We select the letters for these pages from the rapid responses posted on bmj.com favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

LETTERS

MARK THOMAS

CONTINUOUS DEEP SEDATION

Dutch research reflects problems with the Liverpool care pathway

The Liverpool care pathway (LCP) is the UK's main clinical pathway of continuous deep sedation and is promoted for roll out across the NHS.[1] Rietjens et al's study highlights some serious weaknesses in its design.[2]

The eligibility criteria do not ensure that only people who are about to die are allowed on to the pathway. They allow people who are thought to be dying, are bed bound, and are unable to take tablets on to the pathway. In chronic diseases such as dementia, dying can take years, but such patients may be eligible. Reitjens et al's paper shows that GPs often put patients on to such a pathway without palliative care advice. A pathway for general use should minimise opportunities for early or inappropriate use.

Murray et al are concerned that sedation is being used as an inexpensive alternative to assessment and specialist treatment.[3] The LCP recommends sedatives and opiates for all patients on an "as required" basis, even when they are not agitated, in pain, or distressed. An automatic pathway towards prescribing heavy sedatives incurs risks.

Moreover, the LCP recommends setting up a syringe driver within four hours of a doctor's order. This is laudable, if it is needed. But the pathway encourages the use of syringe drivers even when symptoms can be managed without them.

The pathway doesn't mention the need for food and fluids. Reitjens et al show that withholding artificial nutrition and hydration is the norm. The LCP's omission of prompts to reconsider nutrition and hydration may allow serious errors in the care of dying patients. It is not acceptable, as Murray et al suggest, that assessing nutrition and hydration are not part of the pathway.

Sedation is right in some situations. But as Murray et al point out, the anticipated outcome of continuous deep sedation is death. We must learn from Reitjens et al's observation that continuous deep sedation may replace euthanasia. If the methods and pathways that we use for continuous deep sedation in the UK are flawed, then patients will die as a result of inappropriate use. I hope that the LCP will be reviewed and modified.

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1 Marie Curie Palliative Care Institute. *Liverpool care pathway for the dying patient (LCP)*. 2008. www.mcpcil.org.uk/liverpool_care_pathway.
2 Rietjens J, van Delden J, Onwuteaka-Philipsen B, Buiting H, van der Maas P, van der Heide A. Continuous deep sedation for patients nearing death in the Netherlands: descriptive study. *BMJ* 2008;336:810-3. (12 April.)
3 Murray SA, Boyd K, Byock I. Continuous deep sedation in patients nearing death. *BMJ* 2008;336:781-2. (12 April.)

COMPETITION IN THE ENGLISH NHS

Let's return to representative planning for a population

Ham has reached the conclusion that the market approach to health care is not appropriate for disease prevention and chronic disease, and he argues for integration in health care.[1] Most people working in the NHS have thought that the so called market is inappropriate for health care since it was introduced in the 1990s.[2] Competition between health providers is espoused by politicians, journalists, and health economists as the best way to motivate people to work harder and improve efficiency. In fact, the market sets different parts of the NHS against each other and leads to a fragmented approach, rather than ensuring that all work together for the welfare of patients. It sets primary care against secondary care and both types of care against social services. Is this good care?

Ham points to weaknesses in commissioning. It is ridiculous to exclude secondary care specialists from this process. As Ham points out, negotiating contracts in the market is hugely costly. Millions of pounds could be re-directed to patient care, disease prevention, and hospital building by abandoning the market approach and by ridding the NHS of the armies of management consultants.

Let us return to a system where health care is planned for a given population by, for instance, a health authority in which all parts of the NHS are represented. This would ensure an integrated approach and would restore professionalism, pride, and satisfaction in working in the NHS, which have all been reduced by the demeaning market approach. By all means, let health providers compete and be rewarded for providing an excellent and efficient service.

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Competing interests: None declared.

1 Ham C. Competition and integration in the English National Health Service. *BMJ* 2008;336:805-7. (12 April.)
2 Elkeles R. The cash register may drown out the sound of the ambulance. *Independent* 1989 Jan 26.

SUICIDE AND THE INTERNET

Study misses internet's greater collection of support websites

I'm unsure why Biddle et al's study of suicide and the internet focused on methods of suicide rather than on support, treatment, interventions, crisis hotlines, or information on how to stop or prevent suicide.[1] Suicidal behaviour encompasses all of this and much more.

By stacking the deck with the keywords and search phrases chosen, the researchers found a plethora of websites and information resources on methods of suicide. Their results would probably have been very different had they taken a less biased approach and typed in queries such as "suicide support group", "suicide help", "suicide crisis", or "suicide prevention". When I did a search using "suicide" (the keyword used by most people), the top 10 sites contained no pro-suicide websites.

The researchers made a conscious decision to focus on suicide methods and, as would be expected, found many websites with such information. Even an informational resource might briefly mention such methods to inform and describe what the act of suicide encompasses (but this would not make such a resource a pro-suicide site).

The study was designed to emphasise the negative aspects and did not mention that support websites greatly outnumber pro-suicide websites.

