perhaps the royal colleges might question Dr Smith's assessment of ASH, which was set up by the Royal College of Physicians and subsequently given an annual grant by the Government. In 1971, the year ASH was launched, 122·4 thousand million cigarettes were sold in the United Kingdom. Ten years later in 1980 sales amounted to 121·5 thousand million. In the intervening years sales have fluctuated, rising and then falling; but the fact remains that, despite the campaigning of ASH and the efforts of the Health Education Council, there has been no significant reduction in smoking in this country.

If campaigning has been ineffective in reducing the use of tobacco, which most people would accept is damaging to health in any quantity, how can it hope to succeed in the case of alcoholic drinks, which are generally recognised as being beneficial when taken in moderation and which many doctors recommend to patients?

I suggest that if the royal colleges wish to preserve their credibility they should decline to lend their names to a campaign against alcohol that would be both unpopular and totally ineffective.

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Why the alcohol problem?

SIR,—Your studies on alcohol abuse culminating in the leading article (8 May, p 1360) seem be preparing the ground for a concerted campaign along pretty traditional lines of public education and making alcohol more difficult to get. But I wonder if you are concentrating on a symptom rather than the underlying disease. Why are people in many countries drinking more and in an increasingly antisocial manner?

A United Nations expert group chaired by Inga Thorson of Sweden has shown quite convincingly that much of the present economic disruption is the result of excessive military expenditure by most countries. The world is thus caught in a vicious circle of fear, political instability, inflation, unemployment, aggression, and hopelessness. This cannot fail to be sensed by most people even if they do not always understand its mechanisms. The insane proliferation of nuclear weapons in an increasingly disorganised world has created an atmosphere of emotional depression. The majority of young people do not expect to survive long enough to start families or see them grow to maturity; constructive activity seems pointless if what they work for is doomed to destruction. So it is a case of "eat, drink, and be merry, for tomorrow we die." Much of the joy has gone from eating, and it is impossible to be truly merry, so they take to drink.

Back in the 1950s I was in Montreal when the government broadcast a programme meant to be a rehearsal of what to do in the event of a threatened bombing attack (that was in the happy innocent days when civil defence authorities thought people could escape by running away to the countryside). A friend and I listened to a gloomy voice postulating a heavy raid in an hour or so and adjuring listeners to plan their escape routes. My friend said: "We are on an island containing over a million people, who would all have to get away over seven bridges; if this was for real, what would we do?" Simultaneously we said, "Bring out the bottle and glasses." It was some time before we had calmed down enough to stagger out in search of food and an assurance that life in Montreal was indeed proceeding normally.

I live in the multimegaton area between the superpowers. If a planned or accidental nuclear exchange threatens I shall hope for time to reach the rum bottle. At least, for once, I will have little need to worry about next morning's hangover. So I suggest that the BMA should devote more of its attention to the basic problem, supporting and publicising such organisations as Physicians for Social Responsibility and mobilising the profession for an international campaign of preventive psychiatry. If some day we could regain a world atmosphere with some degree of hope and optimism, I think much of the abuse of alcohol would cease spontaneously.

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Is early antenatal attendance so important?

SIR,—In his leading article (10 April, p 1064) Mr James Pearson asked the question: Is early antenatal attendance so important? Jo Garcia and Dr Ann Oakley (15 May, p 1474) rightly raised the difficulties that prevent early attendance, even by so-called educated and motivated women. In my district, we found similar difficulties to those raised by Jo Garcia and Ann Oakley. By the mutual agreement of co-operation between general practitioners and domiciliary midwives, we have introduced a system of notification whereby the general practitioner notifies his midwife as soon as pregnancy is confirmed. The domiciliary midwife then makes a visit to the patient's home and starts the process of educating the mother about antenatal care and persuades the mother to attend the general practitioner's surgery to start antenatal care.

In the survey carried out in my district I discovered that as many as 66% of all the pregnancies were confirmed before 16 weeks. First attendance at a general practitioner's surgery or hospital for antenatal care, before 20 weeks, however, was achieved by only 28% of the total.

The question raised at the beginning of this letter is to my mind purely rhetorical. The difficulties in initiating antenatal care are many but two that spring to mind—one methodological and one educational—are both critically important.

