guidelines laid down for the profession to follow, and this certainly is an area where public participation and debate must be provided.

Nor may the cost-benefit ratio be the only test that is relevant. Some may want to consider the age of the patient, as is done with renal dialysis in Britain. Others may attach weight to the contribution patients make to society or the degree to which they were responsible for their illness. Should haemophiliacs with HIV infection and AIDS be treated any differently from others with the conditions? Should confirmed alcoholics be given an expensive liver transplant if they refuse to give up drink? In Oregon the public expressed interest in 13 social values, but only a few will be incorporated in the process and no one knows yet how it will be done.

There remains the problem of deciding how resources should be allocated. Professor Klein is right to stress the need for public and professional involvement, but this will not make the decision process any easier. Many views will be expressed and health authorities will still have the task of reconciling conflicting priorities. Nor can they ignore political realities. Internal market or not, the acute sector is likely to retain the lion's share of funds with the largest amounts still going to the most powerful specialties—those producing the most revenue. If groups like the mentally ill are to be justly treated then central direction combined with ring fenced financing will be needed.

But the whole process would be greatly facilitated if the NHS were adequately funded. Rationing and resource allocation will be seen to be fair only when Britain devotes as much of its gross national product to health care as does the rest of the European Community.

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1 Klein R. On the Oregon trail: rationing health care. *BMJ* 1991;**302**:1-2. (5 January.)

## Trial by anecdote

SIR,—Dr Michael O'Donnell speaks up on behalf of the drug company that sells the antidepressant Prozac (fluoxetine), the company itself having chosen not to participate in the television programme *Dispatches* on 19 December 1990.[1] Dr O'Donnell is dismissive of a publication of six case reports or "anecdotal accounts," yet happily quotes an unidentified psychiatrist who "has encountered none of the symptoms reported by Teicher." Had the psychiatrist specifically looked?

Dr O'Donnell quotes Professor Bill Inman as having monitored reports from 6000 NHS patients without finding an instance in which the prescribing doctor thought the drug had caused aggressive behaviour. Had those doctors been blind? Had they been asked to question patients' families about aggression? Let it be remembered that the adverse effects of thalidomide were observed during its clinical trials but were ignored because doctors had not thought the effects could be a consequence of a sleeping drug.[2]

Dr O'Donnell did not remind readers that in the past decade the antidepressants nomifensine and zimelidine, having been approved by regulatory authorities, were withdrawn because of adverse effects. Benoxaprofen (Opren) had been marketed by Prozac's manufacturer till it was withdrawn in 1982, Professor Inman's monitoring system of 5000 patients having failed to furnish cause for concern.[3]

Multicentre trials with antidepressant drugs make possible rapid accumulation of patient numbers. The data are fed into a central repository at, or organised by, the drug company. Danger arises because no independent expert surveys all the results, and individual researchers who get a hunch from their small group can be told that others have not formed the same opinions. The United States Food and Drug Administration receives case reports only about patients who died or dropped out during trials. In the case of adverse psychological symptoms it is all too easy to say with Dr O'Donnell that they are just what you would expect from the kind of patients who are given antidepressants.

As I understood the programme, the chief allegation against Prozac was of unnatural irritability. Dr O'Donnell writes of "controlled double blind clinical trials in more than 11 000 patients." Can he direct attention to any published trial, designed with adequate statistical power, that set out to answer the question of whether fluoxetine enhances irritability?

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1 O'Donnell M. Trial by anecdote. *BMJ* 1991;**302**:56-7. (5 January.)
2 Kelsey FO. Problems raised for the FDA by the occurrence of thalidomide embryopathy in Germany, 1960-1961. *Am J Public Health* 1965;**55**:703-7.
3 Anonymous. Benoxaprofen. [Editorial.] *BMJ* 1982;**285**:459-60.

SIR,—Dr Michael O'Donnell's review of the *Dispatches* programme on Prozac (fluoxetine) raises the important issue of what role the media and media seeking organisations have in matters of alleged malpractice.[1]

Dr O'Donnell referred to the Citizen's Commission on Human Rights, an organisation sponsored by the Church of Scientology, which is campaigning against Prozac. I was the commission's medical adviser from 1980 to 1984, when I resigned because of my disagreements with the sponsoring organisation. The quality of evidence that may be gathered by such an organisation by appealing to members of the public who believe that they may have experienced suicidal thoughts or even attempted suicide because of taking Prozac is suspect.

