A report on the severity of the disease has now been published by Dr Christine L Miller and Mr W B Fletcher (17 January, p 117). An expert analysis of the effectiveness of whooping-cough vaccines has been made by Professor G T Stewart (31 January, p 283). There is no report on the hazards associated with immunisation and the joint committee has made it clear that this information will not be speedily provided. Since parents will not be influenced by any statistics about the disease or the effectiveness of the vaccines until they have precise information about vaccine risks, we suggest that any debate on the continuation of whooping-cough vaccine should regard this as the major issue.

Two years ago we started to collect details from parents of serious reactions suffered by their children to immunisations of all kinds. In 65% of the cases referred to us reactions followed "triple" vaccination. The children in this group total 182 to date; all are severely brain-damaged, some are also paralysed, and five have died during the past 18 months. Approximately 60% of reactions (major convulsions, intense screaming, collapse, etc) occurred within 24 hours of vaccination, 80% within three days, and all within 12 days. During the period 1969-74, when 64 deaths resulted from whooping cough, 56 cases of severe brain damage followed vaccination.

These cases have been referred to the DHSS over the past two years. As the figures steadily increased and we discovered that there were doubts about the safety of whooping-cough vaccines we asked the DHSS if current vaccines could be withdrawn until safer vaccines were available. When the recommendation to continue the use of current whooping-cough vaccines was published we asked the DHSS if there were any plans to study our cases. The Department insists, however, that the incidence of severe reactions to whooping-cough vaccines is low and states that there are no plans to study our cases at present.

Health specialists are concerned about the fall in acceptance rates for all immunisations. Paradoxically, perhaps, the statement from the joint committee about whooping-cough vaccination was issued because of a similar concern. It is parents, however, who make or break acceptance rates and they are not convinced that the hazards associated with whooping-cough immunisation are low or that this is a subject which can be shelved while lengthy studies are carried out and available material is ignored.

ROSEMARY FOX
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Association of Parents of Vaccine Damaged Children
Shipton-on-Stour,
Warwicks

Transcendental meditation

SIR,—I feel that your expert has answered the question about transcendental meditation (TM) (10 January, p 88) in what appears to be an uninformed and superficial way as if he has not really studied the subject. It must first be stated that TM has nothing to do with "religious beliefs" and that it has nothing to do with mysticism. I also feel that the reference to "European culture" and "such religions" (by implication TM) is just not to the point. On the other hand it is fair to say that TM has its origin in Indian culture and, having said already that it is not a religion, surely Christianity, which is a religion, has its roots also in another culture, so why reject TM on such grounds? Again, in the last sentence but one your expert speaks about "a need for such religious experience" when every teacher of TM points out that it has nothing to do with it.

Let me therefore try to define what TM is and what its value might be. (1) TM is a technique to achieve relaxation and its experiential aim is to transcend thinking—in other words, to achieve a state of non-thinking ("thoughtlessness"). (2) The value of TM is not only, as mentioned above, relaxation, but a state of peace of mind which permits the practitioner to respond much more purposefully to stress, accept himself and his foibles and those of his fellow men more readily and permits a more purposeful response in a non-aggressive adaptive manner. From the advanced meditators I know it would also seem to induce a state of serene joyfulness. I do not know whether your expert is aware of the considerable amount of scientific data that have been collected by this movement. I recently attended a medical meeting on the subject when, indeed, very convincing research experiments were produced from the departments of physiology and psychology of the universities of Exeter and Bristol, but of course the main body of experimental data has been collected from the United States. One series of data which was especially beyond reasonable doubt showed that once in a community a saturation rate of 1% of meditators was achieved the crime rate went down by 17%. Surely such a promising technique should not be rejected lightly. I also believe that it is a valid method of primary prevention of psychiatric disorder within a certain spectrum of psychopathology. I have included the subject among the techniques of primary prevention of psychiatric disorder in a key paper which I will read to the Joint World Psychiatric Association/South Pacific Commission Conference on Primary Prevention of Psychiatric Disorder to be held in Tahiti in March 1976.

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Ethics of the placebo

SIR,—In their paper "Do placebos alter sleep?" (24 January, p 195) Miss Kirstine Adam and her colleagues report that they deliberately misled volunteers about the nature of a placebo pill. I contend that it is unethical to lie to volunteers.

MARY RICE
Liphook, Hants

**We showed this letter to Miss Adam and her colleagues, whose reply is printed bleow. —ED, *BMJ*

SIR,—The medical profession has, throughout history, relied heavily upon placebo effects and therefore on a degree of deception. It still does. Must it be wrong to investigate placebos? We think it is not.

Our volunteers were actually in a larger study, during which they would later be taking nitrazepam. They had given consent to a sleeping pill, which may make our deception less heinous, though it does not negate it. Our pill, being inert, did no positive harm—certainly less than many genuine sleeping pills can do.

There is no unanimity about whether deception is always wrong—is the surgeon who misleads his patient and says she has not got cancer always wrong? We believe that the general body of thoughtful people would not regard our research as improper, but we are willing to respect the views of those who think differently.

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Effect of beta-blockade in chronic renal failure

SIR,—In 1974 deterioration in renal function after β-adrenergic blockade in three patients with chronic renal failure, one of whom recovered renal function after withdrawal of therapy, was reported from this unit.[1] This provoked some controversy and we wish to report two further cases.

Case 1—A 34-year-old woman had been treated with debrisoquine for seven years for hypertension secondary to chronic pyelonephritis. The control of blood pressure had been poor because of sporadic self-medication with phenothiazines, frusemide, and tryptizol. Renal function had been stable with a plasma urea of 6-7 mmol/l (36-42 mg/100 ml), creatinine 200-205 μmol/l (2·26-2·32 mg/100 ml) and an endogenous creatinine clearance of 30 ml/min. Propranolol 40 mg three times daily was started. After six days the plasma urea and creatinine rose to 15·5 mmol/l (93 mg/100 ml) and 270 μmol/l (3·05 mg/100 ml) respectively and the blood pressure was unchanged at 140/100 mm Hg. The drug was discontinued; the plasma urea reached a maximum of 22 mmol/l (132 mg/100 ml) and then began to fall, but it was nearly a month before renal function returned to control values.

Case 2—A 28-year-old man with chronic renal failure secondary to chronic pyelonephritis had been treated for hypertension with debrisoquine. Outpatient blood pressure recordings varied between 170/125 and 150/110 mm Hg. Renal function had been stable for over six months with a plasma urea of 18-20 mmol/l (108-120 mg/100 ml) and plasma creatinine of 440-450 μmol/l (4·97-5·09 mg/100 ml). Propranolol 40 mg three times daily was started. After six weeks the blood pressure had fallen to 110/80 mm Hg and he developed pulmonary oedema. The plasma urea had risen to 31·6 mmol/l (190 mg/100 ml) and despite stopping the β-blocker renal function did not recover and he is now on intermittent haemodialysis.

The sudden deterioration in renal function in these patients was related to administration of the β-blocker drug as there was no oligaemia, infection, or other change in drug therapy, one patient recovered when the drug was withdrawn, and renal function had been stable for the previous six months. The deterioration was possibly due to reduced renal perfusion following a reduction in cardiac output, accompanied in case 2 by a fall in blood pressure. This further experience confirms our previous suggestion that β-adrenergic-blocking drugs may cause a permanent reduction in renal function in patients with chronic renal failure and should be used only when frequent supervision of renal function is possible.

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[1] Warren, D J, Swainson, C P, and Wright, N, *British Medical Journal*, 1974, **2**, 193.