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Notification of tuberculosis: a code of practice for England and Wales

SIR,—Could I comment on the recommendations from the Joint Tuberculosis Committee of the British Thoracic Association on "Notification of tuberculosis: a code of practice for England and Wales" (15 May, p 1454). Having recently become concerned about the present system of notification, which too often seems to allow the vulnerable set of children at risk to slip through the net, I was heartened to find that the committee had, as I hoped, addressed themselves to the problem, but I was dismayed by their conclusions, which I do not think will do anything to redress the present unsatisfactory situation. Had the committee recruited a paediatrician with the appropriate knowledge and interest he would surely have pointed out to them that a better classification than the one which they appear to have used would have been into primary, secondary, and tertiary tuberculosis, by analogy with syphilis, rather than into pulmonary, mediastinal, meningitic, and other forms. In practice the only important infectious form of the disease is what could be called tertiary pulmonary tuberculosis, which in my view is usually the result of breakdown of a secondary lesion derived from a previous primary infection acquired in childhood. It follows that the identification of recent primary infections in children would be the best way of containing the disease provided that the source of the infection were always tracked down and that of his or her contacts those who were found to be tuberculin positive were adequately treated and those found to be tuberculin negative vaccinated. Perhaps the time has come to abandon universal BCG vaccination at puberty, using the vaccine only for the protection of likely contacts, and by routine Mantoux testing of children at school or attending surgeries and outpatient clinics to make sure that all primary infections are caught early and all infectious cases discovered and treated—as is the policy, I understand, in the USA. It would also be my view that not to radiograph all immigrants on arrival should be regarded as racial discrimination rather than the reverse since there is no reason why Asians should be allowed to flout public health measures that we would not hesitate to apply to immigrants from the white Commonwealth should that prove necessary.

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Advances in respiratory distress syndrome

SIR,—The leading article by Dr N R C Roberton (27 March, p 917) and ensuing correspondence indicate differences of opinion in the prevention of respiratory distress syndrome. He suggested (22 May, p 1558) that steroid therapy is of minimal benefit in the prevention of respiratory distress syndrome, and our preliminary analysis of a large multicentre study of preterm labour supports this view.

From mothers treated with ritodrine alone at or before 32 weeks' gestation only eight out of 73 infants (11·0%) ultimately delivered developed respiratory distress syndrome. Mothers treated with ritodrine plus steroids in the same gestational period ultimately delivered 96 infants, 16 of whom (16·7%) developed respiratory distress syndrome. These findings are in accord with another recent study where no benefit was shown with steroids.[1] They also point to the possibility that there may be considerable benefit in the prevention of respiratory distress syndrome by the use of ritodrine or other betamimetics alone, and this has also previously been reported.[2 3] The question of pulmonary oedema was also discussed and although beta-mimetics alone can cause this, it is clear that the incidence (although still not high) is far greater when

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beta-mimetics and steroids are used in combination.[4]

If one still concludes that steroids offer some protection our results also appear to support the view that girls obtain greater benefit than boys. In the group treated with ritodrine alone five boys and three girls developed respiratory distress syndrome, while in the group treated with ritodrine plus steroids 12 of the 16 infants who developed respiratory distress were boys and only four girls. In both groups the initial sex distribution was about equal. Indeed, one might consider that boys are more likely to develop respiratory distress syndrome irrespective of maternal management or even that steroids may have an adverse effect.

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Intraspinal opiates and itching: a new reflex?

SIR,—Dr D M Justins and Dr Felicity Reynolds (8 May, p 1401) disarmingly demolish our neural theory (3 April, p 1015) for the facial itching which not infrequently complicates systemic and spinal opiate analgesia; "but the true aetiology eludes us."

The kernel of the problem is the *synchronous* appearance of facial itching and segmental analgesia after *intrathecal* opiate.[1] The spatial separation of these effects and their synchrony can be so striking as to make it almost perverse to resist the inference of a neural link.[2] That is why we embarked on a search for possible spinal pathways and for their projection to an imagined medullary itch centre.[3 4]

If we are wrong—if facial itching is not neuronal—it becomes necessary to incriminate redistribution of injected opiate by the bloodstream or by migration within cerebrospinal fluid. Current failure to detect significant amounts of morphine in plasma after a clinical dose (1·0 mg) given intrathecally tends to cast doubt on the systemic vascular route.[5] Equally, the very important observations by Rieselbach[6] on the spread of radioactive material injected into the lumbar sac of cerebrospinal fluid cast doubt on the migratory route.

We are not sure why the addition of local anaesthetic to an opiate solution has failed to prevent itching in obstetric patients, when our theory clearly demands that it ought to do so in surgical patients. Perhaps there was insufficient anaesthetic. During parturition there is a high maternal plasma concentration of the endogenous opioid beta-endorphin.[7-9] The effect may be to "preload" opiate receptors in the spinal cord and medulla so that they become more sensitive to exogenous opiate. Preloading may also help to account for the exceptionally high incidence of itching, nausea, and vomiting characteristic of labours conducted under spinal opiate analgesia.

