

Readers' ideas on obituaries

Letters received	104
Keep obituaries in some form	79
Abandon obituaries altogether	2
Publish only death notices	22
Increase number of pages devoted to obituaries	18
Shorten obituaries further	10
Cut down on other pages in the journal	9
Publish death notices of everybody and the best written and most interesting obituaries	7
Publish death notices of everybody and obituaries of "the famous"	4
Abandon photographs	4
Keep comprehensive archive of all BMA members dying	2
Publish obituaries in electronic form	2
Allow obituaries only of BMA members	2

Other suggestions made (by one respondent each) were to use the margins of the obituary pages to include more text, refuse to publish more than one comment on each person no matter how famous, transfer the obituaries to specialist journals, seek drug company sponsorship for publishing obituaries, exclude "the famous" because they are mentioned in the national press; take a random sample of submitted obituaries, publish only self written obituaries, and publish the obituaries in a supplement.

publish death notices of everybody and then a selection of obituaries that we judged to be the best written and the most interesting. Four readers suggested that obituaries should be reserved for "the famous," but one reader (himself famous) thought that we should do the opposite and avoid the famous because they had already had obituaries in the national press.

The chairman of the Montgomeryshire Medical Society thinks that we should publish only self written obituaries, unless the person is famous, and to that end he plans to hold a competition for the best self written obituary. The *BMJ* will be supplying a prize.

The suggestion of publishing all obituaries in electronic form (perhaps on the internet) has attractions because space ceases to be a problem, but the suggestion ignores the obvious problem that the most avid readers of obituaries are also the people least likely to use computers and modems.

Nothing will change for now, but we are conducting a further survey of a random sample of readers, and may make changes later in the year or next year. As one professor of psychiatry wrote at the end of his letter: "Best of wishes in arriving at a decision. You have the comfort of knowing that whatever you decide an articulate minority will condemn you."—EDITOR

Voluntary agreement of tobacco advertising

EDITOR,—I freely admit that Imperial Tobacco was in breach of the voluntary agreement on tobacco advertising in so far as 10 small items of promotional material in Solihull did not carry a health warning, as Wendy Robertson and colleagues report.¹ This was regrettable, and when it was drawn to our attention all the items were either removed or replaced. They predated the agreement in January 1983, whereby items of over 260 cm² at points of sale had to have health warnings, and should have been replaced years ago by our representatives working in the Solihull area. I make no excuse about this.

I object, however, to the implication that this practice is widespread. Imperial Tobacco takes its responsibilities seriously, and any material that we have produced for cigarettes and handrolling tobaccos that is larger than 260 cm² and is intended

for points of sale has carried a health warning since January 1983.

With regard to the effectiveness of the voluntary agreements, I can do no better than quote Sir John Blelloch, chairman of the Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship, in his 1994 report: "As I have done in each of my two previous Reports, I would like to record again my thanks to the Committee for their approach to the conduct of business and to the resolution of tasks that have confronted them and to repeat what has been said in the past about the industry's continuing commitment to the letter and the spirit of the Voluntary Agreement."²

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- 1 Robertson W, Field NJG, Bird C, Parfitt DE. Voluntary agreement on tobacco advertising. *BMJ* 1995;310:124. (14 January.)
- 2 Committee for Monitoring Agreements on Tobacco Advertising and Sponsorship. *Seventh report*. London: HMSO, 1994.

Advance directives

Register should be kept by GPs rather than hospitals

EDITOR,—George S Robertson's article on advance directives provides useful guidance for those of us dealing with patients with long term and terminal illnesses.¹ One of the strengths of the NHS is the pivotal role of general practitioners, which encourages the creation of a continuing and comprehensive medical record for each doctor's patients. A register of patients who have issued advance directives should be kept by the doctor with whom the patients are registered rather than by individual hospitals as Robertson suggests. This would reduce the risk of a directive not being adhered to through ignorance of its existence.

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- 1 Robertson GS. Making an advance directive. *BMJ* 1995;310:236-8. (28 January.)

