Alcoholism: time for action

SIR,—Your leading article "Alcoholism: time for action" (11 April, p 1177) deserves, and will no doubt receive, wide support from the profession. But if we are to seek to influence national policy, we must ourselves first set an example, as we have done in the past in the case of cigarette smoking. I would not myself advocate a call for total abstinence, but could we not place some voluntary limit to the amount of drink consumed at medical dinners and other functions, and couple with this an undertaking not to drink and drive?

We look to the royal colleges to show us the way, as they have done in the past with the smoking problem. Our responsibility to practise what we preach is very great.

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Breast cancer: a case for conservation

SIR,—I am much interested to read the letter in your issue of 21 March, (p 984) signed by Sir Reginald Murley, and would like to thank him for quoting my name as the pioneer of the principle of conservative surgery in the treatment of carcinoma of the breast. At the same time I would ask to be allowed to make some further comments on this claim, with the explanation that when I first took up this challenging position I was acting only as chief assistant to Professor George Gask, head of the first surgical professorial unit instituted at St Bartholomew's Hospital, and had no surgical reputation to back me up. Gask had set me in 1921 to investigate the seemingly rather uninteresting subject of chronic mastitis. I carried out this task to the best of my ability, and presented the results as a Hunterian Lecture at the Royal College of Surgeons in 1923.

This task completed, Gask set me the far more important and responsible duty of investigating the effect of irradiation of breast cancers with radium. More intense irradiation of the breast and axilla could be given by using hollow platinum needles filled with radium chloride than could be delivered by any form of *x*-rays then known.

At first I conducted the experiment by giving the treatment only to those patients with the disease so advanced that it was regarded as inoperable by my two chiefs, Gask and Dunhill. A few years' experience proved that the results were so satisfactory that it would be justifiable to use it earlier, in fact in all stages, in the disease. Meanwhile, in 1927, I had totally rejected the so-called radical mastectomy in favour of conservative operations combined with radium irradiation. I had been brought up on a trust in radical surgery based on Halstead's work and Samson Handley's theory of "centrifugal permeation," but when I read Handley's book carefully I was greatly relieved and excited by discovering that the theory had been formulated by a distinguished surgeon who was rather old-fashioned in his ideas of the natural history of the disease, so that his concept proved to be based entirely on fallacies and could be discarded. I have said I was excited because, although I had done the radical operation a number of times, I hated the practice of such barbarous mutilation of the female body and was delighted to find further evidence against its performance. It was now recognised that patients never died because of the presence of the primary growth. Invariably they succumbed to the effects of the secondary growths. It was impossible to know when the metastatic growth was established, but it was clear that early diagnosis was the key to the improvement of survival rate. I would tell my friends (not too seriously) that it was obvious that when the diagnosis was made the radical mastectomy was either too late or unnecessary, according to whether metastasis had taken place or not; a deliberately foolish oversimplification, but nevertheless having some element of truth.

I reported the results of the use of radiotherapy with conservative surgery in medical journals, lectures, and conferences, and sometimes in surgical textbooks to which I was invited to contribute. In 1930 I delivered a Hunterian Lecture at the Royal College of Surgeons on the subject which was printed in the *Lancet*. In 1934 I delivered a well-illustrated lecture to the American Association of Surgeons in New York and was given the honorary membership of the Association. In April 1934 I gave an address to the Cardiff Medical Society with the title "Carcinoma of the Breast: The Unorthodox View"; this gave a full review of the history of the treatment of the disease, ending with my own plea for conservative surgery and radiotherapy. This was printed in the Society's *Transactions*, but I was given no offprints and it was read by few. In 1956, as Sims Commonwealth Professor, I lectured to captive audiences in every medical school in Africa and Canada. Only in Halifax Medical School was real interest shown by their request to have it printed in their journal. On most occasions throughout these years I urged the psychological importance of offering patients conservative treatment. Experience had taught me that general fear of what the medical profession would probably offer the patients if cancer of the breast were to be diagnosed delayed their going to see their doctors, resulting in most patients not being seen until in a late stage, allowing plenty of time for the establishment of metastatic disease. In 1933 I published a paper in *The Practitioner* concerned entirely with making an early diagnosis. This, I felt, did influence an increasing number of general practitioners, who sent me their patients because they knew that I would probably offer them conservative treatment.

