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Assisted dying survey

It is extraordinary that the Royal College of General Practitioners (RCGP) has chosen to continue to oppose a change in the law to enable assisted dying when the majority (51%) of its polling members supported either a change in the law to enable assisted dying or a wish for the RCGP to accept a neutral position. Quite apart from wilfully ignoring the result of its own survey, this decision displays the sort of establishment paternalism that should have no place in an enlightened society.

By maintaining such opposition the College has demonstrated unbelievable hubris and scant regard for patient choice, liberty, and autonomy. I urge College Council members to think again, delve deep into their consciences, and tell the overwhelming majority of the UK population why they are wrong in seeking a change in the law to enable assisted dying for those for whom one cannot provide a dignified death.

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Language matters: indeed it does

This February 2020 edition of the *BJGP* contains topics that are more closely interrelated than first appears, and the relationship is crucial for GPs to recognise.

As you say, language matters and *'The chances of a successful outcome are less good when … the consultation includes topics such as common mental health disorders and the highly contested territories of persistent but "medically" unexplained symptoms and maladaptive responses to commonplace adversities'*:[1]

- 'Predicting and preventing relapse of depression in primary care'[2] — *'There has been a shift in the understanding of depression as a discrete or episodic illness to being considered a long-term relapsing-remitting condition with possibly incomplete recovery between episodes …'*
- 'Anxiety and depression in adolescents and young adults'[3] — *'Of particular concern is the alarming apparent rise of these problems in girls and young women. A 2017 UK practice-based study of self-harm showed a 68% rise in incidence in girls aged 13–16 years between 2011–2014.'*
- 'Patients' descriptions of the relation between physical symptoms and negative emotions'[4] — *'Primary care guidelines for the management of persistent, often "medically unexplained", physical symptoms encourage GPs to discuss with patients how these symptoms relate to negative emotions.'*
- 'Medically unexplained symptoms'[5] — *'Most GPs labelled the presented symptoms as medically unexplained soon after the start of the consultation.'*

Taking into account the recent report on the 2018/2019 Public Health England review of prescribed medicines associated with dependence and withdrawal,[6] the links become clear. Many patients who may suffer 'common mental health disorders', and those who suffer economic hardship and commonplace adversities, are prescribed drugs for 'depression', 'anxiety', 'trauma', etc. — which carry underplayed risks of dependence and withdrawal. Many such patients go on to experience all manner of distressing 'unexplained' physical and psychological symptoms. Some of these 'unexplained' symptoms can be very severe indeed, including drug-induced akathisia, which can lead to self-harm and suicide. Antidepressants (and other prescribed medicines) can cause akathisia — especially at certain times of dose change or even after withdrawal — and this serious adverse drug reaction is frequently misdiagnosed as 'anxiety' and 'restlessness', with sometimes tragic consequences.[7]

Language matters very greatly.

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Urgent referral of SSNHL to ENT

The paper from ENT in Gloucester makes slightly depressing reading by advising that GPs should ignore the NICE recommendation to refer sudden hearing loss urgently to ENT because ENT departments can't offer this service.[1]

I would strongly recommend reading the full NICE Guideline[2] section 11, pages 137–174, in particular sections 11.2 and 11.3, which show the extensive evidence surveyed and debated by the committee. Evidence was scarce, especially for oral steroids, which made it difficult to draft a recommendation for routes of administration.

A key issue is that five studies showed clinical benefit from intratympanic (IT) steroids for patients refractory to oral or intravenous steroids.

When administration of both oral and IT steroids was compared with either route alone, the committee commented on the clinical benefit of dual administration for recovery, PTA scores, and speech discrimination scores. There was uncertainty about the optimal route and timing (first or second line) owing to the limited number and quality of the studies.

It noted that practice varies considerably between centres and expressed concern about any delay in offering treatment.

Oral steroids are certainly the current favoured first-line treatment, and GPs should not delay starting them. I believe it is advisable to then contact their preferred ENT department as soon as practicable to agree a plan of action for follow-up and possible IT therapy in the event of failure of oral steroids.