Rundall in February 1991, asking for additional information to permit investigation. No reply was received. After the commission was disbanded Senator Muskie again wrote to Ms Rundall and enclosed Nestlé's comments on the remaining complaints. He invited her, if she was not satisfied with these comments, to pursue the matter directly with Nestlé; with Professor Frank Falkner, the newly appointed ombudsman of the International Association of Infant Food Manufacturers; or with the health authorities of the countries concerned, whose ultimate responsibility it is to monitor the implementation of the international code. Nothing further was heard from Ms Rundall until the claims in Baby Milk Action's propaganda—repeated in Lausanne, and in the *BMJ*—that the complaints had not been answered.

Nestlé and other responsible manufacturers have every interest in seeing the introduction of transparent, impartial, and effective procedures for monitoring the code in every country. Activist groups like that led by Ms Rundall can play a useful part in reporting alleged violations of the code, but they cannot be allowed to represent themselves as supranational arbiters of the code.

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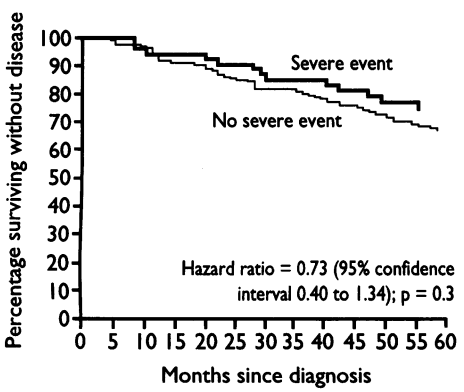
1 Dillner L. Coffins greet Nestlé shareholders. *BMJ* 1993;**306**: 1563-4. (12 June.)

Life events and breast cancer prognosis

EDITOR,—In our prospective interview study of 204 patients with operable breast cancer treated in Southampton or Portsmouth, severe life events were not associated with increased risk of relapse within 42 months of diagnosis.[1] To examine the possibility that life events exert a delayed effect, we have now carried out a case note follow up of our cohort at five years.

Our negative results persist in the longer term (figure). The format of this has been chosen to permit comparison with the case-control study on the same topic from Guy's Hospital.[2,3] Relapsed patients in that study reported more severe life events than controls, events within two years of diagnosis accounting for the excess. Our data, in contrast, show similar survival curves for patients with and without severe events in the first two years. Differences in sample selection and patient characteristics may account for some of this discrepancy. We suggest, however, that recall bias and reporting bias in the Guy's Hospital study were unavoidable owing to the study's retrospective design and contributed towards its strongly positive result.



Five year disease free survival in breast cancer patients with (n=50) and without (n=154) severe life events in the two years after diagnosis

Any influence of life event stress on breast cancer outcome would be part of a complex interaction with other sociodemographic and biological variables. Future research designed to clarify such relationships will be of academic interest. The knowledge already derived from large prospective studies, both clinical[1] and epidemiological,[4] suggests that the issue has little or no practical importance for most patients.

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1 Barraclough J, Pinder P, Cruddas M, Osmond C, Taylor I, Perry M. Life events and breast cancer prognosis. *BMJ* 1992;304: 1078-81.
2 Ramirez AJ, Craig TJK, Watson JP, Fentiman IS, North WRS, Rubens RD. Stress and relapse of breast cancer. *BMJ* 1989;298:291-3.
3 Ramirez AJ, Richards MA, Gregory WM, Craig TJK, Watson JP, Fentiman IS, *et al.* Life events and breast cancer prognosis. *BMJ* 1992;304:1632.
4 Jones DR, Goldblatt PO, Leon DA. Bereavement and cancer; some data on deaths of spouses from the longitudinal study of the Office of Population Censuses and Surveys. *BMJ* 1984; 289:461-4.

How much alcohol is sensible?

EDITOR,—For people with behavioural problems such as alcohol problems, statistics on consumption are one of the few items of hard information that can be obtained. Now that targets shape the collection of data and statistical information influences expenditure by purchasers, the basic figures need to be comparable.

