

LETTERS

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ASSISTED DYING

Why neutrality is not an option

Both the public and politicians reasonably expect medical professional bodies to offer an overall judgment on the desirability of legislation if it affects medical practice or if doctors have special experience of the issue in question. There is nothing different in principle between one issue of public policy and another: NHS reform, smoking, or assisted death.

When a policy is strongly divisive, responsible organisations will consult and publish their members' views, as the Royal College of Physicians did recently about English health reforms. An interested public will want to know both the extent of division and the overall judgment. The public and ultimately its representatives in parliament will reflect on individual and aggregated opinion from all sources, but especially from those with special experience. Withholding information is paternalism.

Nobody has ever made the fatuous suggestion that legislation about assisted death (or anything else) is other than for society to decide. But I would certainly hope that the British Economics Association (if such a thing existed) had a greater influence on economic policy than the local cricket club or the best teller of anecdotes.

The problem is that neutrality is not neutral.¹ By withholding any public judgment, proponents of change interpret neutrality as acceptance, which is presumably why neutrality (an achievable second best) is the preferred position of doctors who want change. This was evident (as Tallis conveniently forgets²) when the Royal College of Physicians had a brief dalliance with neutrality on assisted death many years ago, leading to efforts to correct misimpressions. The royal college's current carefully worded position, coupled with data from its consultation,³ offers responsible, principled information to guide interested parties. We at the royal college owe the public and politicians (and perhaps our members too) no less.

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Competing interests: JS is chair of the Ethical Issues Committee, Royal College of Physicians of London; he represented the royal college before the House of Lords select committee and had the lead role in the royal college's consultation on assisted death in 2006. Views expressed are his own.

- 1 Tallis R. Our professional bodies should stop opposing assisted dying. *BMJ* 2012;344:e4115. (14 June.)
- 2 Saunders J. Ethical decision making in professional bodies. *Clin Med* 2006;6:13-5.
- 3 Saunders J. What do physicians think about physician assisted suicide and euthanasia? *Clin Med* 2008;8:243-5.

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Lessons from abortion reform

Godlee draws parallels between euthanasia and abortion reform in the 1960s.¹ So let's examine what happened after abortion legalisation in 1967. Lord Steel should know as he introduced the Abortion Bill. Forty years later he stated: “Everybody can agree that there are too many abortions . . . There is a mood now which is that if things go wrong you can get an abortion, and it is irresponsible really.”²

Are we, if euthanasia were legalised, one day going to say, “Everyone can agree that there are too many cases of euthanasia . . . There is a mood now which is that if things go wrong you can get euthanasia, and it is irresponsible really?”

Godlee is not the first to compare euthanasia with abortion. In 1974 John Habgood observed: “Legislation to permit euthanasia would . . . bring about profound changes in social attitudes towards death, illness, old age and the role of the medical profession. The Abortion Act has shown what happens. Whatever the rights and wrongs concerning . . . abortion, there is no doubt about two consequences of the

1967 [Abortion] Act:

“(a) The safeguards and assurances given when the Bill was passed have to a considerable extent been ignored.

“(b) Abortion has now become a live option for anybody who is pregnant.”³

Of course fundamental parallels exist between abortion and euthanasia. Both are based on a utilitarian view of life: if a pregnant woman can get rid of her social and financial pressures through abortion, why not get rid of social and financial pressures from the sick through euthanasia? And why do we need consent when

the Netherlands and Oregon have shown that euthanasia and assisted suicide happen without consent, despite “safeguards”⁴

Euthanasia enthusiasts could heed the warnings from abortion history. But we learn from history that we don't learn from history.

