reflection on our current values. Surely the time has come to call a halt to such nonsense.

The journal advertising of drugs also leaves much to be desired. In the *BMJ* of 30 October 1976 there was an advertisement for Fortral (pentazocine) which claimed that with this drug there was "relief from the disadvantages usually associated with the opiates" (stated to be "nausea, vomiting, smooth muscle effects and respiratory depression"). This is quite untrue and dangerously misleading. Pentazocine is a potent respiratory depressant. In equianalgesic doses it can produce the same degree of respiratory depression as morphine and pethidine,^{2,3} and in larger doses it can cause apnoea.³ I know of cases of acute respiratory failure precipitated by the unwise administration of pentazocine by junior doctors who were under the false impression that it does not depress respiration. The perpetuation of this myth by such advertisements is totally irresponsible.

The promotional activities of the pharmaceutical industry have often been criticised by members of the medical profession and this criticism has been extended to the news media.⁶ Although the Government is currently restricting expenditure on drug promotion, further measures are obviously required.

L F PRESCOTT

University Department of Therapeutics,
Royal Infirmary,
Edinburgh

¹ Housley, E, *Prescribers' Journal*, 1974, **14**, 33.

² Potter, D R, and Payne, J P, *British Journal of Anaesthesia*, 1970, **42**, 186.

³ Duncan, S L B, Ginsburg, J, and Morris, N F, *American Journal of Obstetrics and Gynecology*, 1969, **105**, 197.

⁴ Bellville, J W, and Green, J, *Clinical Pharmacology and Therapeutics*, 1965, **6**, 152.

⁵ Evans, L E J, et al, *Lancet*, 1973, **1**, 452.

⁶ *Guardian*, 4 January, 1977, p 8.

Amendment of the Abortion Act

SIR,—The Doctors and Overpopulation Group has as one of its aims the maintenance of a liberal abortion policy, and because there now appears to be a further threat to weaken the provisions of the 1967 Act we would like to advance a few reasons for preserving the status quo.

In the areas where the Act is being properly implemented it is working well and its provisions are being interpreted in a responsible way. If any alterations are to be made these should be directed to levelling out the gross inequalities in NHS provisions for termination in the different areas of the country.

Virtually all the alterations to the 1967 Act were achieved by the Report of the Lane Committee,¹ and all that has happened since then is the waste of a large amount of parliamentary time to very little purpose. Abuses have been dealt with adequately and even if any did remain they would be abolished more effectively by improvements in NHS provisions for termination than by legislation.

The medical profession has shown itself to be sympathetic to the idea of a liberal abortion law and at the same time has made good use of the opportunities provided by the advent of a free family planning service. This has resulted in a downward trend in the number of abortions performed each year and for this reason it would seem even less necessary now than formerly to make any change in our abortion laws.

We believe that any further restrictions, however well-intentioned, will not reduce the number of abortions carried out but will rather cause them to be performed later in pregnancy with a resultant increase in morbidity and mortality. This is a time to leave well alone.

J A LORRAINE
Chairman

J P LESTER
Secretary,

Doctors and Overpopulation Group
Walsall, W Midlands

¹ *Report of the Committee on the Working of the Abortion Act*, London, HMSO, 1974.

Gallup poll on abortion

SIR,—I was intrigued by the letter from Professor R W Beard and Mr D B Paintin (12 February, p 448). At first I thought that a new method of induction by Gallup poll had been discovered (see line 3), but leaving that little matter of English aside I would like a further explanation of our language.

What is the essential difference between "available on demand" and "that abortion should be performed at the request of the woman once she has had adequate counselling" or that the doctor "should 'allow' abortion if she feels sure that it is a better course of action than continuing the pregnancy?" Then too they consider that the concept leaving room "for the conscience of the individual to act as he or she thinks right . . . should extend to the patient as well as to the doctor." Professor Beard and Mr Paintin, however, know right well that it is now virtually impossible for anybody to obtain an appointment as gynaecologist on the staff of a National Health hospital if, for religious or other reasons, he is unwilling to procure abortions. It is a closed shop.

Parliament is entitled to say that life may not be destroyed except in certain circumstances, but I am surprised that a permissive Act has been interpreted by the profession as directive. Is it to be expected that doctors will be virtually compelled to terminate life just because Parliament passes an Act allowing euthanasia? I may add that I was not favoured with a Gallup questionnaire.

G W THEOBALD

Eastbourne, E Sussex

SIR,—With my St Mary's colleagues I, too, received a Gallup poll questionnaire and wondered who was paying for it and who would interpret and publish the findings. Having read the interpretation by Professor A W Beard and Mr D B Paintin of the 1967 Abortion Act (12 February, p 448) I begin to see the value of Gallup-style inquiries. Opinions given in good faith differ widely. For example, the television programme in which Mr Paintin carried out an abortion under local anaesthesia at St Mary's made it clear that, with his lay counsellors, he was impressed by social pressure on his patient—apparently a healthy, married young woman.

