CORRESPONDENCE

District cancer physicians R Buckman, MRCP 1483	Bacterial contamination of home nebulisers B A S Dale, MRCPATH 1486	Micrometastases in bone marrow in patients with breast cancer R W Blamey, FRCS, and others 1487
Response to deoxycoformycin in mature T cell malignancies A D Ho, MD 1483	The blood transfusion service and zidovudine treatment for AIDS C Costello, MRCP, and others 1486	Disciplining doctors Anonymous 1487
Euthanasia P H Millard, FRCP; M J Connolly, MRCP; P D Hooper, FRCP; P Rubner, MB 1484	OKT3 and cerebral oedema D M Thomas, MRCP, and others 1486	The Soviet Union and South Africa A King, MB 1488
Graduated compression and its relation to venous refilling time A N Nicolaides, FRCS, and others 1484	Treatment of primary biliary cirrhosis C Babbs, MRCP, and others 1486	Points Adult epiglottitis (P D Whiteson and J Waldron); Impotence: treatment by auto-injection of vasoactive drugs (K M Desai and J C Gingell); Effects of maternal smoking on the newborn infant (R A Pastel); Leukaemia risks near nuclear sites (L Hawkins and D D'Auria); Testicular cancer (W G Jones); Euthanasia (Sir Reginald Murley); Coronary prevention (D S D Jones) 1488
Mania induced by biochemical imbalance U Tacke, MD 1485	Self injury and mental handicap P G Dale, MB 1487	
Doctors and witchdoctors: Which doctors are which? G Sharwood-Smith, FFARCS; S R Bucknall 1485	Potassium citrate mixture: Soothing but not harmless? R Gabriel, FRCP 1487	

- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

District cancer physicians

SIR,—As a medical oncologist who has emigrated to Canada, I am a spectator at the debate on the future of cancer services in Britain. Even so I should like to add my strong support to the comments of Professors T J McElwain and J S Malpas (31 October, p 1136).

On behalf of the Association of Cancer Physicians McIlmurray put forward a carefully constructed, thoughtful, and realistic blueprint for improving the delivery of cancer care.¹ Dr Liam Donaldson's leading article (19 September, p 682) was extremely disappointing. Britain has too few radiotherapists and far too few medical oncologists. Dr Donaldson's suggestion of strengthening and coordinating services is meaningless unless numbers of physicians in both disciplines are increased. Improvements in cancer services cannot be achieved with a handful of hard pressed medical oncologists. The choice is simple: either the consultant grade must be expanded or the public must be told that cancer services will not be improved. Any improvements will incur some expense (although a cancer physician's job includes identifying patients who will not benefit from expensive or toxic treatment, and the careful evaluation of the efficacy—or inefficacy—of current treatment).

Canada has about 200 cancer physicians for a population of 25 million; Britain has about 70 for a population of 55 million. The model proposed by the Association of Cancer Physicians is very similar to the current system operating in Ontario, and the coordinated care delivered by cancer centres linked to cancer physicians in district general hospitals here is impressive. The proposals put forward by the Association of Cancer Physicians are both realistic and modest—they can work and will work if they are implemented. These

proposals deserve serious consideration rather than the combination of mean spiritedness and flippancy put forward by Dr Donaldson, who, perhaps, might be interested to see the Canadian system in action before drawing any further conclusions.

Had these plans been in effect eight or nine years ago many of the British trained senior registrars in medical oncology who have emigrated to Australia, New Zealand, Canada, and the United States

might have reconsidered. British medical oncologists all share two characteristics: individual talent and scarcity. They—and British patients with cancer—deserve better.

ROBERT BUCKMAN

Toronto-Bayview Regional Cancer Centre,
Toronto, Canada M4N 3M5

1 McIlmurray MB. District cancer physicians: report of a working group of the Association of Cancer Physicians. *J R Coll Physicians Lond* 1987;21:117-21.

Response to deoxycoformycin in mature T cell malignancies

SIR,—Dr Claire Dearden and colleagues (10 October, p 873) suggested that remission in response to deoxycoformycin correlated with immunological phenotype. According to their observation, remissions were obtained “only” in patients with CD4+, CD8– membrane markers (five complete remissions and two partial remissions out of 10), and no responses were achieved in nine patients with a different phenotype.

The relatively high rate of “complete” responses is encouraging. No definition of complete remission, however, was given in this paper. Complete remission, as defined by disappearance of all objective evidence of disease in peripheral blood and bone marrow, could rarely be achieved in patients with T chronic lymphocytic leukaemia and prolymphocytic leukaemia.¹ Deoxycoformycin was given “weekly or twice weekly” but no stipulations for administering once or twice a week were defined. Is it possible that response correlated with administration twice weekly instead of with phenotype?

