This is how many mothers cope with the situation, especially those who fear that social workers will remove their babies, as many do. They conceal their drug-taking throughout pregnancy, probably with husband or boyfriend smuggling drugs into the lying-in ward. As a profession we should feel ashamed that mothers have so little confidence in us and so much fear. The lack of confidence comes partly from the fact that the addict knows immediately if the doctor is ignorant about drug use, and many doctors are. The fear comes from the press, the attitude of so many professional carers, and the fact that many babies *have* been taken away in the past.

An important subject omitted by Dr Riley is injection. Almost everyone who is heavily addicted to opiates injects. Giving up injecting is as difficult as giving up the drugs themselves, whether in pregnancy or otherwise. What does the caring doctor do about that? Many of the 'good girls' apparently reducing on their daily dose of liquid oral methadone are in fact injecting on the side, often in 'secret' sites. Urine tests will not reveal this unless they inject a different drug, in which case they are probably clever enough to fake the urine test, which is usually easy to do. An addict patient of mine described her care during pregnancy under a doctor at a London teaching hospital. She said, "Dr X is a lovely doctor, ever so sympathetic. The only trouble is that if she looks after you, you have to get your drugs from the black market, and I always felt that couldn't be good for the baby."

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DEAR SIRS

Dr Riley's paper (*Bulletin*, November 1987, **11**, 362–365) was read with interest. In the United States there appears to be a policy of methadone maintenance throughout the confinement.[1] Others have suggested treatments varying according to the trimester with stabilising on methadone during the first and then gradual reduction during the second.[2] If the patient presents as late as the third trimester there is a significant risk that withdrawal of opiates may lead to premature labour, foetal distress, meconium aspiration and foetal death should the mother experience withdrawal symptoms.[1,2,3,4]

In an effort to prevent this development it is suggested that the mother is maintained on the minimum amount of opiates necessary during this final stage. The risk with this approach, however, is that the new-born infant may experience a withdrawal syndrome characterised by vomiting or diarrhoea, hyperpyrexia, irritability, tremors, inability to sleep between feeds and convulsions.[3] This syndrome occurs more frequently and is more severe and protracted in babies born to mothers dependent upon methadone as opposed to heroin, the seizure rate for the former group being five times that of the latter.[3] Consequently we suggest that a case can be made for prescribing heroin to the pregnant drug addict who presents for the first time in the final trimester.

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Dr Riley replies:

DEAR SIRS

Drs Thomas and Osborn are correct in stating that the available evidence shows more prolonged and severe withdrawal effects in infants whose mothers are maintained on methadone as opposed to heroin. However, these effects can be mitigated by good neonatal care, and the advantages of using oral methadone are considerable. Our policy has been to maintain patients in the community once the initial assessment has been completed, and it might be considered unwise to increase the supply of injectable heroin and syringes on the drug scene at large by prescribing them for out-patients.

Dr Dally's patients are clearly a very different group from those generally seen at UCH. Those who can afford private consultation and prescription fees are certainly more wealthy and probably more stable than our patients who are often homeless, living on Supplementary Benefit, usually with a criminal record, and with little community support. However, a few patients who have been maintained on a steady dose of methadone for many years have presented for treatment, and even these women have been willing to reduce the dose in pregnancy to minimise the withdrawal effects in their babies. This willingness is perhaps a measure of their attachment to the pregnancy, and of the time spent by medical and nursing staff in careful explanation.

Dr Dally totally overlooks the fact that we are responsible for the treatment of two patients: the foetus as well as the mother. Severe withdrawal symptoms in the infants may include *grand mal* convulsions: a terrible price to pay for the mother's right to continue a high dosage of opiates. The case she reports gives no details of the opiate dosage or

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length of addiction. It is not possible to argue from a single case, nor, perhaps appropriate to bet on such a serious issue. We are currently preparing a report on more than 30 addicts treated according to our protocol, and most of our 'chaotic' addicts have also had healthy babies at term.

Addiction to injection may be less important now in the climate of anxiety about HIV infection. However, injectable methadone is not licensed for intravenous injection, and causes thrombophlebitis and the risk of septicaemia when used in this way. The few patients on injectable methadone in our series have been willing to change to oral medication when the dangers have been explained.

Her statement that it can be 'morally responsible' for the parent to treat her own child with opiates is in itself so irresponsible as to require no further comment, especially in view of the increased incidence of neonatal death in these infants. Paediatricians use chlorpromazine or phenobarbitone to treat the infants because these are relatively safe in the neonate, and do not have the low lethal threshold of opiates. Surely few lay people are experienced in neonatal pharmacokinetics, and infant deaths from opiate poisoning have been reported.

That parents do treat their babies in this way because of 'lack of confidence in their professional advisers' is no excuse. The cornerstone of successful treatment is a trusting relationship between doctor and patient. The plan of treatment is openly negotiated, and the reduction carried out with the patient's full agreement. Good ante-natal care, social support, and flexibility of dosage are part of the total plan.

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Professor Edward Anderson

DEAR SIRS

I was very interested to read the interview with Professor Rawnsley which appeared in January's *Bulletin*. I was particularly pleased to note that he has set the record straight regarding Professor Anderson, who in my opinion also has been much under-estimated. I think Anderson must be credited with a large share of the interest that has developed in recent years in the work done by German-speaking psychiatrists, particularly such figures as Kurt Schneider. He also played a considerable role in making known to us the importance of phenomenology in psychiatry and in particular the contribution of Karl Jaspers. He had a great influence on postgraduate students in Manchester and although he worked in a very modest department, his teaching had a profound and lasting effect on British psychiatry, which he enriched with the treasury of continental scholarship.

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Canadian qualifications for British psychiatrists

DEAR SIRS

Further to our recent correspondence on the above subject (*Bulletin*, January 1988) it has come to our attention that the Canadian Royal College of Physicians and Surgeons has recently implemented a further prerequisite for non-North American psychiatrists in respect of their eligibility to take the FRCP (Psych) examination. It is now required that all non-North American psychiatrists complete a one year rotating internship (in UK terms house officer status) of the North American type, in order to attain eligibility for this examination. This is in addition to the other mandatory requirements of passing a North American screening examination and having one's psychiatric training assessed by the Royal College. The need for this internship, however, may be bypassed if one passes an oral examination of clinical competence organised by a Canadian medical school. While this examination of 'clinical competence' is now available for non-North American psychiatric trainees in Canadian residency programmes, it is not clear, as yet, as to whether physicians outside such residency programmes will be able to avail themselves of this assessment.

We regret that this information was not present in our earlier letter. It does, however, present yet a further significant hurdle to UK psychiatrists achieving Canadian psychiatric qualifications, which we feel British trained psychiatrists considering a career in Canada should be aware of.

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The need for asylum

DEAR SIRS

I cannot rival the eloquence of Drs Garelick and Abrahamson in their complementary papers in February's *Bulletin*. I do, however, wish to support fully the ideas they put forward.

Dr Garelick's account of the local planning process makes extraordinary reading with regard to the lack of weight given to clinicians' opinions in the process. Both he and Dr Abrahamson make a compelling case for the need for asylum as part of the psychiatric service, in turn Dr Abrahamson suggests that the apologetic tone of the consensus statement from the Third Kings Fund Forum is ill-judged.

The reality is that many patients (not clients, consumers or recipients) are crippled by severe psychiatric illness (not merely distressed). I much prefer the medical paternalism which is prepared to state what such patients need (in some cases long-term hospital asylum) to the arrogance of the self-styled patients' advocates who claim to know what they want without benefit of any face-to-face contact.

We are fortunate in Scotland in that whatever difficulties

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