Can be no substitute for good communication

EDITOR,—Advance directives have a substantial role in helping patients to retain the right to self determination and to plan for events at the end of their lives.¹ As with the consent form for hospital treatment, a written advance directive is not a substitute for continuing communication between the patient and health care staff involved in his or her care.

In the light of the cases of Bland,² Re C,³ and Re T,⁴ for an advance directive to be valid it must be made without duress in contemplation of the circumstances that eventually arise. Discussion with medical staff about future care will be essential to ensure validity for most people. Age Concern refers inquiries for advance directives to the Voluntary Euthanasia Society and the Terrence Higgins Trust, both of whose forms have been updated to take the recent case law into account (the Terrence Higgins Trust has done this in conjunction with the Centre for Medical Law and Ethics). The model in George S Robertson's article fails to do so and has other shortcomings.⁵

Deliberate non-compliance with an advance directive by medical staff may be a problem.⁶ The incompetent patient, relatives, and any proxy have no legal power to enforce instructions made when the patient was competent. The Law Commission is working on legislative reform, including the

appointment of health care attorneys and a judicial forum to make decisions for incompetent people. Its proposals should create a statutory basis for advance directives and the appointment of proxy decision makers.

The Patient Self-Determination Act 1990 requires that all patients entering federally funded health care facilities in the United States must be informed of their right to make an advance directive. Analogous initiatives in the NHS may be needed before advance directives become widely used in Britain.

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- 1 Robertson GS. Making an advance directive. *BMJ* 1995;310:236-8. (28 January.)
- 2 Airedale NHS Trust v Bland [1993] AC 789.
- 3 Re C (adult: refusal of medical treatment) [1994] 1 All ER 819.
- 4 Re T (adult: refusal of medical treatment) [1992] 4 All ER 649.
- 5 Lerner MJ. State natural death acts: illusory protection of individual's life-sustaining treatment decisions. *Harvard Journal on Legislation* 1992;29:175-221.
- 6 House of Lords Select Committee on Medical Ethics. *Report. Vol III. Written evidence*. London: HMSO, 1994:76, 85. (HL paper 21-III.)

BMA should evaluate Dutch experience with euthanasia

EDITOR,—When I retired to England early last year one of my main reasons for doing so was that I preferred, as I grew older, to receive medical care in Britain rather than in the United States, where I had lived for 31 years. Therefore, the three articles in the Christmas issue on the suffering experienced by several patients during the final weeks of their lives made depressing reading.¹⁻³

One article referred to a living will, or advance directive.¹ I strongly believe in the potential value of an advance directive, and, fortunately, my general practitioner agrees with me. Many more people should be made aware of these voluntary arrangements and thus given the opportunity to express their wishes. Perhaps, one day, supplies of advance directives will be available in every general practitioner's waiting room.

Since my return to England I have spoken to many people, including several doctors, who are interested in the present situation in the Netherlands, where specific guidelines exist on when doctors may help their patients to die if they are asked to do so, although euthanasia is still officially illegal there. I am well aware of the views of those who are opposed to the Dutch system.⁴

For obvious reasons, euthanasia will always be an issue on which some doctors have forceful opinions. I believe, however, that the Dutch and the British are similar in many ways, such as in having a strong sense of liberty and personal responsibility and being sensitive to human rights issues. Therefore, I suggest that the BMA should take the initiative in establishing a widely representative review body, providing medical, legal, and ethical opinions, to make a new, detailed, and, hopefully, impartial evaluation of the Dutch practices with regard to euthanasia. Then, perhaps, this committee could recommend whether similar guidelines should be introduced in Britain as this might be a way of ensuring that none of us—medical or lay—need fear the possibility of not being able to die with dignity.

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- 1 Dying for palliative care. *BMJ* 1994;309:1696-9. (24-31 December.)
- 2 Going private: time for change. *BMJ* 1994;309:1699-700. (24-31 December.)
- 3 Pink G. The price of truth. *BMJ* 1994;309:1700-5. (24-31 December.)
- 4 Euthanasia [letters]. *BMJ* 1994;309:471-3. (13 August.)

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