in Medicine.—I am, etc.,

A. M. RANKIN.

Aspatria, Cumberland.

REFERENCES

1 *Brit. med. J. Suppl.*, 1967, **1**, 6.
2 *Brit. med. J.*, 1966, **2**, 1649.

SIR,—Dr. Evelyn Fisher (28 January, p. 236) suggests that the post-abortal guilt complex can be assessed "about six weeks after the abortion." I have during recent years encountered two patients who when asked about anxiety recalled abortions that had been carried out 20 or more years before. There are few people so miserable as the childless menopausal woman who bitterly recalls the abortion of her first child. Unfortunately the human conscience has a long memory.—I am, etc.,

Bristol 8. W. M. CAPPER.

Neurosurgery in Haemophiliacs

SIR,—Since you published our article "Management of Intracranial Haemorrhage in Haemophilia" (31 December, p. 1627) it has been brought to our attention that the data originally obtained from Mr. Potter as a personal communication have been published.[1] In conjunction with the Oxford Blood Coagulation Research Unit he has demonstrated, like ourselves, the relative safety of neurosurgery in haemophiliacs suffering from intracranial bleeding who are treated with appropriate factor VIII or factor IX preparations in adequate amounts and under properly controlled conditions.—I am, etc.,

S. H. DAVIES.

Royal Infirmary, Edinburgh.

REFERENCE

1 Potter, J. M., *Acta neurochir. (Wien)*, 1965, **13**, 380.

Pulmonary Artery Thrombosis and the Nephrotic Syndrome

SIR,—In discussing the aetiology of the pulmonary artery thrombosis in their patient with nephrotic syndrome Dr. S. E. Levin and colleagues (21 January, p. 153) point out that the alpha-2 globulins, which are usually increased in the sera of patients with the nephrotic syndrome, have been shown to possess antifibrinolytic activity.[1] It has also been observed that in a normal serum the antifibrinolytic effect of that serum resides very largely in the alpha-2 globulin fraction.[2]

Using the method of R. D. Mann[3] for estimating the inhibitory effect of plasma or serum on fibrinolysis, I have observed in each