

Author's reply

EDITOR—Leung's comment is useful, and anyone treating this age group will find Jones's book helpful.¹ To summarise Jones, a child under 16 can consent to treatment (be "Gillick competent," a fact reiterated in *Re R*²). However, "no minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and *a fortiori* a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor" (Lord Donaldson in *Re W*³).

The approach that a clinician should adopt when assessing whether a child is Gillick competent was identified in the following passage from Lord Donaldson's judgment in *Re R*: "What is really being looked at is an assessment of mental and emotional age, as contrasted with chronological age.... What is involved is not merely an ability to understand the nature of the proposed treatment... but a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects, and equally important, the anticipated consequences of failure to treat." Such competence "is a developmental concept and will not be lost or acquired on a day-to-day or week-to-week basis. In the case of mental disability, that disability must also be taken into account, particularly when it is fluctuating in its effect."

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- 1 Jones RM. *Mental Health Act manual*, 5th ed. London: Sweet and Maxwell, 1996:340-2.
- 2 *Re R* (a minor) (wardship: medical treatment) (1992) 3 WLR 592.
- 3 *Re W* (a minor) (medical treatment: court jurisdiction) (1992) 4 All ER 627.

All women with abnormal genital tract bleeding should have gynaecological examination

EDITOR—Everett is concerned that "many thousands of women who miscarry may be excluded from important health planning processes," and he attempts to quantify and monitor miscarriage rates.¹ He may be setting a wrong precedent by relying on ultrasonography and ignoring the value of a gynaecological examination.

All women with abnormal genital tract bleeding should have a gynaecological examination; this includes women who are pregnant. The possibility of a local cause for such bleeding should be excluded by a speculum examination aided by a good light source. Furthermore, digital examination distinguishes the different forms of miscarriages (spontaneous abortions) into threatened abortion, incomplete abortion, and

inevitable abortion based on the dilatation (or not) of the cervix.²

Recently, three pregnant women in my unit underwent radical hysterectomy because of cervical cancer discovered in pregnancy. In two cases the presenting symptom was abnormal bleeding in pregnancy; one patient was under 20 weeks' gestation. Ultrasonography was of little help in the patients' management and possibly hindered early treatment because it generated a false sense of security by showing "placenta in the fundus" and "viable fetus seen."

Furthermore, a history of a recent smear test might misguide clinical judgment, as cervical carcinoma has been diagnosed in women who are compliant attenders of cervical screening programmes (interval cancer)³; the result of a smear test may be negative despite the presence of invasive cervical cancer.⁴ However, those women at greatest risk of cervical cancer are the ones most likely to fail to accept an invitation for screening.⁵

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- 1 Everett C. Incidence and outcome of bleeding before the 20th week of pregnancy: prospective study from general practice. *BMJ* 1997;315:32-4. (5 July.)
- 2 Chamberlain G. Vaginal bleeding in early pregnancy—*I*. *BMJ* 1991;302:1141-3.
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- 4 Berkeley AS, Livolsi VA, Schwartz PK. Advanced squamous cell carcinoma of the cervix with normal Papanicolaou tests. *Lancet* 1980;ii:375-6.
- 5 Williams C. Ovarian and cervical cancer. *BMJ* 1992; 304:1501-4.

Physician assisted suicide, euthanasia, and withdrawal of treatment

Full debate is needed in Britain...

EDITOR—In view of the recent conclusion by the BMA that the practice of euthanasia should not be sanctioned¹ and the admission by some doctors of their own practice,² it is important that the central issues of the debate over euthanasia and assisted suicide are fully clarified.

The legal framework, although extremely important in regulating practice, is unlikely to be able to resolve the individual moral dilemma presented to a practitioner who is contemplating euthanasia or assisted suicide for a patient.³ It is important to differentiate legal from moral frameworks in this respect. Legal frameworks are designed to enforce a baseline of reasonable behaviour in society. If individuals behave in an illegal way then they can expect to receive punishment for their actions. Moral frameworks, in contrast, are meant to achieve more than this. They are concerned not only with minimal standards of behaviour but also with ideals. In short, moral frameworks can inform how we ought to behave as well as how we must behave if we are not to be punished. Clearly, in some cases of euthana-

sia and assisted suicide, practitioners believe that they ought to help suffering patients but are not legally permitted to do so.