In the leukaemia cooperative study group of the

European Organisation for Research into Treatment of Cancer, we are concurrently conducting a phase II trial on the efficacy of deoxycoformycin in refractory lymphoid neoplasms.² The drug is given at a dose of 4 mg/m² intravenously once weekly for the first three weeks then once every 14 days for the next six weeks. At present, 15 patients with chronic T cell leukaemia can be evaluated for response. A partial remission, defined as a greater than 50% reduction in all measurable tumour indices for at least four weeks, was achieved in three of eight patients with Sézary syndrome, two of five patients with T chronic lymphocytic leukaemia, and one of two patients with T prolymphocytic leukaemia. No patient attained a complete remission. Immunological phenotypes were available in nine patients and the correlation to clinical response is summarised in the table.

Thus according to our experience, patients with CD8+ or CD4+, CD8+ phenotypes respond to deoxycoformycin as well as patients with CD4+ phenotype. Our preliminary data suggested a correlation between biochemical indices and

Clinical response to deoxycoformycin

Case No	Neoplasm	Pheno-type	Response
1	Sézary syndrome	CD4+	Partial
2	Sézary syndrome	CD4+	Partial
3	Sézary syndrome	CD4+	None
4	Sézary syndrome	CD4+	None
5	T chronic lymphocytic leukaemia	CD8+	Partial
6	T chronic lymphocytic leukaemia	CD8+	Partial
7	T chronic lymphocytic leukaemia	CD8+	None
8	T chronic lymphocytic leukaemia	CD4+, CD8+	Partial
9	T prolymphocytic leukaemia	CD8+	Partial

clinical response.³ I agree with Dr Dearden and colleagues, however, that observations on this correlation should be confirmed by further clinical studies.

ANTHONY D HO

Department of Internal Medicine V,
University of Heidelberg,
Heidelberg,
German Federal Republic

- Huhn D, Thiel E, Rodt H, Schlimok G, Theml H, Rieber P. Subtypes of T-cell chronic lymphatic leukemia. *Cancer* 1983; 51:1434-47.
- Ho AD, Thaler J, Zittoun R, Stryckmans P. Deoxycoformycin in therapy of refractory lymphoid neoplasms. *Onkologie* (in press).
- Ho AD, Ganeshaguru K, Hunstein W, Hoffbrand AV. Biochemical parameters in vitro and in vivo after treatment with deoxycoformycin in T-cell leukemia/lymphoma. *Blood* 1986; 38(suppl 1):224.

Euthanasia

SIR,—There are two sides to every debate. Ms Madeline Simms (26 September, p 772) describes how a small determined group of people changed the law with regard to the termination of pregnancy. On the other hand, Margaret White in her book *Two Million Silent Killings* describes the results of the work of that pressure group.¹

Now 19 doctors use your columns (14 November, p 1276) to announce that they have formed a medical group within the Voluntary Euthanasia Society. The skilfully worded letter, which even raises the spectre of the acquired immune deficiency syndrome, urges other doctors to join them; paradoxically, as Dr Murray Parkes wrote, "It is often those who are most afraid of dying who demand euthanasia."² Arguments put forward to legalise euthanasia do not carry conviction among practitioners caring for the dying or among moral theologians.³

Conscious that one of the signatories had a similar surname to my own, I looked up the group in the medical directory; six are not listed, eight qualified before the second world war, and, of the remaining five, three are consultants—in orthopaedics, psychiatry, and geriatric medicine—and two are general practitioners.

Dame Cicely Saunders, who has done so much to improve care of the dying in recent decades, considered that terminal care in the 1970s bore little relation to care in the 1950s.⁴ Members of the Voluntary Euthanasia Society, founded in 1935, inform us that 30% of general practitioners favour legislation, which is a considerable change from the 8% that was recorded in a study I undertook for the Guild of Catholic Doctors in 1980. In that study 313 doctors in general practice (a third of the sample) responded to a questionnaire mailed by Gallup Polls Ltd. The survey concluded that doctors who dealt with the dying were overwhelmingly opposed to a change in legislation.⁵

The moral code that forbids killing by doctors has stood the test of time; we live in an ever changing world yet changing that law would lead to

the destruction of medicine as a caring profession. The ancient Greeks were aware of the dangers of listening to the sweet song of sirens and young doctors too should take care.

PETER H MILLARD

Department of Geriatric Medicine,
St George's Hospital Medical School,
London SW17 0RE

- White M. *Two million silent killings*. Basingstoke: Marshall Morgan and Scott, 1987.
- Murray Parkes C. Psychological aspects. In: Saunders CM, ed. *The management of terminal disease*. London: Edward Arnold, 1978:44-64.
- Dunstan GR. Discerning the duties. In: Saunders CM, ed. *The management of terminal disease*. London: Edward Arnold, 1978:181-8.
- Saunders CM. The philosophy of terminal care. In: Saunders CM, ed. *The management of terminal disease*. London: Edward Arnold, 1978:193-202.
- Keane WG, Gould JH, Millard PH. Death in practice. *J R Coll Gen Pract* 1983;33:347-51.

