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# LETTERS

LINDSEY SPINKS



## LAW ON ASSISTED DYING

### Tallis's slippery slope

Tallis's argument about changing the law on assisted dying invites at least three comments.<sup>1</sup> He claims that being able to “determine what is in your own best interest when you are of sound mind” is a fundamental principle of medicine and that “Nobody else's views should be able to over-ride this right.” Really? Do patients have the right to demand antibiotics for a viral infection? But even if his sweeping claim was true, it would take us beyond assisted suicide for the terminally ill to euthanasia for anyone (chronically ill or not ill also) who thought death was “in their own best interest.”

He claims that to assist a patient's suicide is “to accept their valuation” that they would be better off dead. But, if a doctor thinks that a patient would be better off dead, why withhold this benefit merely because the patient is unable to request it?

He also claims that fears of a slippery slope are not supported by “international experience.” He omits to mention that the Dutch initially claimed that euthanasia would be permitted only at the explicit request of the patient but now the patient must make it clear in advance if they do not want to be killed should they become incompetent. Tallis also omits to mention that Dutch law now permits non-voluntary euthanasia in certain cases.

Assisted suicide for the terminally ill would merely be a foot in the door, and the many expert bodies that have heard the sort of arguments raised by Tallis have rightly rejected them.

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Competing interests: None declared.

<sup>1</sup> Tallis R. Should the law on assisted dying be changed? Yes. *BMJ* 2011;342:d2355. (21 April.)

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## Assisted dying versus assisted living

Tallis states that it is a fundamental principle of medicine “that you should be allowed to determine what is in your own best interest when you are of sound mind.”<sup>1</sup> This is the consumerist view and not fundamental. The fundamental principles of medicine are to do no harm and to serve the health of the patient. Since the Greeks, doctors have used their knowledge to convince patients of what seems to be the best clinical treatment. That isn't paternalistic, just good practice based on good knowledge.

The argument for “assisted dying” takes this off the table. It would say “Your choice,” even when, as clinicians, we might know that death is premature and unnecessary.

So we come to the question of what doctors do—simply respond to patients' desires (even if wholly uninformed) or seek with all their powers to provide the best care and the fullest life for each patient who seeks medical attention?

If the last option is the answer then how do we fulfil the goal in cases of end stage distress? Tallis takes palliative care off his table here. His argument suggests to me that such care needs to be the centrepiece of the doctor's offering.

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## Better framework needed

I have just watched my 91 year old father slowly die of dehydration and multisystem failure as a result of the application of the Liverpool final care pathway. I applaud the intent of this protocol and its goal of facilitating painless death within the current legal framework that surrounds the vexed issue of how to end life. My brother and I, my father's only two close relatives, were both appalled by the spectacle of his slow death, even though the physical care he received was exemplary. It was no comfort for us to know that his medically induced coma spared him the felt experiences we witnessed. The dignity of human life was destroyed by this process. How much better for him and us would it have been if he had

received his five days of coma inducing drugs in a single dose at the outset.<sup>1</sup>

This is not a matter for the ethicists and pontificators of this world, but for the patient, the family, and the patient's doctor. We need a sensible framework that allows us to do better.

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<sup>1</sup> Tallis R. Should the law on assisted dying be changed? Yes. *BMJ* 2011;342:d2355. (21 April.)

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## Anti-euthanasia cards

Fitzpatrick argues against legalising assisted dying.<sup>1</sup> The argument is partly built on quicksand. Particularly when referring to empirical fact, the water becomes turbid.

When he argues that older disabled people's lives are under threat if euthanasia is legal he uncritically cites McColl, who apparently said, “Many elderly people in the Netherlands are so fearful of euthanasia that they carry cards around with them saying that they do not want it.” However, this claim has no empirical foundation. To my knowledge, no such anti-euthanasia cards exist in the Netherlands. What does exist is a living will (the “levenswensverklaring”), which is distributed by the Christian Dutch Patient Association. In this living will people can express their wishes regarding end of life medical and nursing care in case of incompetence and can state that active life termination is not an acceptable option.

It is not known how many people have completed such a living will. McColl's quote is both incorrect and overly suggestive.

