Have you now got any actual evidence to support your hypothesis about infections causing irreversible airflow obstruction? If not, why do you go on advancing it as if it were proved?

C M FLETCHER

Royal Postgraduate Medical School,
London W12

¹ Medical Research Council, *Lancet*, 1965, 1, 775.

² May, J R, *The Chemotherapy of Chronic Bronchitis and Allied Disorders*, 2nd edn, London, English Universities Press, 1972.

³ *British Medical Journal*, 1973, 4, 437.

⁴ Fletcher, C M, *British Medical Journal*, 1973, 4, 672.

⁵ Fletcher, C M, *Community Health*, 1975-6, 7, 70.

* * * In our article we were at pains to point out that "many of the factors leading to progression of the disease are still an enigma," and the roles of cigarette smoking, atmospheric pollution, dusty occupations, and infection were discussed. The association of infection with airways obstruction is clearly stated in a report to the Medical Research Council by the committee on the aetiology of chronic bronchitis,¹ of which Professor Fletcher was secretary. In this report the following appears: "Two other manifestations frequently occur: bacterial infection, which may result in mucopurulent sputum and generalised airways obstruction. Thus it is possible to recognise simple, mucopurulent, and obstructive forms of chronic bronchitis separately or in combination with each other." That infection may cause permanent changes is contained in the following extract from the same paper: "Exacerbations of infection with the production of purulent sputum are a common feature of chronic bronchitis. Since these episodes may be disabling in themselves and may ultimately lead to permanent bronchial and pulmonary damage, those cases in which the sputum is persistently or intermittently mucopurulent, indicating active bronchial infection, may usefully be distinguished from those in which it is mucoid." There is some pathological evidence that episodes of infection lead to progression of the disease,² but, as we pointed out, treatment of bronchial infection does not appear to halt the deterioration in pulmonary function.—ED, *BMJ*.

¹ Medical Research Council, *Lancet*, 1965, 1, 775.

² Reid, L, in *Recent Trends in Chronic Bronchitis*, ed N C Oswald. London, Lloyd-Luke, 1958.

New look at malaria

SIR,—Dr S L Henderson Smith (5 June, p 1402) asks whether it is humane to eradicate malaria in African countries as this will lead to a further increase in population with subsequent starvation. He suggests that the WHO should concentrate instead on family planning in these areas.

Having worked in one country in Africa for some years, may I make the following points? There are already several organisations and many individuals who are working in the field of family planning in Africa. Before their efforts can be effective their programmes must first gain acceptance by the governments concerned, which are sometimes suspicious about the imposition of foreign ideals on their people. The decision to limit family size is a personal one which can be made only when the individuals concerned are satisfied that it is a desirable end. To most rural Africans children are regarded as an asset, and sterility is a tragedy.

Along with many others I believe that only

when parents have some guarantee that their children will grow up healthy will they accept family planning. The mortality of children under 5 years in the part of Africa where I worked is around 30%, and malaria is one of the major causes of death in that age group as well as causing much morbidity and mortality in the rest of the population. It would therefore seem to me both logical and humane for the WHO to continue to use its expertise in attempting to control this disease.

HELEN KINGSTON

Craig Dunain Hospital,
Inverness

Coeliac disease and diffuse lung disease

SIR,—I am grateful to Drs O E Eade and W T Berrill (1 May, p 1076) for their comments on my report on coeliac disease and farmers' lung (27 March, p 745).

I have had an opportunity of repeating the jejunal biopsy in case 1 and this shows marked improvement. The original biopsy showed subtotal villous atrophy with a mosaic pattern and the repeat biopsy after one year on a gluten-free diet shows regeneration of villi with persistence of chronic inflammatory cells. The patient's weight has increased from 53 to 70 kg and all tests of absorption are normal.

I have noted the association of farmers' lung and HLA-B8 and at present I am undertaking a larger survey on patients with farmers' lung, in whom, among other tests, histocompatibility typing is being done. I hope to publish my results.

T J ROBINSON

Craigavon Area Hospital,
Craigavon,
Co Armagh

A question of conscience

SIR,—Mr R Walley's article (12 June, p 1456) makes sad reading, for he is both illogical and, if I may say so, a little selfish. I admire and indeed I share his respect for human life, but in my opinion his only genuine grievance is that the rules were changed while he was in training, his conscience preventing him from adapting to the new service requirements.

However, he is illogical in complaining that he is being discriminated against. The will of the people, as expressed through Parliament, now lays down that certain abortion facilities shall be provided in the NHS, and the area health authorities have the duty to see that this regulation is implemented. In all fairness, it is wrong of Mr Walley to object if the authorities prefer to engage staff who are willing to comply with the current service requirements. As a citizen it is open to Mr Walley to try to bring about a reversal of these new rules, but he is selfish in demanding that he be excused some of the duties which his colleagues must accept. There are many other openings in medicine and it may be recalled that some colleagues have been forced and will be forced to change their specialty because of unexpected disability or other circumstances.

If one assumes that the average clinical area is staffed by four consultant gynaecologists, then each of them will cover 25% of the abortion work because it is part of their job. If one of them were to contract out, the share of

the other three colleagues would increase to 33%, and in times of holidays or sickness to 50% for each of the remaining two colleagues. This would quite obviously be grossly unfair and would undoubtedly have immediate and justified repercussions among his colleagues.

Similarly, a medical Jehovah's Witness would probably refuse to give as well as to receive blood transfusions, and his convictions would surely be respected. But he should not seek to work as a physician or as a surgeon in the NHS, in which branches of medicine such practice is obligatory.

A man of high morals and convictions commands our respect. However, if he is unwilling to make any sacrifices for his principles but, on the contrary, requires that others make sacrifices for him, then some of us will question whether such admiration is justified.

R SALM

Falmouth,
Cornwall

Restriction of right to prescribe

SIR,—I most heartily agree with Drs B Caplan and J H Scotson (12 June, p 1471) regarding the Medical Practitioners (Restriction of Right to Prescribe) Bill. On no account should we allow non-professional people access to records for medical audit.

Most general practitioners would agree that the public's insatiable demand for drugs should be curtailed, but nothing will be achieved by the interference of vote-touting politicians with schemes which nullify the confidentiality of medical practice and cast a slur on the abilities of prescribers. The threat to freedom is sufficiently serious to warrant immediate and effective protest by the BMA.

N L HIGGINS

Neston,
Wirral, Cheshire

Priorities in the NHS

SIR,—Dr R B Hopkinson (12 June, p 1449) commented during your conference on priorities (12 June, p 1447) on "the huge regional variation in health indices." He referred to the latest triennial report on maternal mortality and quoted an Oxford figure of 5.9/1000 live births and another region with a figure of 17.2/1000. This was an error. The correct figures are much better, at 5.9 and 17.2/100 000 births respectively. A critical study to find reasons rather than theories for these, and other, inequalities would indeed be appropriate at this time of financial difficulty.

The Oxford results were not achieved by expensive electronic equipment, valuable though this can be when used with clinical judgment. The relevant triennium ended as the superbly equipped new John Radcliffe Hospital was opened, so it played no part in producing these results. They are the fruits of years of hard clinical work and dedicated caring by a large group of general practitioners and consultant obstetricians working in harmony in integrated teams.

Further evidence of what this can achieve is provided by the fall in perinatal mortality in general practitioner units from 30/1000 in 1951-3 to 3/1000 in 1970, with an associated progressive fall in the uncorrected figure for the combined consultant-practitioner division