programme combines consultative activities with intensive training of Polish staff in Scotland and Ireland and provides the infrastructure to support these activities (for example, advanced desktop publishing facilities). On completing their training Polish staff immediately participate in the day to day management of the programme. A lipid clinic has been established by the Gdansk-Glasgow team and is now run by Polish staff trained in Glasgow. The postgraduate course in which we participated was designed by the three nation team, led by Dr Z Jakubowski from Gdansk.

We should emphasise that the course was not advisory: it entailed critical comparison of the three systems. The 30 senior Polish clinical biochemists who participated were selected from over 60 applicants. They had extensive theoretical and research knowledge of their subject but face the consequences of the past centralised planning of purchase of equipment combined with little, if any, management training. This was probably the most serious problem that emerged from discussion.

We submit that this programme illustrates a different approach to what is generally termed aid or "foreign advisers . . . spending a great deal of time and money arriving at conclusions which [Polish professionals] reached long ago." In our view, the best approach is carefully planned, integrated programmes that combine training and interchange of staff and consultation, with funds to support the infrastructure required for development. Such collaboration should be followed by the establishment of longer term contacts between participating institutions. Advice is best taken from people you know; this takes time.

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1 Chopin K. Too many advisers, not enough aid. *BMJ* 1992;**304**: 1429-32. (30 May.)

Withdrawal of a monopoly treatment

EDITOR,—Over the past 20 years the renal unit in Dundee has investigated and advocated the use of intravenous iron dextran to treat anaemia in patients receiving dialysis.^{1,3} The advent of recombinant human erythropoietin has brought intravenous iron treatment to the fore again⁴ as the drawbacks of oral iron (gastrointestinal side effects, lack of compliance, and variable absorption from the gut) are more relevant when the need for iron is increased.

We are therefore seriously affected by Fisons Pharmaceutical Division's recent action in stopping the production of its iron dextran product (Imferon). The situation has been made worse by the lack of prior notice and the lack of an intravenous alternative. To date information has been circulated only to hospital pharmacists, not to physicians. Our understanding is that production of Imferon has ceased, with no indication of when or if it will resume, so that the production system can be updated to meet new regulations of the US Food and Drug Administration on dextrans for intravenous use.

We question the ethics of this. Should a pharmaceutical company with a monopoly in the treat-

ment of an illness be able to stop producing a drug at will and without either consultation or due warning? Should it be allowed to do this merely to change manufacturing processes, when there is no legal requirement to withdraw the drug from the market on clinical grounds? Fisons has emphasised that Imferon has not been withdrawn because of unacceptable side effects. We do not understand why Fisons cannot continue to supply iron dextran to its customers in the United Kingdom while improving its production to meet the requirements in another country.

Intravenous iron treatment for patients receiving dialysis may represent only a small corner of the market, but there is no substitute. Our plea is for more consultation between drug companies and physicians before the supply of monopoly drugs is arbitrarily stopped.

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- 1 Stewart WK, Fleming LW, Shepherd AMM. Haemoglobin and serum iron responses to periodic intravenous iron-dextran infusions during maintenance haemodialysis. *Nephron* 1976; **17**:121-30.
- 2 Fleming LW, Saleem AKN, Goodall HB, Stewart WK. Bone marrow iron and plasma ferritin in dialysed patients given intravenous iron-dextran. *Clin Lab Haematol* 1984;**6**:23-32.
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**We sent this letter to Fisons Pharmaceuticals, who replied as follows.

EDITOR,—Though I sympathise with Laura W Fleming and colleagues, I must point out that Fisons' decision to stop producing Imferon was not a commercial one. Revised quality control procedures have brought to light questions about the product's acceptability. These were first highlighted after the much publicised discussions with the US Food and Drug Administration.

Fisons is anxious to resume production of Imferon as early as possible and is currently ascertaining whether it is feasible to produce iron dextran in a way that would satisfy all the regulatory authorities of relevant countries.

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Gene therapy

EDITOR,—In the light of David Weatherall's review of my book¹ I urge readers of the *BMJ* to study the Clothier report for themselves.² Though Weatherall states correctly that the Clothier committee decided that germ line gene therapy should not be pursued, he wrongly implies that we therefore need not concern ourselves with its wider ethical implications.

Firstly, the Clothier report, in line with much of the medical scientific literature, recommends banning germ line therapy at present but makes allowance for it happening in future. "Gene modification of the germ line should not yet be attempted," states the report (section 5.2). The reason is, "we are clear that there is at present insufficient knowledge to evaluate the risks to future generations" (7.2).

Secondly, the distinction between somatic cell and germ cell therapy is not clear cut. Well respected commentators ask us to consider that if somatic therapy works then people treated successfully will grow up and reproduce. Would it not be better, they ask, to alter the egg and sperm cells of these people? Another reason for considering germ line therapy in future is that some diseases may not be treatable by the somatic cell approach—for instance, brain cells may be inaccessible to somatic therapy owing to the blood barrier.

Thirdly, as the Clothier report admits, a possible danger is that germ cells may be affected inadvertently. "If the means of inserting the gene were faulty, it is conceivable, although in the present state of knowledge improbable, that the gene, or parts of it, might emerge from the cells and be 'infective,' moving to other somatic cells or germ line cells, or even to other individuals. This might cause harm to the treated patient and to others" (2.27c). Not only may germ lines be affected but people other than the patient may be physically affected.

These matters require intense public scrutiny and discussion. Yet the Clothier report paid relatively little analytical attention to these and other apparently non-scientific issues while much of it was devoted to explaining state of the art methods. The result has been a foreshortening of the discussion and inadequate scrutiny of the ethics of gene therapy.

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Torpid MPs

EDITOR,—John Warden describes parliament as already in a "state of torpor before it goes into three months' hibernation."¹ I know that parliament has some ancient customs, but I think that at this time of the year it aestivates (*Concise Oxford Dictionary*: "spend the Summer espec. (Zool) in state of torpor") rather than hibernates.

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- 1 Warden J. Doctors, dentists, and chemists. *BMJ* 1992;**305**:14. (4 July.)

Balloon inflation and chronic bronchitis

EDITOR,—As a bagpiper, I was interested in Anoop J Chauhan and colleagues' report that inflating rubber balloons may help patients with chronic bronchitis.¹ I have observed over many years that members of my pipe band, many of whom smoke and drink heavily, have a surprising degree of stamina. I suggest that this is due to regular lung exercise and the positive social and psychological factors associated with belonging to a band of musicians.

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