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<sup>1</sup> Fitzpatrick K. Should the law on assisted dying be changed? No. *BMJ* 2011;342:d1883. (21 April.)

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## European-wide debate needed

The dilemma faced by healthcare professionals in caring for patients with terminal illness was cogently presented by Tallis, with the sanctity of life being discussed by Fitzpatrick.<sup>1 2</sup> Tallis's sentiments will doubtless resonate with clinicians who care for the elderly and carers of people with chronic debilitating illness. This

debate reminds me of Devlin's Maccabean lecture in jurisprudence entitled, "The enforcement of morals," in which he contended that criminal law should be used against behaviour generally condemned as immoral. The experiences of the population of Oregon run counter to the slippery slope hypothesis, and the matter of the trust vested in doctors is reinforced by the experience of patients in the Netherlands.

But what of the rights of the terminally ill distressed patient as set against the moral feelings of the rest of society and inconsistencies in the application of the law among members of the European Union? The European Convention on Human Rights cites the right to life under Article 2 as an inviolate positive right protected by law. A multicultural multidisciplinary European-wide debate on this key issue is surely long overdue before government initiatives further fracture the delivery of holistic patient based care.

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- 1 Tallis R. Should the law on assisted dying be changed? Yes. *BMJ* 2011;342:d2355. (21 April.)
- 2 Fitzpatrick K. Should the law on assisted dying be changed? No. *BMJ* 2011;342:d1883. (21 April.)

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## NHS REFORMS

### Issues MPs and the media have missed in Lansley's bill

The Commons Public Accounts Committee review makes damning criticisms of Lansley's deeply flawed Health and Social Care Bill, exposing the shallowness of parliamentary scrutiny.<sup>1</sup> But it fails to note that the bill would end the accountability of the secretary of state for the continued provision of health services and ignores the loss of local accountability.<sup>2</sup>

GP consortiums, the NHS Commissioning Board, and health and wellbeing boards are not required to meet in public, publish board papers, or consult locally on changes. Nor are foundation trusts directly accountable to parliament—parliamentary questions are not answered by ministers but referred to the trust chair.<sup>3</sup>

Monitor has argued that foundation trusts should focus on services that deliver a surplus and pull out of services that don't.<sup>4</sup> Consortiums do not need to ensure that an appropriate range of services is accessible in each area. Instead "any qualified provider" approved by Monitor can compete to provide services anywhere they choose, regardless of the impact on struggling foundation trusts. Monitor's primary brief is to maximise competition. GP commissioners would have no say over which companies would be included in the register.

Primary care trusts have drawn up long lists of "low priority" treatments no longer routinely covered by the NHS, including hip and knee replacements.<sup>5</sup> Nothing in the bill deals with these gaps in NHS provision, leaving patients confronting a brutal choice: go private or go without.

The bill would also scrap limits on how much foundation trusts can raise from private medicine. Some trusts will focus on commercial services to paying customers, leaving NHS patients—for whom trusts receive declining tariff payments—to wait.

If these questions are not raised, MPs could push the bill through in a haze of public ignorance and misinformation.

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Competing interests: None declared.

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Cite this as: *BMJ* 2011;342:d3194

## MEDICAL ABORTION

### Surgical intervention after medical abortion

Niinimäki and colleagues found a 10.7% rate of surgical intervention after medical abortion in adolescent women.<sup>1</sup> This complication rate is important, because in 2009 in the UK, just over 40 000 women under 20 years underwent termination of pregnancy,<sup>2</sup> 40% by medical abortion, and the number of medical abortions is increasing.

A systematic review of premature delivery after induced abortion showed that the odds of premature delivery after induced surgical abortion (odds ratio 1.36, 95% confidence interval 1.24 to 1.50) increased with further surgical abortions (1.93, 1.28 to 2.71).<sup>3</sup> Niinimäki and colleagues' figures suggest that one in 10 young women who undergo medical abortions will be at risk of surgical intervention, and will then be at risk of subsequent premature delivery. One study estimated that induced surgical abortion

accounts for 31.5% of the excess risk for births at less than 32 weeks' gestation.<sup>4</sup> Prematurity is a major risk factor for cerebral palsy.<sup>5</sup>

Providers of induced medical abortions should obtain informed consent from their clients in relation to the risks of failed medical abortion, which should include the risk of surgical evacuation, the subsequent risk for preterm delivery, and possible resulting neurological abnormality in their child.