The study paints a pessimistic, biased, and bleak picture of the internet and the suicide resources it offers. Although this picture may be true for a small subset of suicidal keywords and

search phrases, it is not an accurate portrayal of the internet's greater collection of suicidal resources, organisations, and support websites.

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1 Biddle L, Donovan J, Hawton K, Kapur N, Gunnell D. Suicide and the internet. *BMJ* 2008;336:800-2. (12 April.)

FETAL *RHD* TYPING

Is fetal *RHD* typing in all RhD negative women cost effective?

Finning et al show that non-invasive detection of fetal *RHD* status can be performed in a high throughput laboratory with high sensitivity.[1] The associated editorial suggests that universal fetal genotyping of all RhD negative women is a logical extension that would allow the targeting of antenatal anti-D prophylaxis. But would mass testing be cost effective and, if so, under what conditions? The original National Institute for Health and Clinical Excellence guidance on routine antenatal anti-D prophylaxis in the UK was based on a detailed economic analysis.[2 3] This guidance is currently being reviewed, but the introduction of non-invasive prenatal diagnosis is not being dealt with.

We represent the socioeconomic group of the SAFE Network of Excellence funded by the European Commission to inform the implementation of non-invasive prenatal diagnosis tests.[4] We have been investigating fetal *RHD* genotyping using international data on the diagnostic accuracy of non-invasive prenatal tests.[5] Unlike previous developments in the care of RhD negative women, the clinical and economic advantages are unclear.

Several important questions need to be answered before implementing non-invasive prenatal diagnosis:

(1) Is mass testing based on it clinically advantageous, given the current system is so effective at preventing alloimmunisation and adverse fetal outcomes?
(2) Can cost and supply of anti-D alone provide a rationale for its introduction, and how should missed cases be taken into account?
(3) Can its implementation be viewed as a simple extension of current routine antenatal anti-D prophylaxis programmes with measurable efficiency gain?
(4) Can universal adoption be recommended for all population based EU prenatal health systems?

We are looking at these questions for three European countries, with the aim of providing information to support appropriate implementation of non-invasive detection of fetal *RHD* status. Our future work will also help inform difficult decisions on non-invasive prenatal diagnosis in other areas such as Down's syndrome testing.

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RADICAL MUSLIM DOCTORS

Sweeping misrepresentation will fuel fear and prejudice

Al-Alawi and Schwartz suggest that many of the world's Muslim doctors are followers of a fundamentalist and radicalised Islam.[1] I find this an offensive and sweeping misrepresentation that will fuel fear and prejudice.

The authors' views are clouded by the idea of an "intra-Islamic 'jihad' to impose an ultra-militant outlook on more than a billion Sunni Muslims across the globe." They state that radicalisation of elite professionals is more the product of conflict within Islam itself than of social conditions in Britain. This completely disregards other factors, such as the important role of foreign policy on radicalisation.

As an example of "the role of Muslim doctors in taking extremist ideology to the masses," the authors cite the Islamic Code of Medical Ethics, which states that "The physician should be in possession of a threshold knowledge of jurisprudence, worship and essentials of Islamic religious law, enabling him to give counsel to patients seeking guidance about health and body condition with a bearing on the rites of worship." To me this is an example of the interface between faith and health and trying to deliver holistic and religiously/culturally sensitive health care. Doctors, Muslim and non-Muslim, can improve the experience of health care for Muslim patients if they have the knowledge to advise on matters relating to health and worship—for example, managing the Ramadan fast.

I believe the doctors who allegedly were involved in last year's bombing attempts in London and Glasgow represent a disturbing freak phenomenon and are worlds apart from the thousands of hard working and humane Muslim doctors who contribute so much to the NHS on a daily basis.

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1 Al-Alawi I, Schwartz S. Radical Muslim doctors and what they mean for the NHS. *BMJ* 2008;336:834. (12 April.)

Pure speculation is dangerous

The title of Al-Alawi and Schwartz's article suggests there is a "problem" with Muslim doctors working in the NHS.[1] It implies that many Muslim doctors are part of a "fifth column" within the NHS and are actually subversive radical imams with medical degrees, who are more powerful than the "actual" imams in their communities. I read the report referred to by the authors (Scientific Training and Radical Islam) for evidence of this problem in the NHS. None was available, not even an estimate of how many radical doctors are to be found in the NHS.

Pure speculation of this kind is dangerous. Even though the authors dismiss the notion of vetting Muslim doctors, this is precisely what patients, colleagues, and managers will informally and perhaps unconsciously do. Any social or ethical comment from such doctors will be viewed through a prism of them being potential terrorists. Yes, a small proportion of Muslims in the UK may subscribe to extremist ideology, and yes, some may be doctors, but to classify this as a medical problem that needs to be dealt with is inappropriate.

The authors may wish to reflect on the actions of the Muslim doctors who attacked Glasgow Airport. What medical training do you need to drive a jeep into an airport? The answer is none; these people were criminals who happened to be doctors.

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Competing interests: SA is a Muslim doctor working in the NHS.

1 Al-Alawi I, Schwartz S. Radical Muslim doctors and what they mean for the NHS. *BMJ* 2008;336:834. (12 April.)