letters TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Thomas.Allum@rcplondon.ac.uk.

Medical treatment at the end of life

Editor – The position statement *Medical treatment at the end of life* (*Clin Med JRCPL* March/April 2001, pp115–7) is, in the main, a welcome outcome to the Working Party's hard work and deliberations.

However, I find it strange that the Working Party should be at such pains to include the word 'active' in its definition of euthanasia when, two paragraphs later, it seeks to abandon the use of the adjectives 'non-voluntary', 'involuntary' and 'passive'. This is hardly logical!

The most important point they make (p 116) is that 'it is clear that the intention behind a therapeutic decision…is a central issue'. This is indeed ethically fundamental. Consequently it cannot be true to say, without qualification, that 'an intention to withhold or withdraw burdensome or futile treatment is not an intention to kill'. It is not an intention to kill precisely to the extent that the treatment is being withheld or withdrawn for another reason, ie because it is burdensome and being withdrawn specifically to relieve the burden. Treatment can be withheld or withdrawn with the intention of ending the patient's life and this is no less lethal than a positive act. The intention behind such an act (or omission) can, it is true, only be clear to the doer but I find it hard to see why the Working Party failed to recognise the distinction. Let us hope treatment will not be withheld or withdrawn from patients for no better reason than that the BMA/RCP said that this was right.

I also regret the Working Party's support for the BMA guidelines *Withholding and withdrawing life-prolonging medical treatment* which, in several respects, is on much less sure ground, both ethically and even legally, with its recommendations.

IAN JESSIMAN
Chislehurst

Aspirin against cancer

Editor – Professor Elwood (*Clin Med JRCPL* March/April 2001, pp132–7) meticulously describes the development of aspirin as an antiplatelet drug over the past three decades, and elegantly illustrates that the axiom 'if a little bit works, a lot works better' is not necessarily true. Unfortunately, his allusion to a similarly structured approach to the development of aspirin as an anticancer agent is falsely optimistic.

Although the epidemiological evidence that aspirin reduces the incidence of colorectal cancer is convincing[1], only one truly large-scale randomised Phase III trial is taking place. Unlike the highly focussed clinical development of the selective cyclooxygenase-2 inhibitors such as celecoxib, licensed last year in the USA for the chemoprevention of colorectal cancer in patients with familial adenomatous polyposis[2], the choice of subject population and biomarker (recurrence of sporadic polyps, whose aetiology is known to be more multifactorial than inherited cancer) is weighed against positive results for aspirin.

Unless research funding bodies are willing to support the development of aspirin as an anticancer agent in the way that selective cyclooxygenase-2 inhibitors have been driven by the pharmaceutical giants, this well known, pleiotropic, natural derivative will be superceded by its younger, relatively unknown, selective relatives. Since aspirin inhibits many of the carcinogenic processes that the selective agents do not[3], this is not necessarily progress.

References

1 Sharma RA, Manson MM, Gescher A, Steward WP. Colorectal cancer chemoprevention: Biochemical targets and clinical development of promising agents. *Eur J Cancer* 2001;**37**:12–22.

2 Steinbach G, Lynch PM, Phillips RKS, *et al*. The effect of celecoxib, a cyclooxygenase-2 inhibitor, in familial adenomatous polyposis. *N Engl J Med* 2000;**342**:1946–52.

3 Marnett LJ. Aspirin and the potential role of prostaglandins in colon cancer. *Cancer Res* 1992;**52**:5575–89.

RICKY A SHARMAN
Oncology Department
University of Leicester

Temporary cardiac pacing and the physicians of tomorrow

Editor – I read with interest the clinical and scientific letter by Murphy *et al* (*Clin Med JRCPL* March/April 2001, p156). In my three years as a specialist registrar in general internal medicine (GIM) and gastroenterology, I have had to insert a temporary cardiac pacing wire on approximately ten occasions, while on call. As yet there have been no significant complications, suggesting that I have probably not performed enough! My only training consisted of watching the procedure done twice by a registrar during acute medical on calls as an SHO, and one supervised procedure soon after. Only once was I supervised whilst on call as a registrar, and this was during 'office hours'. I once asked my GIM consultant if he would be able to help me, should I have trouble pacing at night, and he admitted to never having performed the procedure himself. I am sure this is not an unusual occurrence and fully sympathise with the authors who suggest that temporary cardiac pacing is inadequately taught, and question whether it should be performed by non-cardiologists.