The public's right to know must be upheld in matters of relevance to public health, including the adverse effects of drugs; witness the cases of thalidomide, Eraldin, and Opren. But the media and organisations with a vested interest should not be considered to be the judge and jury in matters of adverse reactions to medicines. The complex nature of such problems means that final decisions are best left to experts, and expert committees should assess case reports and population derived data.

Drugs and the media have the potential to produce more harm than benefit. The limitations of both need to be appreciated.

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1 O'Donnell M. Trial by anecdote. *BMJ* 1990;**302**:56-7. (5 January.)

SIR,—Dr Michael O'Donnell reviewed the *Dispatches* programme that suggested an association between Prozac (fluoxetine) and suicidal or aggressive behaviour, or both.[1] The day after the programme was broadcast we received several telephone calls at my clinics from distressed patients. All patients spontaneously commented that they thought the programme was alarmist and biased but wanted reassurance, particularly after having seen the vivid re-enactments of behaviour supposedly driven by fluoxetine.

Several weeks earlier I had been approached by the producers of the programme and gave an extensive interview by telephone. I was repeatedly told during the interview that the points I was making were already known to the producers and that they had "other doctors saying that." When I saw the programme I was dismayed to find that none of these points were made by anybody. The central point of the programme was that aggressive or suicidal behaviour, or both, had emerged in several people taking fluoxetine. I had pointed out that such changes in clinical state occurred with many other antidepressant drugs and that there was no evidence that this occurred more commonly with fluoxetine. I had said that such changes occurred in patients who were not receiving antidepressant drug treatment at all and that they could occur as part of the natural course of a depressive disorder or emerge during psychotherapeutic treatment in which no drugs were used. I also pointed out that there is some theoretical and some clinical evidence to suggest that drugs such as fluoxetine and fluvoxamine might be preferentially used in patients with suicidal behaviour, because of the link between suicidal tendencies and low concentrations of serotonin.

One of the recommendations in the programme was that doctors should have been warned about the supposed complications associated with Prozac. Depressed patients are vulnerable and often isolated. I wonder if such programmes should not carry a health warning, such as "This programme presents a particular point of view; no attempt has been made to produce a balanced programme."

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1 O'Donnell M. Trial by anecdote. *BMJ* 1990;**302**:56-7. (5 January.)

## Homoeopathy: medicine or magic?

SIR,—We entirely concur with Dr Robert Winter's remark that the controlled clinical trial is the basis for medical advances.[1] We were disappointed, however, by his implication that such methods had not been used to research the potential value of homoeopathy and would like to point out that several clinical trials in homoeopathy have been carried out in a rigorous manner and published in medical journals. The trial by Reilly *et al* in 1986 on the use of homoeopathic treatment in hay fever showed a significant benefit.[2] More recently, Fisher *et al* showed that homoeopathic Rhus toxicodendron 6c was effective in treating fibrositis, particularly with regard to the characteristic tenderness of fibrositis.[3]

The trial by Reilly *et al* was partly supported by the Blackie Foundation Trust, which promotes scientific research into homoeopathy. The trust is currently supporting a further investigation into the hypothesis "Is homoeopathy a placebo response?" in which homoeopathic immunotherapy is being tested in patients with atopic asthma. Dr Winter wished to know more about this study; the results will be submitted to a medical journal later this year.

Research into homoeopathy can, as in any other branch of medicine, be advanced by properly conducted trials. The trust continues to support this aim despite the difficulties of working in a specialty that attracts such adverse criticism from sceptics.

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1 Winter R. Homoeopathy: medicine or magic? *BMJ* 1991;**302**: 120. (12 January.)
2 Reilly DT, Taylor MA, McSharry G, Aitchison T. Is homoeopathy a placebo response? Controlled trial of homoeopathic potency with pollen in hay fever as a model. *Lancet* 1986;ii: 881-5.
3 Fisher P, Greenwood G, Huskisson EC, Turner P, Belon P. Effect of homoeopathic treatment on fibrositis (primary fibromyalgia). *BMJ* 1989;**299**:365-6.

SIR,—Dr Robert Winter's implication that few clinical comparisons of homoeopathic and orthodox