These are not sufficient arguments for an editorial in the *BMJ* to recommend one class of β blockade and should be accompanied by the proviso that measurements of blood pressure are only a surrogate: it is the prevention of cerebrovascular accidents and myocardial infarctions that matters.

As a doctor treating patients with hypertension or ischaemic heart disease most days of the week, I tend to use low doses of the most β_1 selective lipophilic agent, bisoprolol, for hypertension and the highest affinity non-selective agent, timolol, for ischaemic heart disease. These drugs have been selected on the basis of theoretical arguments and surrogate measures on which Cleophas and Kalmansohn and I agree. As a clinical pharmacologist unhappy at such evidence, I set up the East Anglian comparison of the two classes of drug in ischaemic heart disease that I mentioned in my editorial and included them in a long term randomised comparison of antihypertensive drugs that started in 1986.

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Withdrawing artificial feeding from children with brain damage

EDITOR,—Ronald E Cranford's editorial on withdrawing artificial feeding from children with brain damage aims to encourage debate about basic medical and ethical principles.[1] Yet I believe that the central medical and ethical issues are not fairly addressed.

Firstly, Cranford states that so called artificial feeding is medical treatment but implies that normal eating and drinking are not. Surely this is specious. Tube feeding, whether by nasogastric tube or gastrostomy, is largely done to protect the patient's airway from soiling and for nursing expediency. Moreover, "it serves the same purpose that eating and drinking do, [to provide] the food any human being needs."[2] Tube feeding is better considered to be part of tender, loving care rather than to have any therapeutic benefit itself. I am sure that doctors would never want tender, loving care to be removed from a patient. This point is supported by my experience that nursing staff are generally extremely reluctant to countenance withdrawal of feeding because they have an instinctive belief that it is part of nursing care and explicitly not a medical treatment.

Secondly, Cranford concludes that allowing a child to die is not the same as euthanasia (or, presumably, infanticide). But in what way is it different? Both produce certain death. This sets the withdrawal of feeding apart from the withdrawal of other medical treatments, which merely increases the likelihood of death but does not guarantee it. The difference here is between, say, 99% and 100%—infinity. A spade should be called a spade. The proponents of withdrawal of feeding are, in truth, asking for permission to practise infanticide through privation. The next logical step is to give drugs to hasten the process.[3] The Rubicon has been crossed.

Children with severe brain damage present immense challenges to everyone. If our only solution to the problem is deliberate killing what does that say about us? Can we see no intrinsic value in a person created in the image of God, or do we value only possession of abilities? Dyck at Harvard School of Public Health asks "whether we are the kind of persons who will care for [such children] without doubting their worth."[3] He believes in the equality of life rather than the quality of life ethic. Koop, a former surgeon general of the Public Health Service in the United States, agrees with him.[3] So do I. So did Hippocrates.[3]

Ethical principles exist to guide us with difficult issues despite the ever changing technology of medicine. We must recognise the difference between good medical practice and killing people.

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Informed consent for trial of elective ventilation will not be forthcoming

EDITOR,—J Fabre seeks the continuation and legalisation of the unlawful procedure of elective ventilation on the grounds that it is not harmful to patients.[1] Later Fabre contradicts this by admitting that elective ventilation might result in a persistent vegetative state and adds that the British Transplantation Society advocates "a carefully audited clinical trial." Surely such a trial, even if it was considered to be ethical, would require the explicitly informed prior consent of the patients concerned; it is difficult to see how this could be obtained.

A persistent vegetative state is not the only possible harm to a patient, as elective ventilation must prolong the process of dying. Once death is inevitable many people would prefer it to occur as quickly and naturally as possible and would wish to be able to trust their medical attendants to allow this. A badly damaged but artificially oxygenated brain (not necessarily brain stem dead) might also produce unpleasant and distressing subjective sensations, which the patient would not be able to communicate to the attendants.

Though I appreciate the great boon that successful transplantation confers on recipients and the natural desire of the British Transplantation Society to maximise this, we should never forget the legitimate interests of our many other patients.

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Misuse of dothiepin

EDITOR,—Recently we have become aware of a considerable population of intravenous drug misusers in the Greater Dublin area who are misusing the tricyclic antidepressant dothiepin (Prothiaden). The Drug Treatment Centre, Dublin, runs an evening programme of low dose methadone maintenance and harm reduction with needle exchange and health promotion advice but without urine testing. A self report questionnaire administered at this programme showed that 46% of clients (38/83) had misused this drug orally in the previous six months. Of all urine samples tested on 14 March of clients attending the centre by day who were not taking prescribed tricyclic or neuroleptic agents, 19% (19/99) were positive for tricyclics. The Emit tox test (Syva, San Jose, CA) was originally designed for serum samples, and the presence of phenothiazines is a known cause of false positive results. We conclude that this percentage is an indication of misuse of tricyclic drugs in those tested.

Patients who misuse dothiepin report euphoria and sedation with complex visual and auditory hallucinations. The experiences are pleasant and seem to occur in clouded consciousness. The drug was taken orally in all cases, and the total amount taken varied from 150 mg to 600 mg each day.

We know of no previous report of dothiepin misuse, although there have been reports of abuse of another tricyclic, amitriptyline.[1,2] Dothiepin is the leading antidepressant in Ireland, with over 140 000 prescriptions each year, representing 24% of total prescriptions for antidepressants. A recent review concluded that the major tranquillisers and tricyclic antidepressants had no dependence liability and no abuse potential of any clinical importance.[3] Given our experience we must disagree. Concerns about the abuse potential of any centrally active or mood altering drug are not new,[4] and clinicians should be aware of the potential of dothiepin and other similar compounds for misuse.

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Palliative care in general practice

Should GPs do it at the expense of commoner problems?

EDITOR,—As a former general practitioner who is currently undergoing higher specialist training in palliative medicine, I am concerned at Zoe Kenyon's vision of a future in which a diploma in palliative medicine is a criterion for entry to general practice.[1] My concern arises not least because to get the diploma one must attend a part time course lasting at least a year, which would distract focus away from vocational training.

The editorial raises a larger question: is palliative care delivered by general practitioners for all patients a realistic option? The general practice palliative care facilitator project described in Kenyon's editorial was designed to enhance the quality of palliative care delivered by primary care teams. As the evaluation makes clear, the educational activities directed towards generic skills such as teamwork and communication were well received.[2] There was a poor response, however, to initiatives focused on more specific aspects of palliative medicine, such as control of symptoms, as these subjects are not considered "mainstream" by general practitioners. As the report states, "There is little evidence to suggest that the visits [of facilitators to practices] were able to . . . influence the 'peripheral' nature of palliative care as part of the workload of the primary care team."

While many aspects of good palliative care—multidisciplinary, holistic care, centred on the patient and family, that values good communication—are directly comparable with good general practice, the average general practitioner will see only about five patients dying of cancer each year and probably fewer with other end stage diagnoses but similar needs. Other problems seen more frequently, such as asthma, are bound to take priority. Criteria for entry to general practice would be better focused on the attainment of skills in good general practice, including communication skills, team working, holistic care, and a basic knowledge of first line control of symptoms.