If, as stated in their letter, the St Mary's team operate under the phrase "if she feels sure it [abortion] is a better course of action than continuing the pregnancy" surely this is abortion on request. One of my senior and respected colleagues, when discussing the pros and cons of legal abortion, reads the 1967 Act to his patient. The operative clause 1 (1) (a),

which is used to cover most NHS and private abortions, reads "that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated."

Had Parliament thought it right to allow abortion according to a doctor's "own sense of right or wrong" it would have said so and we should have had abortion on demand. But Parliament did not say that. Thus we have confusion which in practice means the matching of women who wish abortion with doctors who will do it for them. In the meantime we have the 1967 Abortion Act which in its initial stages was called by David Steel and the Abortion Law Reform Association "The Medical Termination of Pregnancy Bill" (my italics).

HUGH CAMERON McLAREN

University Department of Obstetrics
and Gynaecology,
Birmingham Maternity Hospital,
Birmingham

* * * We have received a number of other letters expressing views very similar to those of Professors Theobald and McLaren.—Ed, *BMJ*.

Allergy to diazepam

SIR,—We would like to comment on the report from Dr Louis Milner (15 January, p 144) and the subsequent letters from Drs Donald Blatchley and R H Falk (29 January, p 287).

We are investigating the mechanisms involved in the reactions to Althesin and propanidid and preliminary reports have appeared.^{1,2} Concurrently we are applying the same investigatory techniques to the use of diazepam and diazepam diluted with Cremophor EL, given intravenously. Although we have few results as yet it seems that diazepam provokes in some patients similar subclinical reactions to those manifested by Althesin and propanidid.

Of seven patients treated with diazepam, five showed significant white blood cell variations of a type which we have previously suggested results from complement C3 activation and implies drug recognition or immunological memory.² Our records show that all these patients had probably received diazepam on at least one previous occasion. Three of the patients were given diazepam mixed with Cremophor EL (0.1 ml) and diluted with water. It was noted that while one of these patients showed no measurable leucocyte response the phenomenon was very marked in the other two and significant falls in platelet counts, indicating aggregation, also occurred. Although one would not attempt to analyse such limited data statistically, it is interesting that the incidence of subclinical response, five out of seven, is similar to that observed with the intravenous hypnotic agents (60%). We have previously suggested that, although Cremophor is most unlikely to initiate immunological reactions, its surfactant properties may enable it to present the drug to immunocompetent cells in more active form—that is, to act as an adjuvant.

Although correlation and threshold between subclinical and clinical responses remain obscure, any degree of immune memory probably infers a potential hypersensitivity

response. The increasingly widespread use of drugs such as diazepam and the tendency to use Cremophor solubilisation to prevent thrombophlebitis and injection pain must increase the chances of clinical responses occurring. The next few years may well see an increasing number of reports of anaphylactoid phenomena to what have long been considered "safe" drugs.

ADRIAN PADFIELD
JOHN WATKINS

Department of Anaesthetics and
Immunology,
Hallamshire Hospital Medical
School,
Sheffield

¹ Watkins, J, et al, *British Journal of Anaesthesia*, 1976, 48, 457.

² Watkins, J, et al, *British Journal of Anaesthesia*, 1976, 48, 881.

Dream, mirage, or nemesis?

SIR,—Your leading article (25 December, p 1521) gave the impression that Professor Thomas McKeown dealt at length in his Rock Carling lecture with the misconceptions of medicine as dream, mirage, and nemesis, as indeed does his subtitle.¹ In fact, all three of them are dismissed in only 12 of the 180 pages. I concentrate on nemesis as the most serious and topical attack on the medical establishment.

McKeown and you base your criticisms on Illich's draft and ignore the revised and enlarged book published earlier in 1976 and reprinted in November.² I find it more lucid though still difficult reading (but so is Gibbon) and profusely referenced, while McKeown makes only a few passing historical allusions in this section, as in most of his book. The first two areas of criticism levelled at Illich and echoed slavishly in your leading article have been considerably weakened if *Limits to Medicine* is read. On the third point Illich does not regard suffering as an inescapable feature of the human condition nor does McKeown accuse him of this.

Most importantly, in my view, this attack on Illich has entirely ignored the fact that medical nemesis is but his latest of several models for social assessment and political action aimed at an inversion of industrialised society. This contemporary Savonarola will hardly be worried, as he avowedly wrote for laymen and believes doctors to be incorrigible.

DONALD S McLAREN

Department of Physiology,
University Medical School,
Edinburgh

¹ McKeown, T, *The Role of Medicine: Dream, Mirage or Nemesis?* London, Nuffield Provincial Hospitals Trust, 1976.

² Illich, I, *Limits to Medicine: Medical Nemesis: The Expropriation of Health*. London, Marion Boyars, 1976.