Since submitting our paper, it is only fair to say, of 22 surgical patients given heroin and bupivacaine as we described three have complained of facial itching. But—and it is a big but—itching began 5-8 hours after injection at a time when the effects of the anaesthetic had worn off as judged by the return of segmental sensation to pinprick.

Of one thing we are certain. When the "true aetiology" becomes known, the symptom of facial itching will be recognised for what it is: a cardinal side effect which points the way to a better understanding of the physiology of pruritus, of opiate activity in general, and of spinal opiate analgesia in particular.[10]

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SIR,—The finding that naloxone can relieve an itch by interfering with an opiate reflex is of interest (3 April, p 1015); but the fact that 0·4 mg of naloxone given intravenously "left the analgesia unaffected" is perhaps also of considerable interest.

There is mounting evidence that low doses of naloxone given either alone[1-4] or in combination with opiate analgesics[5 6] can initiate[1-4] or potentiate[5 6] analgesia. These effects have been observed as a result of both intrathecal[3 4] and systemic[1 2 5 6] administration of this drug. To explain this and other puzzling effects of naloxone a dual system has been hypothesised,[7] in which low doses of naloxone would tend to alter the equilibrium of an opiate and antiopiate system in favour of analgesia, while at higher concentrations of naloxone the equilibrium would be shifted towards hyperalgesia.

In view of the well-known problems (tolerance, addiction, and respiratory depression) associated with the use of opiate agonists it may be helpful to try very low intrathecal doses of naloxone either alone or in combination with opiate agonists as a possible analgesic, thus perhaps obviating these difficulties.

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Ethics and in-vitro fertilisation

SIR,—Professor Priscilla Kincaid Smith's leading article "Ethics and in-vitro fertilisation" (1 May, p 1287), though interesting, confuses the issues. The ethics of experimentation and implementation of technology do not come from science but from one's view of human nature. The value that we place on people, the fetus, or the zygote influences our decision about what is moral in relationship to them. Ethics can never be independent of religion, whether based on the Judaeo-Christian world view or on the secular humanist world view, which is in itself a religion. The assumptions of the humanist influence ethical options just as much as the assumptions of the Christian, though the latter believes that his assumptions are more consistent with the available evidence concerning the nature of the universe and of human life than those of the humanist. The material universe itself gives no basis for values. Science can describe a technique but cannot indicate the ethical basis for its use. Marquis de Sade (1740-1814) concluded that whatever is possible is right. He showed the impossibility of deriving ethics from rational argument alone. His sadism was the natural result of his beliefs. Friedrich Nietzche (1844-1900) understood that "If God is dead, everything is permitted." Nazi atrocities were the natural result of following his philosophy.

Secular humanism gives no basis for absolute truth or absolute morality. All that is left is relative truth and relative morality. Given time even the "certainties" of our ethical systems can be undone, including the charters of freedom and principles of justice. Alexander Solzhenitsyn understands this—and not only as a theoretical problem of humanist philosophy: he has suffered under its implications. He writes, "Communism has never concealed the fact that it rejects all absolute concepts of morality. It scoffs at good and evil as indisputable categories. Depending upon circumstances any act, including the killing of thousands, could be good or bad."[1]

Christians believe that ethics derive from the character of the personal-infinite God as expressed in the Bible and the life and teaching of Jesus Christ. It is because He has revealed His character to men that we have absolute standards of right and wrong. As far as the question of torture quoted by Professor Kincaid Smith is concerned, those who were guilty of such inhumanity were wrong because they had substituted their own standards in place of the revelation of God's character in the scriptures.

The birth of test-tube babies is undeniable evidence that the ovum fertilised in vitro is alive and unmistakably human. The issue at stake with this technique is whether or not our society can justify destroying innocent human life at whatever stage for the purpose of gaining scientific information or facilitating medical developments that will benefit others. Professor Paul Ramsey of Princeton, USA, offers four rational arguments against in-vitro fertilisation and embryo transfer[2]: (*a*) the need to avoid bringing further trauma on a nation that is already deeply divided on the matter of the morality of abortion and about when the killing of a human being can occur; (*b*) the irremovable possibility of producing a damaged human being; (*c*) the immediate and not unintended assault this procedure brings against marriage and the family, the possibility of exploitation of women as surrogate mothers with wombs for hire, and the immediate and not unintended prospect of beginning to "design" our descendants; (*d*) the remote prospect of substituting laboratory generation for human reproduction—that is, complete extracorporal gestation.

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