and produced a proper and sensible random sample of size 637. Alas, such are the needs of ethics in human experimentation, this superb sample has to be given the right not to participate. Five hundred and twenty-seven of them exercised this right producing an acceptance rate of 17.3%. The failure of a further six people to complete the experiment reduced this to 16.3%. Both these figures are ludicrous in epidemiological terms. Five hundred and thirty-three of the random sample (size 637) did not contribute to the results.

It is sad that their final paragraph of conclusions and advice has entered the literature—it is quite wrong. On the data presented, the true incidence rate of (for example) poor dapsone metabolisers in the population of Newcastle upon Tyne may indeed be the same as the 53% seen in this self-selected sub-sample: it might also be as high as 92.3% or as low as 8.6%. This is not the stuff of which good science is made.

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Reference

Blain, P. G., Clark, D. W. J., Roberts, D. F. & Rawlins, M. D. (1984). Sampling from the adult population for pharmacokinetic and pharmacogenetic studies. *Br. J. clin. Pharmac.*, **17**, 611P–612P.

Sampling from the adult population for pharmacokinetic and pharmacogenetic studies. Professor Rawlins and colleagues reply.

Dr Maxwell's (1984) characteristically robust criticism of our survey (Blain *et al.*, 1984) fails to appreciate the aims and scope of the study we undertook. The project was undertaken to determine the feasibility of constructing a sample of around a hundred individuals from the general population to investigate pharmacokinetics and pharmacogenetics. From previous experience, we anticipated that only 15%–20% of those we contacted would be willing to participate and so the initial quota was deliberately large. We were also aware that these volunteers might represent a biased sample, and the principal purpose of the investigation was concerned with studying this possibility.

The results showed that our sample did not appear to be biased for gender, social class, smoking habits or red cell antigen polymorphisms. Current drug consumption was similar to that observed in larger UK surveys, and the distribution of two polymorphic pathways of drug metabolism was also concordant with the results of other British studies.

We did not conclude in our final paragraph that the distributions of the pharmacogenetic polymorphisms were similar in Geordies and the UK population as a whole (although this, in fact, is likely). We did, however, conclude that our results suggested that sampling from the general population was a feasible technique, and one which produces a sample who are reasonably representative of the local populus in respect of a number of major demographic, sociological, environmental and genetic factors. Misquotation is not the stuff of which good scientific criticism is made.

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