Systemic chemotherapy for primary breast cancer

SIR,—In view of the article by the Co-ordinating Committee for Clinical Trials of the Treatment of Breast Cancer (5 February, p 361) may we report that a second adjuvant chemotherapy trial began in Birmingham in December 1976. It is a multicentre trial within the West Midlands area, organised by the West Midlands Oncological Association and designed using the guidelines of the International Union Against Cancer.¹

All surgeons are asked to perform a simple mastectomy with axillary node sampling and patients are randomised according to node and menopausal status and tumour size. Node-positive patients receive a combination of vincristine, adriamycin, 5-fluorouracil, cyclophosphamide, and methotrexate, given intravenously, and node-negative patients receive oral cyclophosphamide, methotrexate, and chlorambucil. Both regimens are given for eight cycles at three-weekly intervals. Minimal investigations are full blood count, biochemical profile, bone scan, and x-rays of chest and skeleton. Additional studies include the collection of serum samples for the evaluation of tumour markers and the collection of the tumour for oestrogen and prolactin receptor assay and for hormone and drug sensitivity assays.

With 1800 new cases of breast cancer in the West Midlands per year we envisage that the majority of patients will be entered within one year.

MICHAEL MORRISON
Chairman,
West Midlands Oncological
Association Breast Group

A HOWELL
Trial Co-ordinator

Breast Trial,
Health Services Research Centre,
University of Birmingham Medical School
Birmingham

¹ International Union Against Cancer (UICC), *Controlled Therapeutic Trials in Cancer*, Technical Report Series, vol 14. Geneva, I.U.C.C. 1974.

SIR,—The timely report by the Co-ordinating Committee (5 February, p 361) setting out the clinical trials of treatment of breast cancer already being undertaken in Britain and Ireland, and spelling out in some detail the requirements for a satisfactory trial, leads one to question the wisdom of setting up any more trials of chemotherapy in Great Britain at the present time. It is important that our slender resources of manpower and money should be used wisely. The 13 trials reported are in Great Britain alone and there are many others already in operation in other countries from which information will be available to all.

Perhaps an equally important question hinted at in your leading article in the same issue (p 336) is, "What is the general surgeon to do in dealing with breast cancer? What is his contribution?" He can treat in what he believes to be the best way, having kept himself informed of past and ongoing work, or he can join a multicentre trial if he feels that he himself and his hospital have the resources necessary to follow the protocol. It seems unlikely that the latter conditions can be fulfilled in many instances—to follow a protocol is no sinecure and would involve, in most cases, the surgeon giving up some other area of his work.

Regarding controlled trials in breast cancer, even if run under optimum conditions one must question their value as there are many areas (for example, pathology, the exact date of recurrence) in which differences arise between one centre and another. Thus unless results are outstandingly beneficial they are unlikely to be universally applicable and, if they are so outstanding, they will shine through over the poorest of protocols.

MARGARET MCCrackEN

General Infirmary,
Leeds

SIR,—The recent report (5 February, p 361) by the Co-ordinating Committee on prospective trials of treatment of breast cancer carries one implication which is liable to pass unnoticed and unquestioned—namely, that the type of treatment affects the prognosis. This, I think, is a tragic misconception. The fact of the matter is that the mortality from cancer of the breast in Britain has not altered in the past 50 years despite the introduction of many so-called modern forms of treatment. This in itself leaves the whole question of the type of treatment of cancer of the breast in grave doubt. It further casts grave doubt upon whether it is worth while to attempt such trials and whether the very genuine efforts being made by all the people involved in these expensive and time-consuming trials would not be best employed in thinking up some method whereby people could be treated earlier, because the one thing that sticks out like a sore thumb in the treatment of breast cancer is that the prognosis depends on the stage at which it is treated and not how it is treated.

It seems to me that in the past 50 years we have had enough experience in treating cancer of the breast to know that the only way we are going to get significantly better results in the future is by making sure we see patients earlier. So far we have waited for Mahomet to come to the mountain—that is, for the patient to visit the doctor. This is obviously an unsatisfactory way of dealing with this disease and the only way of improving the results is to move the mountain to Mahomet—in other words, to arrange to see the patients before they have any symptoms.

KEITH ABEL

London W1

Drug information services

SIR,—As another relative newcomer in the field, I would like to amplify the comments made by Dr D M Davies and his colleagues (8 January, p 89) on the provision of drug information services. Pharmacists, particularly those in hospital, have always been asked questions about drug-related problems. To support this role drug information centres were established in Leeds and London in 1970. Since that time centres have been established in many parts of the country, such that a network is now developing.¹

Therefore all members of the health care professions can benefit from improved access to information about drugs. Drug information centres provide details of pharmaceutical problems such as stability or intravenous additive incompatibilities, the availability or suppliers of drugs or medicines, adverse effects of drugs, identification of pharmaceuticals, their indications and contraindications in clinical use, interactions with other drugs, foods, or laboratory tests, pharmacology and pharmacokinetic data, together with many other, less usual topics, such as legal problems. Information on the above topics may also be actively distributed in the form of bulletins on such topics as drugs excreted in breast milk or interactions with oral contraceptives.

Dr Davies and his colleagues interpret "drug information" to relate only to toxicological problems or to those on which clinical opinion is needed, and in that interpretation their claim to be "comprehensive" is valid. On this basis they may also be justified in agreeing with the