TABLE—Details of cases of Distalgesic overdose from the Birmingham District Coroner's Court

Age and sex	Blood alcohol or other drugs	Estimated overdosage (tablets)	Source of tablets	Time to fatal onset (hours)	Verdict
26 (F)	280 mg/100 ml. No other drugs	15	50 tablets prescribed 16 days before death	1	Killed herself
33 (M)	Nil	40	Prescribed for mother	Considerably less than 10	Killed himself
29 (M)	Nil	30	100 tablets (three four-hourly) prescribed by GP for sinusitis	<2	Killed himself
20 (M)	145 mg/100 ml. No other drugs	20–30	Prescribed for friend	5	Open verdict. Intention uncertain
25 (M)	Nil	40–45	Not known	Uncertain	Killed himself
47 (F)	Alcohol nil. Quinalbarbitone 400 mg	10–20	60 prescribed for self 3 days before	<6	Killed herself

the dosage prescribed was up to 18 tablets to be taken a day—more than twice the manufacturers' recommended maximum dose. Both doctors and patients, therefore, may be lulled into a false sense of relative complacency over the taking of this drug. For instance, to take 20 aspirins may not be disastrous, but an equal number of Distalgesics may kill in a very short time. The manufacturers themselves state in their latest data sheet* that the product in serious overdosage is narcotic and provokes respiratory depression, and this may be additive with alcohol. Dependence with dextropropoxyphene has been reported and overdosage symptoms are indeed similar to morphine with the addition of convulsions.

The very real dangers from overdosage with products containing dextropropoxyphene, particularly when taken with alcohol, are becoming clear to forensic toxicologists but may not be appreciated by clinicians, as the unfortunate people, often young and healthy, who take these drugs, whether intentionally to kill themselves or not, often die rapidly at home before they are found and so never reach hospital for treatment. Prescribing physicians, therefore, should remember the potential

toxicity when considering to whom to prescribe dextropropoxyphene, the dosage advised, and the quantity to be dispensed.

I am indebted to the Director of the Home Office Forensic Science Laboratory, Birmingham, and Mr W B Yeoman, Director of the Regional Toxicology Laboratory, Dudley Road Hospital, Birmingham, for information used in preparing this article.

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Letter from . . . Denmark

Planning of scientific-ethical committees

POVL RIIS

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During the past few years the Western European societies have been increasingly interested in citizens' rights in relation to professions, and medicine has certainly not been excluded. The medical profession itself has also shown an increasing interest in the ethical and judicial aspects of medicine. Examples are the recommendations on genetic manipulation and on human experimentation. Recommendations on human experimentation were contained in the revised Helsinki Declaration of the World Medical Association, as adopted by the WMA's General Assembly in Tokyo 1975. The revised declaration, called the Helsinki Declaration II, aimed at increasing

the protection of the research subject while not inhibiting medical research unnecessarily.

Helsinki Declaration II

Among the important paragraphs of Helsinki Declaration II are those stating that the declaration covers not only treatment, but also diagnoses and prophylaxis and those that make a written research protocol obligatory; emphasise that ethical aspects of biomedical research should always be included in a report; emphasise the patients' and other research subjects' right to decide (via informed consent) whether to join the project or not; accept the use of control groups as a necessary tool of the controlled trial; realise that clinical research can never guarantee a result beneficial to the patients participating—but only a *potential* gain; and, probably most important, demand that the research protocol, if man is the scientific object, be referred (paragraph 1 2) to an independent committee "for consideration, comment, and guidance."

The Danish Medical Association, as one of the Nordic

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medical associations initiating the revision of the 1964 Helsinki Declaration, accepted the revised declaration in November 1975. Since then it has been considered a norm for Danish doctors engaged in biomedical research. As a consequence several independent ethical committees have to be established, and such committees represent an innovation in Danish scientific life. A preparatory group was set up, representing such different institutions and organisations as universities, the National Health Service, hospital owners, general practitioners, the pharmaceutical industry, dental and pharmaceutical high schools, scientific societies, the Medical Association, etc. The preparatory group ended its work in March this year and summarised its recommendations in a report.

Procedure

The report suggests that all types of biomedical research in Denmark should be covered by the ethical committees. The investigators will have to add a "self-declaration" to the research protocol, stating that the project has been considered in the light of Helsinki Declaration II (stage 1). The protocol then has to be referred to a regional scientific-ethical committee (stage 2). Such committees will have to cover one or two counties (250 000-500 000 inhabitants) and include all research activities in the area. Scientists and citizen representatives will share the six (or 7) seats on an equal basis. If the investigator relies on his self-declaration, and thus does not ask for evaluation, the committee may still evaluate the protocol on its own initiative, but the investigator is free to start the project im-

mediately, and to continue it if no committee comments have appeared within one month. If the investigator asks for evaluation or if evaluation is statutory—for instance, when informed consent is considered inappropriate—the committee again has to consider the protocol within one month. It is suggested that membership should be honorary and the members bound by secrecy. The lay members are to be elected by the county councils and the scientific members by the scientists of the region.

A central scientific ethical committee (third stage), covering all Denmark, is planned to comprise 10 to 12 members, again with an equal number of lay and scientific members. The central committee will receive appeals from the regional committees or scientists, counsel regional committees or individual scientists, survey the field of scientific ethics, and serve ministries, courts, etc.

In the near future all groups affected (already represented in the preparatory work) will start negotiations to implement the suggestions of the report. The first committee should be elected before the end of this year.

The alternative to a committee system, as outlined, would certainly be legislation, with the risk of seriously hampering even ethically acceptable biomedical research, and probably not increasing the protection of the individual. The end result might easily be a loss to present and future patients if pathophysiological and clinical science were considerably restricted.

We in Denmark believe that a flexible committee system is a better way than restrictive legislation of obtaining a balance between the need to protect the people on whom research is performed and the need to make scientific advances that will benefit society, including patients.

Today's Treatment

Diseases of the urinary system

Treatment of blood disorders in renal disease and renal failure

T R MITCHELL

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The outstanding haematological complication presented by patients with renal disease and renal failure is moderate to severe anaemia. Less common problems are abnormal haemostasis and erythrocytosis.

Anaemia in renal disease

The anaemias of renal disease are largely resistant to treatment. An understanding of the pathophysiology of the anaemia in the context of the patient's disease is essential for effective and safe management.

ACUTE RENAL FAILURE

A rapidly progressive anaemia occurs during the oliguric phase of acute renal failure. Usually by the second to third week of the illness the packed cell volume falls to 0.2-0.3. This volume is maintained regardless of the period of oliguria.

The normocytic normochromic anaemia is due to a combination of haemodilution, shortened red cell lifespan, and bone marrow depression.

In most patients blood transfusion is dangerous and unnecessary. The danger lies in the expansion of an already overloaded extracellular space, which may result in cardiac failure. Blood transfusion is unnecessary as oxygen delivery to the tissues is invariably adequate unless heart failure supervenes. In a normal man the oxygen-carrying capacity of the blood is 200 ml/l—(that is, a haemoglobin concentration of 150 g/l $\times$ 1.36 ml of oxygen per gram haemoglobin). Assuming a cardiac output of 5 l/min the oxygen available to the tissues is 1000 ml/min. The basal tissue oxygen need is 250 ml/min. Even a 50% reduction in red cell mass will leave adequate oxygen available for the tissue needs of a patient lying in bed.

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