SIR,—The letter from the medical members of the Voluntary Euthanasia Society stated that nearly 40% of general practitioners "would be prepared to administer voluntary euthanasia if it were legalised." The basis for this statement was a national opinion poll carried out this year in which 35% of the general practitioners responding said that they would be prepared to "consider" a signed request from a patient with incurable, intolerable illness to "end his/her life."

Willingness to "consider" such a request by no means implies willingness to "administer" legalised voluntary active euthanasia. The outcome of consideration may be a decision to withhold or withdraw active intervention (passive euthanasia). This might be the case even when active euthanasia had been specifically requested by the patient. The use of the term "administer" (implying prescription) is unjustified.

MARTIN J CONNOLLY

Leeds LS16 6DG

SIR,—The letter by Dr Mary Bliss and others failed to identify the main group of people who request (and in my opinion deserve) euthanasia.

We all know that pain can be adequately controlled by correct medication, and people suffering painfully or otherwise from cancer know that they have a limited lifespan. The people who really want to die, and I have visited four of them in the past week, are old people suffering from stroke who are hemiplegic; the bedbound or chairbound; the aphasic; the incontinent; the deaf (never the blind); and those who are so old that they have grown too weak to move or even feed themselves. True, they can be nursed in one of the many homes for the elderly now available, and they are indeed often looked after with great care and devotion, with the result that their unhappy lives are further prolonged. They are often lonely, even in the midst of company, because all their loved ones have already departed. They feel guilty that, by living so long, they are consuming the family's financial resources to no good purpose; they feel that their lives are finished; they have no further contribution to make and they await death with eager anticipation. "I wish I could go" is a phrase constantly heard; it was constantly on the lips of my own mother during the three years in which she survived my father even though she played a keen game of bridge until a month before she died. Are we to continue to deny relief to our aged and weary patients?

P D HOOPER

Newport, Isle of Wight

SIR,—The leading article by Dr Roger Higgs (14 November, p 1221) gives the impression that the profession is filled with doubt on the subject of treatment refusal by terminally ill patients or their relatives and that doctors need to pluck up courage and to seek legal subterfuges to accede to their wishes. The article goes on to argue that this should not be so.

I would like to argue that far from needing encouragement to accede to requests for treatment refusal or "death with dignity," we need encouragement to accede to the contrary request of providing treatment to prolong life to the last minute in the face of inevitable death when this is demanded by relatives.

In hospitals all over the country when a patient is in the terminal stages of illness "death with dignity" is allowed to take place and no further steps are taken to prolong life—indeed, it may be shortened by the administration of diamorphine ostensibly to keep the patient comfortable. No intravenous infusions are put up if the patient cannot take fluids by mouth and dehydration is allowed to play its part. As a general practitioner who has worked in a geriatric department I can vouch for this from personal experience. The British attitude to death is stoical and pragmatic, and, as stated in the article, too, "patients and relatives have a trusting relationship with doctors." Death with dignity appears to be acceptable.

The same cannot be said about some of our ethnic minorities such as orthodox Jews, who form a large part of my practice. To them life is all important and its preservation has to be attempted no matter how hopeless the outlook. A geriatrician I know holds uncompromising views on death with dignity, and if a terminally ill member of this minority is admitted under his care treatment is withheld even in the face of entreaties by the relatives. Once when in desperation the relatives approached me to do something I telephoned the senior house officer and explained that for the sake of appearances she should put up an intravenous infusion on an unconscious dying patient so that the relatives could be happier, but this was refused. The following day I was admonished by the consultant. There have been similar incidents with other consultants.

It is all very well to seek legal loopholes for death with dignity for those patients and relatives who request this, although from my experience this seems hardly necessary; what is really needed is an article to warn of the rights of those opposed to it.

P RUBNER

London N15

Graduated compression and its relation to venous refilling time

SIR,—The paper by Miss Julia Cornwall and colleagues (31 October, p 1087) describing the effect of graduated compression appears to be a careful study but the results do not agree with long term clinical experience. These unexpected findings could be due to defects in the methods.

The photoplethysmograph has failed to live up to its early potential. In normal legs the curves obtained are similar to the ambulatory venous pressure patterns but refilling times are inversely proportional. In venous disease, however, there is little change in a short refilling time, although the ambulatory venous pressure may vary from 80 to 40 mmHg.¹ The study was based on the refilling time with the stocking in situ and a 1 cm hole cut out to accommodate the photoplethysmograph probe. We have found in extensive tests that with