The two main moral arguments used to condemn euthanasia and assisted suicide are the "doctrine of double effect" and the "slippery slope" argument.⁴ The doctrine of double effect essentially differentiates between the morality of the action of a doctor who intends rather than foresees a patient's death. For example, pain relief for a terminally ill patient is seen as morally acceptable, whereas an injection of potassium cyanide is not.⁵ In normal medical practice, however, the distinction between intending and foreseeing death is far from clear. There are occasions when doctors give patients pain relief knowing that their actions will dramatically shorten the patients' lives. In short, how much morphine must a doctor give a patient before the action becomes morally indefensible?

The other argument against euthanasia and assisted suicide is that if it were to be legalised, patients would be open to abuse and doctor-patient trust would substantially decrease. In view of the recent admissions by doctors that they have practised euthanasia, we must now question whether a regulated framework would protect patients more than the current official and legal ban, which is not adhered to. A full debate on the moral issues of euthanasia and assisted suicide is now needed between the public and professionals.

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- 1 Beecham L. BMA opposes legalisation of euthanasia. *BMJ* 1997;315:80. (12 July.)
- 2 Dyer C. Two doctors confess to helping patients to die. *BMJ* 1997;315:206. (26 July.)
- 3 Churchill LR, King NMP. Physician assisted suicide, euthanasia, or withdrawal of treatment. *BMJ* 1997;315:137-8. (19 July.)
- 4 Jeffrey D. Active euthanasia: time for a decision. *Br J Gen Pract* 1994;44:136-8.
- 5 Campbell R, Collinson D. *Ending lives*. Oxford: Blackwell, 1988:153-4.

... and Argentina

EDITOR—Further to the editorial by Churchill and King on physician assisted suicide, euthanasia, and the withdrawal of treatment, we wish to report data on physician assisted death in Argentina.¹ We assessed doctors' attitudes about decisions not to treat, physician assisted suicide, and the ending of life without an explicit request from the patient. We interviewed young Argentinean doctors who attended the sixth national congress of medicine organised by the Argentinean Society of Medicine in November 1996 in Argentina. To be eligible, doctors had to be ≤ 34 years old and to have practised medicine for ≤ 10 years.

Of the 407 doctors who participated in the survey, 287 supported the withdrawal of life sustaining interventions; of these, 145 had already withdrawn such interventions. A quarter (97) of the doctors supported physician assisted suicide. Almost two thirds of the respondents (257) supported active euthanasia in terminally ill patients unable

to request or consent to it, and 162 already practised it.

Our survey showed that over half (218) of the doctors interviewed had withdrawn life sustaining treatments or practised active euthanasia, or both. This proportion is similar to the 53% of Dutch doctors who admitted in a recent study that they had taken active steps to end a patient's life.²

Although doctors in Argentina are known to practise different types of physician assisted death, this subject has rarely been explored and official data are lacking. We consider that there is an urgent need to open the debate in our community.

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- 1 Churchill LR, King NMP. Physician assisted suicide, euthanasia, or withdrawal of treatment. *BMJ* 1997;315:137-8. (19 July)
- 2 Van der Maas PJ, van der Wal G, Haverkate I, Carmen M, Kester JGC, Bregje D, et al. Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995. *N Engl J Med* 1996; 335:1699-705.

Euphemisms must be avoided

EDITOR—To advance the discussion relating to euthanasia we need to stop using euphemisms such as "physician assisted suicide" and "withdrawal of treatment" as this simply clouds the fundamental moral arguments.¹ The key issue, as Chief Justice Rehnquist pointed out in the United States, is intent and outcome.² This is best demonstrated by exploring the case of a patient dying of lung cancer and acquiring pneumococcal pneumonia. There are three fundamental medical ways of "allowing" the patient to die: withholding penicillin; gradually increasing the dose of morphine for pain relief, which results in respiratory suppression; and giving a lethal injection of intravenous potassium. The first two options are commonly practised and are completely legal while the third is deemed to be murder. Philosophically speaking, the intent and the outcome in all three cases is the same—the hastening of the patient's death. The logical extension of this is that the three options are morally identical; only the method is different.³

When the intent is clearly agreed between the patient and the doctor, the methods become secondary in the debate.⁴ Using euphemisms simply appeases the anti-euthanasia lobby and clouds the honest dialogue between the patient and the doctor. Such clouding of the dialogue happened in the past when euphemisms, such as "growths" or "lumps," were used to describe malignant cancers. The euphemisms simply resulted in misinformation and left patients unable to determine their own outcome. There is a risk of a similar situation developing if the medical and legal professions continue to use euphemisms relating to the method of death rather than explicitly discussing intent and outcome. From the patients' point of view the crucial time is

when they decide that they do not want to live any more and suffer the consequences of terminal illness. That is when the decision about the intent to die is made. The method, be it by morphine or intravenous potassium, is irrelevant. To get to the heart of the matter the doctor and the patient need an honest discussion about the validity of the intent rather than distortion of the issue by using euphemisms relating to the method.