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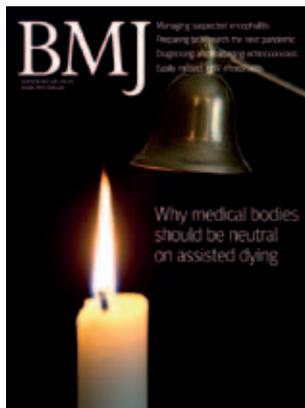
A carefully crafted law should protect vulnerable people

Of course the BMA should reinstate its neutral position on assisted dying.¹ For terminally ill people the concern is removing the fear of suffering whether or not they ultimately choose it. Evidence that deep sedation is used more often in terminally ill people in the UK than in Belgium or the Netherlands suggests an acceptance that relief of symptoms may mean shortening life.²

Conflicts remain about who should be in control, which is also an issue for society. The right of a patient to refuse treatment, even when earlier death is likely, is widely accepted. There is no evidence that society sees this or assisted dying as “cheapening” life or leading to a mistrust of doctors.

Most opposition to assisted dying now focuses on protecting “the vulnerable,” an objection repeated with monotonous regularity and always with the rider that it “can't be done.” Some of the arguments used are bizarre, some have a clear religious basis, but, for whatever reason, anxiety about this issue remains. The ethics of using vulnerable groups to raise such anxieties, with almost no attempt to assess whether they are true or have implications for other aspects of care, have to be questioned. A carefully drafted law could be the best way of providing the very reassurance that vulnerable people need and allow them freedom of choice as well.

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Competing interests: SK is a member of the BMA, Healthcare Professionals for Assisted Dying (HPAD), and Dignity in Dying.

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Safe laws on assisted dying are working worldwide

Opponents of voluntary euthanasia often muddy the waters with words and concepts that evoke really bad connotations.¹ They are wilful misrepresentations of the facts.

Numerous independent audits of existing euthanasia laws from several jurisdictions have shown them to be safe. The “slippery slope” does not exist. Vulnerable people are less likely to take advantage of assisted dying:

Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS. While extralegal cases were not the focus of this study, none [has] been uncovered in Oregon; among extralegal cases in the Netherlands, there was no evidence of higher rates in vulnerable groups.²

Courtney Campbell, Hunder professor in religion and culture at Oregon State University, and not a supporter of assisted dying, nevertheless concluded in his review of the operation of the Oregon Death with Dignity Act: “The procedures embedded in the statute for ensuring informed and voluntary decisions by terminally ill patients have been substantially effective. The pre-implementation concerns of critics about coerced or compromised choices do not seem borne out in practice.”³

In Canada the Royal Society of Canada Expert Panel reported: “There is no evidence from the Netherlands supporting the concern that society’s vulnerable would be at increased risk of abuse if a more permissive regime were implemented [in Canada] . . . What has emerged is evidence that the law is capable of managing the decriminalisation of assisted dying”⁴

Safe laws are already working well in Oregon, the Netherlands, Belgium, Washington State, Switzerland, Montana, and Luxembourg. Change is inevitable.

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Competing interests: None declared.

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My journey from anti to pro assisted dying

I support the move to make doctors’ professional organisations neutral about assisted dying.^{1 2} As a consultant in hospice and hospital palliative medicine for 27 years, I have, however, been fervently against changing the law in this respect. I remain sceptical about euthanasia (the deliberate ending of a life by an act performed by another person). But in recent years I have radically moved my position on assisted suicide—when a competent person acknowledged to be dying chooses to take a fatal dose of prescribed medication to end his or her own life.

A major factor in my shift has been professional visits to countries where assisted dying is legal. I spent a week in Oregon for the Commission on Assisted Dying meeting healthcare professionals, hospice volunteers, a high court judge, and patients.³ I am visiting professor at the University of Amsterdam, where I teach palliative medicine to hospital specialists and GPs. In both places good local palliative care coexists with assisted dying, as confirmed globally in a report by the European Association for Palliative Care.⁴ In some real cases of terminal suffering discussed with me in the Netherlands I have sometimes thought that British palliative care would have nothing more to offer—therapeutically or spiritually.

