has a protective function. It protects the vulnerable from misinformation due to mistakes by or the ignorance of the informer, from pressure by those with malintent, from economically driven judgments on their future, and from much more. It also protects us, as doctors, from ourselves: our ignorance or arrogance, any temptation to cover up medical mistakes, our difficulty in asking for help from a colleague, overinvolvement with a patient that colours our judgment, our fatigue, or personal prejudice or bias about clinical or social conditions. It protects us from undue pressure by relatives weary of caring or who stand to gain financially. Managers cannot put pressure on us to clear those who are dying from our beds rapidly, and purchasers cannot question why we strive to provide quality care to patients with a poor prognosis.

As a pathologist Kevorkian may be desensitised to corpses. We provide long term care and bereavement support and are increasingly aware of the absolute import of death. Currently, prognosis cannot be predicted accurately, there are errors of diagnosis, depression is difficult to diagnose in medically ill people, patients' priorities alter often during the course of a life threatening illness, hope can re-emerge from hopelessness, we find some patients' problems overwhelming at times, and sometimes our judgment is clouded by ignorance or fatigue. Why no cries to enshrine in law the right of all patients to a second opinion if their suffering remains intractable for a week? Why call for legalising carelessness?

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1 Roberts J, Kjellstrand C. Jack Kevorkian: a medical hero. *BMJ* 1996;**312**:1434. (8 June.)

His actions are the antithesis of heroism

EDITOR,—John Roberts and Carl Kjellstrand are entitled to their view that Jack Kevorkian is a medical hero.[1] They should, however, be aware that those who are fortunate enough to have avoided coming into contact with him do not share their view.

Kevorkian is famous for taking at their word those who are sick or disabled who say that they want to die, and of "helping" by killing them. His defence has always been that his aim is to kill their pain and suffering and that the death of the organism is an unfortunate side effect of this laudable intention. Where this value system falls down is in its assumption that death is the best—indeed the only—remedy for intractable suffering and that sick and disabled people are right to want to die while able bodied people are inherently wrong to want to die, even though people in both groups may request death equally fervently and for much the same reason.

Roberts and Kjellstrand are right to say that the medical profession must say "enough" to pain and suffering. The point they miss is that there are ways of saying this that do not entail killing the patient.

I might well once have sought out Kevorkian's "services." I am severely disabled, and some years ago it was thought that my life expectancy was severely reduced. Additionally, I was (and still am) suffering great pain, and several unconnected factors combined to make me decide that I wanted to die—a wish that lasted many years. I would have satisfied all the "strict criteria" proposed by the voluntary euthanasia lobby, let alone the much more lax standards set by Kevorkian himself. Had he been practising in my vicinity, I would quite possibly have availed myself of Kevorkian's services and thus have been denied the chance to see again the beauty of life, albeit a life still restricted both by my disability and by severe pain.

I suggest that the real heroes of sick and disabled people are those who give of themselves; who stay with us, hold our hands, and, when the best efforts of modern medicine fail, say that they will not desert us. People who are sick and feel hopeless need the very best that medicine, in its widest sense, can offer. What they do not need is to be told, "Yes, you are right; death is the only answer to your problems." That, I suggest, is the ultimate desertion and the antithesis of heroism.

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Editorial's objectivity is in doubt

EDITOR,—It is interesting that nowhere do John Roberts and Carl Kjellstrand explicitly support what Jack Kevorkian is doing; indeed, they record "actions that most of us find dubious" and say that "to be a hero does not mean being right."[1] They do, however, give explicit support for why he acts thus, and many readers will interpret this as implicit approval of his actions. This subjective relativism is a betrayal of the academic objectivity we expect and deserve from the *BMJ*. There has been recent, rational discussion of all the issues in Britain, and the profession and parliament have overwhelmingly rejected euthanasia.[2,3]

Another commentary adds to the catalogue of Kevorkian's dubious actions[4]: "For his next trick, Dr Kevorkian will assist at a suicide and then, with the prior consent of the deceased and the appropriate medical tests, his or her organs will be removed soon after death for use in transplant surgery" and "He courted controversy early in his career with his suggestion that death-row prisoners could be used for medical experimentation just prior to death and that organs be harvested from executed criminals." The omission of these relevant facts from their editorial casts further doubt on the authors' objectivity.