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- 1 Niinimäki M, Suhonen S, Mentula M, Hemminki E, Heikinheimo O, Gissler M. Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ* 2011;342:d2111. (19 April.)
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Cite this as: *BMJ* 2011;342:d3192

## Authors' reply

We showed that medical abortion has no additional short term adverse events or complications in adolescents compared with adults.<sup>1</sup> Thus medical abortion can be used as an alternative to surgical abortion once the decision to terminate the pregnancy has been made. About 90% of the women treated medically did not need surgical intervention.

Previous studies, including the meta-analysis

by Shah and colleagues,<sup>2</sup> indicate that repeat surgical abortion is a risk factor for premature delivery. However, less is known on the effect(s) of previous medical abortion on the risk of prematurity. A recent study performed in China indicated that repeat surgical, but not medical, abortion was associated with increased risk (odds ratio 1.22 (95% confidence interval 1.03

to 1.64) v 1.03 (0.53 to 1.63)) of prematurity in subsequent pregnancies.<sup>3</sup> Similarly, a Danish cohort study found no difference in the incidence of prematurity after medical or surgical



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abortion in the first trimester.<sup>4</sup> Thus offering a choice of medical or surgical abortion is not likely to increase the risk of preterm delivery in subsequent pregnancies. We therefore fail to follow the logic in Johnston's letter.<sup>5</sup> Providing women with a choice between medical and surgical abortion in early pregnancy does not increase the rate of repeat induced abortion either.<sup>6</sup> Nevertheless, the possible effect(s) of medical abortion on future pregnancy warrants further studies.

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- Niinimäki M, Suhonen S, Mentula M, Hemminki E, Heikinheimo O, Gissler M. Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ* 2011;342:d2111. (19 April.)
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**Cite this as:** *BMJ* 2011;342:d3199

## PARACETAMOL POISONING

### Paracetamol concentrations should be in mg/L in UK

Ferner and colleagues highlight the risk of confusion between the units of concentration mmol/L and mg/L. Values are numerically very different, and this has led to deaths.<sup>1</sup>

This plurality of units extended across all drug concentration reports in the UK, so on 30 June 2006 a consensus meeting with representatives of the Royal College of Physicians, National Poisons Information Service, Royal College of Pathologists, and other interested organisations was hosted at the Association for Clinical Biochemistry to debate the merits and demerits of the different concentration units.

For reasons of pragmatism and to make understanding world literature easier it was agreed that mg/L should be universally adopted. This view was communicated to UK laboratories through publication and the External Quality Assurance Schemes that

all laboratories participate in.<sup>2</sup> Therefore, confusion over units should no longer cause a fatal error.

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- Ferner RE, Dear JW, Bateman DN. Management of paracetamol poisoning. *BMJ* 2011;342:d2218. (19 April.)
- Watson I, Barth J. Consensus meeting on units for reporting drug concentrations. *ACB News* 2006;522:14-5.

**Cite this as:** *BMJ* 2011;342:d3029

## ATRIAL FIBRILLATION GUIDELINES

### Don't forget HASBLED score

Anticoagulation in atrial fibrillation is a key priority.<sup>1</sup> As junior doctors working in both general medicine and cardiology, we have found the CHA<sub>2</sub>DS<sub>2</sub>-VASc system no more onerous than its predecessor, CHADS<sub>2</sub>. The scoring system and the new guidelines also help in what is often a poorly managed condition on general medical on-calls.

The HASBLED score is included in guidelines but was not mentioned in the editorial.<sup>2</sup> It calculates the risk of bleeding on the basis of seven variables: hypertension (1 point), abnormal liver/renal function (1 or 2 points), stroke (1 point), bleeding (1 point), labile international normalised ratios (1 point), elderly (>65, 1 point), drugs/alcohol (1 or 2 points). The maximum score is 9, ≥3 points suggesting a high risk of bleeding.