It is patronising to say that a few people should suffer unbearable distress and indignity because palliative care preaches that it values all lives—regardless of how meaningless they have become to their owners. It is inconsistent for palliative care to boast how it enables people to face the reality of dying and decide about place of care but then to deny choice for timing of death. Moreover, it is hypocritical to deny competent patients who are acknowledged to be dying the right to die in the manner of their choosing, while allowing doctors and nurses to choose when to place them on a so called care pathway, which often entails increasing sedation and withdrawing fluids—unintentionally leading to a protracted form of assisted dying, but one that is medically determined.

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- 1 Godlee F. Assisted dying. *BMJ* 2012;344:e4075. (14 June.)
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Editorial note on results of assisted dying poll

The voting in the poll “Should doctors’ organisations be neutral on assisted dying?”, which ran on bmj.com during 14-25 June 2012, was Yes: 1137 (17%) and No: 5455 (83%).

Of the total 6592 respondents, some 72% were from the UK; we don’t know the proportions of doctors and non-doctors among them. Although the poll software is meant to prevent this, there were a few examples suggestive of single individuals voting multiple times. The most extreme example was someone who voted “No” 168 times (and “Yes” just once) from two Icelandic IP addresses.

The breakdown of responses by day (table) suggests the existence of campaigns to get supporters of both sides to vote. For the first six days the “No” vote averaged 64%, with a daily variation of a few per cent. However, on 20 June the “No” vote dropped to 28%. During the next day, 10 times as many people voted, almost all of them voting “No.” The average for the first six days of the poll is therefore probably closer to the “true” result.

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Competing interests: TD believes that the law on assisted dying should be changed.

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“No” answers to bmj.com poll “Should doctors’ organisations be neutral on assisted dying?” by date

Date	No of votes cast	No (%) voting “No”
14 Jun	122	81 (66)
15 Jun	138	98 (71)
16 Jun	89	51 (57)
17 Jun	74	47 (64)
18 Jun	231	152 (66)
19 Jun	166	102 (61)
20 Jun	294	81 (28)
21 Jun	2848	2566 (90)
22 Jun	1695	1501 (89)
23 Jun	564	469 (83)
24 Jun	297	249 (84)
25 Jun	74	58 (78)
Total	6592	5455 (83)

MENTAL AND NEUROLOGICAL DIVIDE

Suggested merger is premature

White and colleagues' suggestion that the distinction between mental and neurological illnesses should disappear is premature.¹ It is perfectly reasonable to argue that mental illnesses are brain diseases—that was clearly stated more than 150 years ago²—but this is not a reason to combine mental and behavioural disorders and diseases of the nervous system in one classification. Although all mental events have brain correlates, we currently have no unequivocal brain biomarkers for most mental disorders, and classification relies, however imperfectly, on clinical signs and symptoms. Thus assessments and interventions differ from many of those in neurological practice. When White and colleagues suggest “the first priority should be to merge the mental and behavioural and neurology chapters of ICD-11 [international classification of diseases, 11th revision]” they may not be aware that each diagnosis in ICD-11 has a unique diagnostic number that can appear in more than one group in the classification while preserving its primary allocation for statistical purposes. Along with scientific validity, a central guiding principle of ICD-11 is clinical utility. Every good classification satisfies the needs of its users. With greater knowledge the systems may merge, but to do it now would not help professionals of either discipline.

Patients are more interested in the care they receive than in questions of nosology. Excellent clinical care depends on access to psychiatrists and neurologists who can liaise effectively but do not need to be yoked prematurely to an unwieldy classification system.

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- 1 White PD, Rickards H, Zeman AZ. Time to end the distinction between mental and neurological illnesses. *BMJ* 2012;344:e3454. (24 May.)
- 2 Bucknill JC. The diagnosis of insanity. *Br J Psychiatry* 1856;2:229-45.