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1 Roberts J, Kjellstrand C. Jack Kevorkian: a medical hero. *BMJ* 1996;**312**:1434. (8 June.)
2 Beecham L. Legalised euthanasia is categorically rejected. *BMJ* 1993;**307**:132.
3 Select Committee on Medical Ethics. *Report*. London: HMSO, 1994. (Para 237.)
4 Hunt L. Can Dr Death be a true hero? *Independent* 1996 Jun 8:19.

Doctors should indeed cry, "Enough"

EDITOR,—Thomas Carlyle wrote, "The Hero can be Poet, Prophet, King, Priest or what you will."[1] John Roberts and Carl Kjellstrand choose Jack Kevorkian as their hero.[2] How do they square this choice—which is akin to choosing Barabbas—with the Hippocratic Oath or the Geneva Declaration, in which doctors promise to maintain the utmost respect for human life? Dr Everett Koop, a former surgeon general in the United States, predicted that such choices would be made before the century was out when he wrote in 1980 that practices once labelled unthinkable would be considered acceptable. He went on to plead: "Let it never be said by historians in the latter days of this century that there was no outcry from the medical profession. Let it never be said that a euthanasia programme for various categories of citizens could never have come about if physicians had stood for the moral integrity that recognises the worth of every human life."[3]

Is it not time for us as a profession to decry this form of hero worship and indeed cry "enough" of this perverse destruction of the principles of our professional founders?

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1 Goldberg MK, Brattin GJ, Engel M. *On heroes, hero worship, and the heroic in history*. Oxford: Oxford University Press, 1993.
2 Roberts J, Kjellstrand C. Jack Kevorkian: a medical hero. *BMJ* 1996;**312**:1434. (8 June.)
3 Schaeffer FA, Everett Koop C. *Whatever happened to the human race?* London: Marshall Morgan and Scott, 1980.

⁂We received 17 other letters about the editorial, all of which expressed views similar to those published here.—EDITOR

Haem iron intake in young children

Other health promotion activities would have higher priority in Africa

EDITOR,—As a result of their study of haem iron intake and serum ferritin concentration in children aged 12-36 months in Australia, Michael Mira and colleagues urge that lean meat be introduced at 6-9 months and state the amount of meat that will give a daily intake of haem iron of 0.71 mg/day.[1]

We have three questions. Firstly, what is the experience of vegetarians, who have better health than omnivorous eaters? Are their young children likely to be detectably disadvantaged? Vegetarian women, described as being in good health, have low ferritin concentrations (mean 13.6 μg/l).[2] Could a low ferritin concentration have a different connotation with regard to health in different contexts?

Secondly, what are the implications for infants in the Third World, especially those in impoverished Africa? The regimen suggested by the authors is almost impossible there, especially in high parity families, because in most populations meat is eaten at most once or twice a week. The alternative of general prophylaxis with iron is far beyond the means of the masses. Since in such populations there are so many other adverse factors, dietary and non-dietary, would the particular drawback of low ferritin concentrations be likely to be clinically discernible? In an African village would the group in the lowest quartile of ferritin concentration be at a demonstrable disadvantage if compared with the group in the highest quartile, apart from in areas where malaria and hookworm are endemic?

Thirdly, what is the magnitude in young children of disabilities linked with low ferritin concentrations? Much in this field remains unclear.[3] Mira and colleagues refer to studies of very young children. In that undertaken in Chile the scores on the mental development index in the contrasting groups differed by 6%.[4] In the oft quoted Costa Rican study the Woodcock-Johnson scores in the anaemic and non-anaemic groups differed by 1%.[5] While other reported