merely exchanging one form of death for another.—I am, etc.,

R. J. JARRETT

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1 Pearce, M. L., and Dayton, S., *Lancet*, 1971, **1**, 464.

SIR,—In your leading article on "Clofibrate in Ischaemic Heart Disease" (25 December, p. 765) mention is made of the numbers and percentages of patients in the clofibrate and placebo groups who "died suddenly from myocardial infarction." This statement embraces both sudden deaths and fatal myocardial infarction. In the analysis of the results we deliberately distinguished sudden deaths from fatal myocardial infarcts and believe that this distinction may be important in such clinical trials.—We are, etc.,

H. A. DEWAR

Newcastle

M. F. OLIVER

Edinburgh

*** We regret that the word "or" was inadvertently omitted from the sentence in question. It should have read "died suddenly or from myocardial infarction."—ED., *B.M.J.*

Health Service or Sickness Service?

SIR,—While I agree with much of the wisdom that Dr. Eliot Slater propounds (18 December, p. 734) I must take him to task about babies born with spina bifida. The doctor does not have "the duty of keeping them alive" nor of ensuring their death. The real choice is not between life and death, but whether or no a human being should be allowed to develop the preventable complications of an already serious disability in a community which has established a National Health Service. The routine control of infection in the new born nursery has saved the lives of more handicapped babies than all the paediatric surgeons in the Kingdom. That there is an ethical problem cannot be disputed. Let us be quite sure that it is discussed on the right basis.—I am, etc.,

London W.1 ALFRED WHITE FRANKLIN

SIR,—The article by Dr. Eliot Slater (18 December, p. 734) was timely, forthright, and logical. His comments under the heading of "perinatal risks" are overdue and merit the serious consideration of us all, not the least the paediatricians.

What the public press refer to as "breakthroughs" in their ever-glamourized reporting on hospitals' life-prolonging procedures in infancy are all too frequently transformed into domestic disasters, when time has shown that the sequel is so often a life of dependency—on the mother, the family, and/or the State.

The problem resolves itself into deciding whether measures aimed at prolonging infant life—which often call for the most expensive deployment of medical personnel and the use of sophisticated equipment—are justified where the probability of the child attaining a fully independent existence are very slender by reason of extreme physical and/or mental disability. Today the amount of clinical and statistical data available are sufficient to remove the decision from the realms of guesswork into an acceptable probability. We have all encountered the domestic human tragedies of a mother wearing herself out by the continuous and unremitting care given to her child who can never expect anything approaching a normal full life.

Priority in money and staff in our hospitals today is too frequently directed towards what Dr. Slater calls high prestige procedures—that is, haemodialysis units, organ transplants, paediatric resuscitation units, etc., all of which have a high news value.

I would suggest that priorities need reversing. Make the first priority attention to, research into, or where appropriate propaganda towards a reduction in morbidity from the common diseases affecting the age group 20-50 years—namely, lung cancer, coronary thrombosis, rheumatism (in a broad sense), and those psychiatric disorders that tend to fill a doctor's waiting room.—I am, etc.,

Hyde, Cheshire ALAN S. SIMPSON

Psychiatrists' Attitudes to Abortion

SIR,—During 1967 the Society of Clinical Psychiatrists conducted a survey of its members' attitudes to therapeutic abortion. The result of the first hundred replies was published in a letter to *B.M.J.*[1]

During 1971, with an increased membership, an essentially similar questionnaire was sent out to Society members. A statistically significant shift in opinion towards a more permissive approach is clearly demonstrated in the replies of that 40% of the Society's United Kingdom members who returned the completed questionnaire.

A choice of one of four opinions was sought as to the conditions under which termination of pregnancy was considered advisable:

(1) Free choice of abortion by the woman in the first trimester of pregnancy; (2) termination should be recommended if the woman's health or life is seriously threatened, the decision to include appraisal of the whole social situation; (3) termination possible only if the woman's health or life is seriously threatened—the medical viewpoint before present legislation; and (4) termination insupportable on any account at any stage.

Opinion	1967 (n = 100)	1971 (n = 140)
1.. ..	24%	59 42%
2.. ..	56%	69 49·25%
3.. ..	16%	10 7·25%
4.. ..	4%	2 1·50%
Totals ..	100%	100%

χ^2 11·824 d.f. 3 P <·01

The most conspicuous change over the four years, as identified from the replies of admittedly limited samples of senior psychiatrists, has been a 75% increase in the proportion of psychiatrists replying in favour of free choice by the woman during the first three months as to whether she wishes or not to carry on with her pregnancy.—I am, etc.,

J. C. LITTLE
Honorary Secretary,
Society of Clinical Psychiatrists

Dumfries, Scotland

1 Howells, J. G., *British Medical Journal*, 1967, **2**, 53.

Proprietary Drugs

SIR,—In a leading article (25 September, p. 724) you said: "the fact remains that a well-known firm's brand name on a product is the best guarantee there is of its purity, efficacy, and potency." The truth of this statement has been emphasized by the report in the *Prescribers' Journal*[1] of 11 patients at University College Hospital who were well controlled on a British brand of cortisone, and who were then given other cortisone tablets, made in England from continental bulk materials. These second tablets were found to comply with pharmaceutical standards, including assay and disintegration time. Soon after the change of tablets, three patients went into Addisonian crisis. On being given the original tablets, they quickly began to improve. That this is no isolated example of "*B.P.* equivalent" drugs not being as good as proprietary ones is shown by the *Drug and Therapeutics Bulletin*.[2] Under the heading of "Non-equivalent preparations of the same drug" it quotes 10 drugs where *B.P.* equivalents failed to have an equivalent effect. Even where a "*B.P.* equivalent" drug is pharmacologically identical it may have a taste so unpleasant that patients fail to continue their treatment.

We are always encouraged to be scientific and so we should be able to repeat accurately our work. Some people are now trying to encourage us to prescribe *B.P.* drugs, but there are no such things in scientific terms. We have to give somebody's brand of a preparation. It is therefore more specific and scientific to prescribe a drug by its branded name rather than by a *B.P.* name. It is only by the use of the branded name that we can be sure that our patients get the drugs we want them to have. If we do not use proprietary names we cannot accurately know what treatment they are having.

We must ask those who are trying to make us prescribe only in *B.P.* nomenclature to let us revert to the more scientific habit of prescribing our drugs accurately by name, and we must make sure that no-one is allowed to substitute a "*B.P.* equivalent" when we prescribe a specific drug.—I am, etc.,

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1 Whittet, D., *Prescribers' Journal*, 1971, **11**, 48.
2 *Drug and Therapeutics Bulletin*, 1971, **9**, 65.

Fibrin and Cancer

SIR,—Your leading article "Fibrin and Cancer" (11 December, p. 641) mentions the various results found in animal experiments using anticoagulants. These results can probably be explained by considering anticoagulant action as separate from the direct effect on the cancer cell. Both plasmin and warfarin are cytotoxic.[1 2] Warfarin must be given to a rabbit for five to seven days to inhibit the locomotion of transplanted cancer cells. This action is likely to be due to uncoupling of oxidative phosphorylation for recovery of cells occurs in four to five days if warfarin is stopped and vitamin K is given.[3]

Your reference to A. S. Ketcham and his colleagues' work with warfarin mice, misprinted 1961, reminds me how long it took them to change from heparin to long-term