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Minding the brain

In 1967 the neurologist Henry Miller provocatively stated that “psychiatry was neurology without physical signs.”¹ It was unclear then whether Miller was half a century behind or ahead of his time. In their call for diagnostic fusion between psychiatry and neurology, White and colleagues clearly think he was ahead.² In their view, psychiatric illnesses are brain diseases and should be classified as such.



Their mistake is to prescribe treatment before adequate diagnosis. True, psychiatry is in trouble: poor recruitment, underfunding (21% of illness, 13% of resources), uncertain identity, stigma, competition from psychology. It is also true, trivially, that psychiatric disorders have brain correlates. In addition, neurology has lost some of its allure—it is no longer the intellectual pinnacle that it was before the advent of neuroimaging. Neurologists also complain about inadequate resources. But the suggestion for fusion is absurd. As Craddock and colleagues said, “psychiatry is the only specialty in which its practitioners are fully trained doctors, incorporating psychology and social based knowledge and skills as major components of training. The absence of such skills in other medical specialties is a common cause of patient dissatisfaction.”³ Psychiatry needs to work collaboratively with all medical specialties, not just neurology; cutting edge epigenetics shows how many “brain diseases” result from the environmental and developmental processes that psychodynamic psychiatry is beginning to unravel.⁴ What’s needed is new thinking, not nostalgia.

Let neurologists see their illnesses as psychiatric if they will, but not vice versa. Only psychiatry can encompass the “social brain”⁵—that is, or should be, the future of a truly biopsychosocial medicine.

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- 1 Miller H. Depression. *BMJ* 1967;1:257-62.
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ANTI-VEGF TREATMENT

Safety in pregnancy is unclear

We agree that there are safety issues surrounding the use of anti-vascular endothelial growth factor (VEGF) agents.¹

Younger patients may also be treated with intravitreal anti-VEGF and the suppression of plasma VEGF concentrations may be important, especially in pregnant women. Systemic bevacizumab is teratogenic in rabbits at doses twice the recommended intravenous human dose (US Food and Drug Administration 2005).² Rosen and colleagues reported the absence of fetal side effects after exposure to intravitreal bevacizumab during the second trimester.³ A recent study of four pregnant women concluded that intravitreal bevacizumab during pregnancy for off-label ocular indications can significantly improve vision with no adverse events related to treatment.⁴ However, two of our patients experienced early loss of pregnancy after intravitreal bevacizumab injection.⁵

The safety of intravitreal anti-VEGFs during pregnancy is therefore unclear. However, we believe that pretreatment counselling should include a discussion with all premenopausal women that outlines all the possible risks and benefits of treatment.

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Competing interests: None declared.

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INTEGRATED CARE STORY

A one sided story

It was a surreal experience reading this article as it dawned on me that it was describing the same integrated care project that my practice has been engaged in.¹

The reduction in admissions should not be so baldly attributed to the project because it has not been running long enough, the target provider of inpatient services was closed to admissions for substantial periods, and the project is not the only area where we and other practices are working on reducing admissions.

The clinical meetings are time consuming and in our experience of limited benefit. The care planning tool, when it works at all, is almost completely unhelpful.

No mention is made of the expensive involvement of the management consultancy firm McKinsey. Although we cannot get accurate figures (so called commercial confidentiality), it is rumoured that this has cost the NHS £7m (€8.7m; \$11m) so far.

Although some practices are impressed with the project, we know that ours is not the only one that is not, and the article completely lacks balance in this regard—but then it seems it was not peer reviewed, which is odd for such a high profile article in a prestigious journal.

Given that the project is currently up for review, the timing and lack of balance in the article make it seem little more than a piece of propaganda. A survey of patients engaged in the project that was published a few months ago was highly uncomplimentary, something the author neglects to mention.

Overall, this one sided presentation does no credit to the editorial integrity of the *BMJ*.
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Competing interests: None declared.