General practices claiming health promotion payments in band 3 are required to report annually the number of patients (aged 15-74 in six age bands and by sex) whose alcohol consumption is recorded; the number who state that they drink amounts exceeding the recommended sensible limits; and the number with this risk factor who are offered advice, follow up, and health promotion interventions.[1]

The Royal College of General Practitioners gives a guide to the risk at different levels of alcohol consumption (table).[2] Safe limits are defined as less than 15 units a week for women and less than 20 for men. All practices have been issued with a definitive guide to health promotion, which states that sensible limits are 21 units a week for men and 14 units a week for women.[3] The authority for this is quoted as Wilson,[4] and a figure from Wilson's paper is reproduced which clearly shows 21 units for men and 14 units for women to be above the sensible limit. *The Health of the Nation* sets a target to reduce the proportion of men drinking more than 21 units of alcohol a week from 28% in 1990 to 18% by 2005 and the proportion of women drinking more than 14 units of alcohol a week from 11% in 1990 to 7% by 2005.[5]

Thus it seems that if a woman drinks 14 units a week she is safe, according to the Royal College of General Practitioners, the guide to health promotion, and *The Health of the Nation* but not according to Wilson. If a man drinks 21 units a week he is not safe according to the Royal College of General Practitioners and Wilson but is safe according to the guide to health promotion and *The Health of the Nation*. Perhaps the criteria given in *The Health of the Nation* should take precedence in the health service and the statement of fees and allowances should guide primary care teams.

Risk associated with different levels of alcohol consumption (units/week) according to Royal College of General Practitioners[2]

Risk	Women	Men
Low	<15	<20
Moderate or intermediate	16-35	21-50
High	≥35	≥50

Because consumption is only reasonably recorded in whole numbers, the current confusion would be reduced if everyone agreed that if more than 14 units a week for women and more than 21 for men is unsafe, then sensible drinking must be less than 15 units a week for women and less than 22 for men.

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1 NHS Management Executive. *General practice contract health promotion arrangements: guidance annex J. Reporting on health promotion programme/chronic disease management.* London: NHS Management Executive, 1993.
2 Royal College of General Practitioners. *Alcohol—a balanced view.* London: RCGP, 1986:20. (Report No 24.)
3 Department of Health, General Medical Services Committee, Royal College of General Practitioners. *Better living, better life.* London: DoH, GMSC, RCGP, 1993.
4 Wilson P. *Drinking in England and Wales.* London: HMSO, 1980.
5 Department of Health. *The health of the nation.* London: HMSO, 1992:57.

Doctors are vulnerable to managers

EDITOR,—In July last year there was considerable publicity about my "resignation" as clinical director of medicine at Southmead Hospital in Bristol.[1,2] I would like to describe what actually happened.

On 9 July last year the junior medical staff at Southmead Hospital, exasperated by the Trust's inaction, took part in a television programme, in which they complained about the lack of locums, which they said had put patients' lives in danger and caused delays in patients being seen. The junior staff also discussed the loss of three house physician posts, which had greatly increased the work of the remaining junior medical staff at a time of increasing medical activity. In fact, these three posts had been reallocated by the regional health authority despite my and other consultants' vigorous protests. The programme did not mention my name or blame the medical directorate.

The next morning, while I was in the middle of an outpatient clinic, on the instructions of Mr Colin Williams (the chairman of Southmead Health Services NHS Trust) I was coerced into resigning —otherwise I faced an uncertain future as a consultant. I was to take the full blame for the problems of junior medical staffing.

On 12 July 1992 Mr Williams gave an interview to the *Western Daily Press*, in which he stated "Dr Harrison has been the person responsible for this matter. It relates solely to medicine. At no time in the three months since we became a trust on April 1 has he come to the board and raised this as an issue." Mr Williams resigned as chairman three days later.

On 14 June this year, 11 months after my forced resignation, I won an action in the High Court for libel and slander against the *Western Daily Press*, Mr Williams, and Southmead trust. My counsel, Mr George Carmen, QC, in reading out an apology from both the *Western Daily Press* and Southmead Health Services NHS Trust, said that Mr Williams and other members of the trust board had been well aware of the problems of the junior medical staff; also, Mr Williams had failed to state that I had been in the forefront in trying to increase staff