The score should be calculated at the same time as CHA<sub>2</sub>DS<sub>2</sub>-VASc to help to guide decisions about oral anticoagulant treatment. It is useful in assessing the risk-benefit ratio of starting oral anticoagulation, as well as the frequency of follow-up. This is increasingly important with the new guidance recommending warfarin over aspirin for patients with lower CHA<sub>2</sub>DS<sub>2</sub>-VASc scores.

Objective scoring systems aid the subjective clinical assessment of an individual patient's risk of stroke and bleeding. They should be used to give prognostic information to patients to enable them to make a truly informed decision about their ongoing management.

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## COST OF PREVENTIVE DRUGS

### Dare to tell?



I commend an alternative, but perhaps more patient centred, interpretation of the Cochrane hierarchy of evidence described by Järvinen and colleagues.<sup>1</sup> The first rungs on the ladder—"Can it work?" and "Does it work?"—are answered by the science underlying the intervention and the controlled trial. But the third rung—"Is it worth it?"—should not be asked first of health economists but of patients, the proposed target of the intervention.

Bisphosphonates have statistical benefit in preventing fractures and have reached the second rung. But for most they would fall at the third if we asked the patient, "Is it worth taking a drug which has been shown to be of no benefit to 99.8% (number needed to treat 667) of those who take it and which may have side effects?" Many preventive drugs would fall at this step if we were honest with patients: statins, warfarin, aspirin, β blockers, antihypertensive drugs all score under 1% absolute risk reduction per year.<sup>2</sup> We should still promote them; some patients will benefit, and many will take drugs no matter how small the chance of benefit, but many will not; and the evidence suggests that for most the level of preventive benefit falls below their expectation.<sup>2</sup>

To withhold figures on absolute risk reduction because they are difficult to express, or because patients may stop taking the drugs if told how small their chance of benefit, is patronising and perhaps dishonest. Heath asks whether in terms of risk illiteracy we "dare to know."<sup>3</sup> Yes, we must. But dare we tell? As patients' impartial treatment broker and advocate, we must know and we must tell, even if this results in a decrease in the uptake of preventive drugs in the community.

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**Cite this as:** *BMJ* 2011;342:d3198

## PRIVATE ALCOHOL DETOX CLINICS

## Please tell us about them

An anonymous view describes the awful experiences of the author's son at several, mainly private, detox and rehabilitation clinics.<sup>1</sup> It is relevant to the Medical Council on Alcohol, a charity committed to improving medical understanding of alcohol related problems, to hear about such poor quality services—it is hard to get systematic data, which makes patients and families vulnerable.

As medical director of the Medical Council on Alcohol, I welcome any information (good and bad) on experiences at similar facilities. All information will be treated in absolute confidence.

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1 Private alcohol detox clinics should be regulated. *BMJ* 2011;342:d2399. (19 April.)

Cite this as: *BMJ* 2011;342:d3033

## BIPOLAR II DISORDER

## Bad medicine or bad mouthing?

Spence's column about bipolar II disorder is disappointing and disconcerting.<sup>1</sup> He launches an uninformed attack on psychiatry with selective quoting of evidence, which raises some concerns for the patients he sees with mental health problems.

This is a shame because implicit in his article are issues that we as a profession struggle with, and which are not confined to psychiatry. The first is how to deal with a continuum of disease severity ranging from normality to severe illness, given that we are wedded to the use of categorical diagnoses. Spence's last paragraph about iatrogenic harm and "overrampant diagnosis" could be applied to a range of other disorders, including the milder end of hypertension, type 2 diabetes mellitus, and hypercholesterolaemia.

Spence's singling out of psychiatry comes across as an outdated prejudice, based in mind-body dualism, that mental disorders are not "real" illness. However, informed debate is needed about how best to manage sub-threshold to mild forms of disorders when many treatments may not have a favourable risk-benefit balance. If we accept (as Spence seems to) that bipolar I disorder is worthy of diagnosis and treatment, then some patients will have milder forms of elevated mood, as has been consistently shown in epidemiological studies. Rather than dismissing this as manufactured illness to sell drugs, we need to understand better the impact of these milder forms to know how best to manage them.

The second issue is the potential for over-reliance on purely self-report measures such as questionnaires. People may have many reasons for

giving exaggerated, or even fallacious, accounts of their symptoms. Bipolar II disorder's current celebrity fashion status feeds into this. However, every doctor has to deal with unexplained medical and psychological symptoms. The increasing "tick box" approach to medicine, at the expense of clinical judgment, weakens the ability to make a full assessment; which usually needs to incorporate third party information.