Yet in spite of my widely published views on this important subject, they were to be almost universally ignored by other writers on the subject. My views were clearly unpalatable to most surgeons. They turned their heads and looked the other way, preferring to follow a surgical dogma, however irrational it might be shown to be, rather than making the effort to regard each patient as a separate problem for the treatment best suited to the individual circumstances. Unknown to me, Sir Reginald Murley, who had been my pupil at Barts, was practising according to my pattern. In the United States two distinguished surgeons had pricked up their ears—Oliver Cope at the Massachusetts School in Boston, and George Crile at Cleveland, Ohio. Dr Crile, having almost completed a modest book on conservative surgery for the breast, discovered to his embarrassment that I had already published much of it more than 30 years earlier. He then generously dedicated his book to me in recognition of my priority.

McWhirter, in Edinburgh, had attracted much attention by persuading a group of surgeons to abandon radical operations in favour of intensive radiotherapy, but his work was similar to my own practice during the years we had spent working in the radiotherapeutic department at Barts. Having pursued a consistent course of conservative surgery with radiotherapy, I had slowly built up a large body of evidence based on a careful follow-up of both hospital and private patients amounting to several hundreds. I was aiming at the publication of results covering five to ten years. With the help of a professional statistician, Lady Forber, I was confident that the figures would justify my unorthodoxy. I did not expect a sensational improvement in the rate of survival yet there would be much improvement in the quality of life for all the patients. These hopes were dashed in 1939 by the coming of the second world war. I was appointed senior consultant to the Royal Air Force and had to leave London so that my follow-up systems of private patients collapsed. I ought then to have handed over the follow-up to a colleague, but foolishly did not do this. It had not occurred to me that the gap might extend to six years. By the time I was able to resume civilian life I had lost touch with all my patients and the record could not be re-established. In any event the use of radium needles had to be given up owing to the danger of enemy bombing. By 1945 it had become evident that the use of radium was outdated, and I decided to depend for the future on the use of deep *x*-ray therapy developed during the years of war. In addition, my private practice had vanished beyond recall, and I had become deeply involved in the treatment of myasthenia gravis with Jack Piercy at New End Hospital and Barts.

Since my retirement from the profession of surgery nearly 30 years ago, I have watched with interest the swing of the pendulum of opinion against the dogma of radical mastectomy. The "curious reluctance to face the facts" mentioned by Sir Reginald Murley in his letter is at last giving way before a tide of commonsense in favour of more rational treatment.

Sir Reginald has raised another issue of great importance, in my opinion, namely the obsession of our profession with the concept of "prospective randomised trials"—otherwise the "controlled experiments" now so widely practised. The "control" of these trials is too often a form of self-deception, the supposed control being upset by too many uncontrollable variants in the conditions under investigation. Sir Reginald has suggested that the alternative of "planned retrospective studies" or, in one word, "experience" (subjected to close scrutiny) is likely to be a more positive source of information; it will also eliminate the chance of harming individuals who fall on the wrong side of the experiment.

Some years after I had, as I thought, established, in the face of opposition from the Mayo Clinic, the operation of thymectomy as the preferable form of treatment for properly chosen patients suffering from myasthenia gravis, I learnt of a "controlled experiment" carried out by a teaching institution to establish its own standard of practice. In this tragic experiment a number of patients who happened to fall on the wrong side of the line (medical) perished, yet it seemed to me that with surgery some of their lives could have been saved.

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Disability in the developing world

SIR,—Your leading article on this subject (21 March, p 928) was timely and appropriate as the International Year of Disabled People should be a stimulus to make us consider the obligations of the Western world to those less fortunate.

Many countries in the developing world are already devoting a larger proportion of their gross national product to health than we are ourselves, and increases in health expenditure must come from outside sources. Both governmental and non-government organisations have important parts to play in supporting the health endeavours of overseas—especially Commonwealth—countries of the Third World, but the world recession limits money and makes it all the more important to spend it wisely.

Rehabilitation programmes are very labour intensive and expensive. It is only too obvious in, say, African countries that the overwhelm-