RICHARD MAKINS
Specialist Registrar GIM, Gastroenterology
The Middlesex Hospital

Editor – The advent of thrombolysis has greatly reduced the need for emergency temporary pacing and in some district general hospitals so also has the provision of permanent pacing. However, removing training in temporary pacing from general internal medicine (GIM) training with a view to the service being provided entirely by cardiologists would have major implications. There are still significant numbers of district general hospitals in this country with only a single cardiologist, often without a specialist registrar. In many other

districts there are only two cardiologists. To expect these consultants to be on call at all times for temporary pacing would be unreasonable. To adopt this approach would require an enormous increase in the number of consultant cardiologists in district hospitals (perhaps to four or five). Such an enormous expansion is unlikely to occur.

A more sensible approach therefore, would be to ensure that all SpRs training in general internal medicine receive appropriate training in temporary pacing. Clearly this is not occurring in the region that was surveyed by Dr Murphy. Perhaps all SpRs in GIM should be seconded to cardiac units for a period of time so that they can have greater exposure to temporary pacing. We were certainly surprised that two of the 49 SpRs who responded within two years of completing their training, admitted to never performing a temporary pacing. How could they expect to provide an acute medical service? Surely trainees do have to take some responsibility for their training and should be expected to make local arrangements to correct such local arrangements to correct such large deficiencies in their training.

DAVID M WALKER
RICHARD WRAY
Consultant Cardiologists
Conquest Hospital, East Sussex

Paediatricians should be more interested in adult disease

Editor – Professor Weaver's article (*Clin Med JRCPL*, Jan/Feb 2001, pp38–43) challenges both paediatricians and adult medicine physicians to pay more attention to each other's clinical problems. More and more children with congenital heart disease are surviving into adolescence and adulthood and come under the care of adult physicians who may know little about them or their disease. By the same token, paediatricians may not be fully aware yet of the influence of the mother's health, wealth and nutrition during pregnancy on 'adult' diseases such as hypertension, atherosclerosis, and type 2 diabetes, when their children reach middle age.

ABDULLAH A ALABDULGADAR
King Fahad Hospital
Saudi Arabia

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Statin therapy

In *Who should receive statins?* (The Drug and Therapeutics Bulletin, March 2001, pp21–3) it is stated that statins provide useful benefit in preventing coronary heart disease in those with an absolute risk of 15% or more over 10 years. The writer states that this is not achievable with current NHS funding, and that a more realistic approach is to treat all those with an absolute risk above 30% over 10 years and to extend statin therapy to remaining individuals with a risk level of at least 15% over 10 years, as resources permit. The writer concludes that it is practicable to treat patients without clinically overt atherosclerotic disease only if the absolute risk of CHD events exceeds 30% over 10 years. This fits with government policy.

This 'independent review' from the consumers association does neither consumers or doctors any favours. There is a very real danger that such an approach, particularly when supported by detailed advice on how to calculate risk, will be taken as correct medical practice rather than, as it is, a financial imperative for the government. A patient consulting his doctor still expects that doctor to give the patient the best advice for his or her health. The risk is that the doctor will tell the patient who has perhaps a 15% risk of coronary heart disease over 10 years that treatment with statins is not needed. This is in no way ethically justifiable and I am sure a court of law would agree. To withhold a drug which is apparently harmless, and which will reduce risk from 15% to 10% over 10 years cannot be justified. The only ethical justification for withholding such a drug is if the physician believes that the long-term risk will out weigh the long term benefit.

Physicians are not in practice to decide how the tax payers money should be spent. We are here to help patients. If politicians do not wish to spend taxes on statin therapy then they should pass a law and stand or fall at election as a result.

In the meantime we should continue to do our best for our individual patients; if we do that and it costs money our budget is not overspent it is underfunded and politicians not doctors should take the responsibility.

RICHARD A BEST
Consultant Cardiologist
Burnley General Hospital