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**Competing interests:** IMA leads a tertiary service for mood disorders. He has had research support and received honorariums for speaking from pharmaceutical companies marketing drugs for bipolar disorder.

1 Spence D. Bad medicine: bipolar II disorder. *BMJ* 2011;342:d2767. (4 May.)

Cite this as: *BMJ* 2011;342:d3185

## Trivialisation of suffering

As the partner of a sufferer of bipolar II disorder, I feel trivialised, patronised, and dismissed by Spence.<sup>1</sup> We are not the victims of celebrity fashion, pharmaceutical advertising, or the mind games of psychiatrists but a couple brought to crisis by this disease.

Over nine months the disease risked my partner's physical health and safety, employment, self esteem, driving licence, marriage, relationships with family and friends, children's wellbeing, and freedom from a criminal record. And, yes, the fridge steadily emptied and became full of caffeinated drinks. While Spence enjoys his polemic, there is real suffering and risk with this illness. Thankfully, a low dose of an antipsychotic drug had dramatic effects in days.

Spence's case seems to be:

- An illness that may be common cannot exist
- An illness that is poorly understood cannot exist (did tuberculosis not exist before the bacteria were found?)
- An illness suffered by celebrities cannot exist
- An illness for which industry is developing drugs cannot exist.

Clearly this is nonsense.

**Anonymous**

**Competing interests:** Partner of a patient.

1 Spence D. Bad medicine: bipolar II disorder. *BMJ* 2011;342:d2767. (4 May.)

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## Author's reply

I did not intend to single out psychiatry<sup>1</sup>: I have written pieces on many clinical topics, including general practice as bad medicine.<sup>2</sup> Of course I believe in mental illness.

Although disease severity is a continuum, boundaries exist. Hypertension and cholesterolaemia have boundaries, but bipolar II

disorder steps over the boundary. If 20% of the 20 million people who experience a depressive illness have unrecognised bipolar illness, then 4 million people have a lifelong chronic mental illness—equivalent to the population of Birmingham, Glasgow, Manchester, and Liverpool combined. Tell me this isn't an issue, tell me this isn't overdiagnosis, tell me this wouldn't be a shame.

I never intended to trivialise or dismiss people's problems, and I am sorry that my article was taken this way.<sup>3</sup> I have never suggested that people don't have symptoms or that drug treatment has no role.

My argument is that the diagnostic criteria are too loose and that the definition of hypomania in the DSM is so open as to have no real world validity. It will see millions potentially labelled with a lifelong diagnosis with no evidence of benefit. This is a concern for the psychiatric community to address and acknowledge, which so far it has not.

As for enjoying my polemic, I write these articles only because I believe in the need for more medical dissent.

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- 1 Anderson IM. Bad medicine or bad mouthing? *BMJ* 2011;342:d3185.
- 2 Spence D. Bad medicine: general practice. *BMJ* 2010;341:c7336 (22 December)
- 3 Anonymous. Trivialisation of suffering. *BMJ* 2011;342:d3189.

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## Constructionism

Surely one can only agree with Spence's intriguing insight that modern psychiatry is "merely an intellectual construct,"<sup>1</sup> and the same is true, of course, of other medical disciplines, as well as the modern scientific project in general.<sup>2</sup>

Indeed, for some time the ontological status of Spence himself has been contested as a possible *BMJ* construct: a frontline, not to say "full time", no nonsense, hard-headed, GP whose very appellation (Dispense) underlines the pervasive reach of big pharma.

Baudrillard has pointed out that in the post-modern media world the purpose of a simulation is to attest to the reality of the culture that generates it.<sup>3</sup> Clearly by signalling the illusory nature of bipolar II disorder, this article is nothing less than an audacious attempt to persuade us that there is a real person called Des Spence. Nice try.

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**Competing interests:** PJC is one of the authors of the *Shorter Oxford Textbook of Psychiatry*, which treats bipolar II disorder as if it were a medical condition.

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Cite this as: *BMJ* 2011;342:d3195