Society needs to discuss this crucial point honestly and make a judgment about the validity of intent and apply safeguards in securing an acceptable notion of intent to prevent the "slippery slope."

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- 1 Churchill LR, King NMP. Physician assisted suicide, euthanasia, or withdrawal of treatment. *BMJ* 1997;315:137-8. (19 July)
- 2 Washington v Glucksberg, No 96-110 (US June 26, 1997).
- 3 Watt H. Killing and letting die. *Update* 1997;52:833.
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Epidemiological data can be gathered with world wide web

EDITOR—In their note, "Piloting patient attitudinal surveys on the web" Suchard et al rightly point out that the web is a powerful resource to use in developing surveys quickly and effectively.¹ But the power of the web goes far beyond that. Psychologists and sociologists are already using the web for surveys,² and there has also been a recent experiment to collect health status information for medical outcomes research with a web based questionnaire.³

The web may further become a new means of gathering data from patients for studies of quality of life and epidemiological research, as it allows questionnaires to reach a worldwide population of patients and healthy controls with a minimum of cost and time. Researchers may rapidly explore various hypotheses—for example, about relations between a disease and its symptoms, predisposing factors, patients' demographic data, and associations with other diseases.

In an experiment with a web based questionnaire about atopic eczema we are making use of the fact that dermatological patients, especially those with chronic diseases, are usually well informed about their disease and may therefore answer questions about their symptoms precisely. We developed a web based patient information system about atopic eczema to attract patients to our website and provide an electronic questionnaire to explore the relation between atopic stigmata and symptoms, demographic data, and environmental factors.⁴ As an incentive for filling in the questionnaire, an atopy score is calculated⁵ and presented to the user. Answers of all users are stored anonymously in our database for further analysis. At present, each month about 240 patients and healthy

web surfers as controls complete the questionnaire.

With Internet questionnaires one may obtain data from an entirely different population of patients to those seen in a clinical setting. For example, minimal variants of atopic eczema are not severe enough for patients to see their doctor, so patients taking part in a questionnaire study on the world wide web are different from the population seen at university hospitals. It will therefore be interesting to compare data obtained via the world wide web with published data obtained by traditional questionnaires.

Obviously, the web community is not a representative sample of the whole population, and results obtained with questionnaires on the web are biased towards self selection; thus they must be interpreted with care and verified in an unbiased population.

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- 1 Suchard MA, Adamson S, Kennedy S. Netpoints: piloting patient attitudinal surveys on the web. *BMJ* 1997;315:529. (30 August)
- 2 Batinic B. How to make an internet based survey. www.psychol.uni-giessen.de/~Batinic/survey/faq_sofit.htm [accessed 26.9.97].
- 3 Bell DS, Kahn-CE Jr. Health status assessment via the world wide web. Proceedings of the American Medical Informatics Association annual fall symposium, Washington, DC, 1996:33-42.
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- 5 Diepgen TL, Sauerbrei W, Fartasch M. Development and validation of diagnostic scores for atopic dermatitis incorporating criteria of data quality and practical usefulness. *J Clin Epidemiol* 1996;49:1031-8.

Paper in *BMJ* influenced prescribing of minocycline

EDITOR—In January 1996, Gough et al reported the potential adverse effects of minocycline¹; an editorial in the same issue amplified the position.² Their paper highlighted the fact that minocycline is the most widely prescribed systemic antibiotic for acne, and one for which no resistance has yet been described. They noted, however, reports of 11 cases of systemic lupus erythematosus induced by minocycline and 16 cases of autoimmune hepatitis due to the drug. Seven further cases had also been reported. The editorial suggested that use of tetracycline or oxytetracycline was a safer and cheaper first line treatment, with minocycline being reserved for patients not responding to other tetracyclines.

We have examined national PACT (prescribing analysis and cost) data to see what, if any, effects resulted from this reporting. Up to March 1995, use of the drug (in terms of defined daily doses) had been increasing (figure). For the rest of 1995, use levelled off or showed a small decrease. In the quarter to March 1996, however, there was a marked drop to less than 70% of the previous quarter (and the spring quarter was previously