1 Vize R. Integrated care: a story of hard won success. *BMJ* 2012;344:e3529. (31 May.)

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Author's reply

The article illustrated the complexities of establishing integrated care schemes. It focused on the fact that successful integration in health and social care ultimately depends on overcoming professional boundaries and developing strong relationships among clinicians, managers, and others, rather than on technology. It also emphasised the high cost and legal and financial difficulties that stand in the way of providing patients with the integrated service they deserve. The article and wider issues it raised were discussed at length at the health select committee on 26 June.

The data quoted on clinical outcomes are the best available.

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MISAPPROPRIATION OF FUNDS

Beware of Greek universities seeking grants

It is logical that more money is dispensed for medical research than for research in any other university discipline, not only in Germany, but in every country. Demand is high, innovations are fast, and future profits are high. In such a multi-billion dollar sector we must be careful where funds

go. Even minimal research fraud would mean serious loss of money.

Research institutions and universities that have had corruption, fraud, or plagiarism problems in the past must no longer receive state or European research funds until independent international committees have decided that it is safe and cost effective to do so.

For many years researchers, academics, and even rectors in one of Athens's biggest and most prestigious universities have been using research accounts to buy luxury villas and even sports cars.²⁻³ They have also charged university research accounts for tens of thousands of cafeteria lunches.³

It took 20 years of investigations and court procedures to finally arrest and jail these "researchers."⁴⁻⁵ The court ordered the seizure of property, including an old Ferrari, but the rest of the research money they have been daily spending is permanently lost, including donations from the prime minister himself.¹⁻²

Unfortunately, research in Greece still has no strategy, no formal standards, no evaluation procedures, no transparency, no evaluation of research staff, and no ranking body; instead heavy bureaucracy pervades.⁶ Therefore, we can never be certain that these appalling practices are not occurring in other Greek universities and research institutions.

European donors and research institutions should be advised not to finance projects in any Greek university until proper efficiency, transparency, evaluation, and ranking criteria are established by independent international committees.

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Competing interests: SS is a diligent taxpayer who has been financing Greek public universities for years. He is outraged to see such extreme and embarrassing embezzlements.

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OLYMPIC PUBLIC HEALTH LEGACY

Inspiration far from ideals

Campbell asks if the London Olympic Games will increase physical activity, in view of Sebastian Coe's claim that, "London's vision is to reach young people all around the world... with the inspirational power of the Games."¹

The International Olympic Committee claims that a "fundamental objective" of Olympic marketing is "to control and limit the commercialisation of the Olympic Games."² Yet many messages young people receive in association with the games will inspire activity that is far from healthy.

The Olympics' "top sponsors" include Coca-Cola and McDonald's.³ Both companies are heavily promoting their association with the games. McDonald's ("the official restaurant of the Olympic Games") has even built a special restaurant alongside the Olympic Stadium. The London 2012 website recognises the incongruity of the association with an FAQ: "Why are McDonald's a sponsor?" (<http://ask.london2012.com>). The rationale is simply that McDonald's has sponsored the games since 1976.

Cadbury ("the official treat provider of the London 2012 Olympic Games") is an "Olympic partner." Its associated company Trebor is a "provider and supplier."³ As "official lager supplier and sponsor of London 2012," Heineken apparently hopes "to reach untapped audiences in emerging markets through its sponsorship of the Olympic Games."⁴ Bibendum Wines, the "official" Olympic wines, will be sold at most Olympic venues.

The IOC aims "to control sponsorship programmes to ensure that partnerships are compatible with the Olympic ideals." They duly ban tobacco promotion, but their alcohol promotion bans are inexplicably restricted to beverages "other than beer and wine."² Why does the IOC not want to protect young people from exposure to promotion for beer and wine?

Regrettably, "the inspirational power of the Games" will leave a legacy of junk food and alcohol promotion in association with sporting excellence and the Olympic ideals.

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Competing interests: None declared.

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4 Simon Zekaria. Heineken sees Olympics boosting exposure in emerging markets. 2012. <http://english.capital.gr/News.asp?id=1538018>.

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