

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: Clinicalmedicine@rcplondon.ac.uk.

Withdrawing nutrition and hydration

Editor – I wonder if I detect a semantic 'trick', played on us by the legal profession, in Keith Andrew's helpful paper on withdrawing nutrition and hydration (*Clin Med* July/August 2003, pp 342–5).

Recent attempts to define 'best interests' have been very unsatisfactory and I agree that the issue of nutrition and hydration is a complicated one. However, to say 'where the treatment is not benefiting the patient the treatment is not in the patient's best interest' may intend to convey no more than that the proposed treatment is of no apparent value to him and is unlikely to advance his immediate 'well-being'. From an ethical viewpoint, there would be no obligation for such measures to be offered or accepted.

Unfortunately, the legal profession takes the phrase 'not in his best interests' to mean not just 'of no value to him' but also to carry the connotation that the treatment is actually contrary to his best interests and therefore deleterious or 'harmful to him'. In other words, by a trick of language, they will argue from a statement that something is of little or no value to the patient, but harmless, to the position that it is positively contrary to, and thus harmful to, his best interests and therefore not only need not but must not be given.

IAN JESSIMAN
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In response

Editor – Dr Jessiman raises a point arising from the case of Tony Bland, in which Keith Andrews was a witness and has voiced strongly held objections since (*Clin Med* July/August 2003, pp 342–5).

The issue in the case was whether an incompetent person's best interests could ever include the withholding or withdrawal of life-sustaining treatment. The House of Lords reasoned that it was futile to continue Bland's treatment since he had no hope of recovery. It could not therefore be in his best interests to continue. Thus it would be lawful to withdraw the life support (in that particular case, hydration and nutrition) and indeed it might be unlawful to continue. The judges distinguished this from a doctor actively and intentionally bringing about the death of a patient. The law, they said, drew a distinction between acts and omissions: withdrawal was an omission. Withdrawal could only be unlawful if the omission amounted to a breach of the doctor's duty of care to the patient. The Lords held that it did not.

In the view of Dr Jessiman therefore, the treatment is harmful to the patient in the sense that his interests are harmed and not his corporeal body as such. His body is not harmed by artificial nutrition: it was sustained by it. In English law doing something that is not in a person's best interests is not harmless because those interests are significant and valuable. They are valued equally with other interests, such as in being hydrated and ventilated simpliciter.

Dr Jessiman seems to me to be correct in averring that the 'legal profession takes the phrase "not in his best interests" to mean not just "of no value to him" but also ... "harmful to him"'. However, I do not think he is correct to argue that the harm is of no significance. It is an acceptance that continued treatment may be deleterious, even when compared to death.

DEREK MORGAN
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Diagnosing acute headache

Editor – We found the piece by Dr Davenport on Diagnosing Acute Headache (*Clin Med* 2004 March/April pp 108–12)

very informative. However, Figure 1 appears to suggest that patients presenting with headache should be referred to a neurologist from the emergency department prior to excluding both meningitis and sub-arachnoid haemorrhage.

We would automatically look for these in our department and initiate the appropriate treatment prior to referral for a specialist opinion. We feel that a practice of referring all acute headaches directly to the neurologists would incur unnecessary delays in the intervention for these two conditions.

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JONATHAN HUTT
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In response

Many patients presenting to the emergency department (ED) with headache may be dealt with adequately by ED staff, without requiring a referral to a neurologist immediately. However, any patient with a true acute onset headache will almost certainly require admission for further investigations, and I believe that these patients should be admitted to a neurosciences unit, rather than a general medical or ED observation ward.

Of course, antibiotics for suspected meningitis should never be delayed, and I would expect the ED staff to have already administered these and any other potentially life-saving treatment prior to referral. But once the ED team have identified that the problem is an acute onset headache, they should be calling their neurologist (assuming they have one). A useful analogy might be the management of acute chest pain; the diagnosis and immediate treatment of an acute myocardial infarction may be initiated in the ED, followed by rapid and seamless transfer to the care of a cardiologist. As a general rule, I believe that outcomes are better if patients are treated by specialists (by which I mean neurologists, cardiologists etc, rather than super-specialist headache doctors), and there is evidence to support this assertion (eg stroke units for stroke patients rather than general medical wards).

The problem of course is that there are far too few neurologists in the UK, and a neurologist of any grade in a UK ED is a rare sight indeed, with one or two notable geographic exceptions. However, I believe this has to change, and neurologists must become more involved in the assessment and management of acute neurological problems, of which acute headache is surely one of the most common. The Association of British Neurologists thinks the same, and the document 'Acute neurological emergencies in adults' that critically ill patients with neurological disease should be seen by a neurologist immediately, and that all patients with neurological disease who do not require immediate intervention should be seen within 24–48 hours of admission. The document noted that currently there are insufficient numbers of neurologists to hope to achieve this UK wide, but it is certainly an appropriate aspiration, and without such carefully calculated plans for the future, expansion is unlikely to happen.

Reference

- 1 Association of British Neurologists. *Acute neurological emergencies in adults*. www.theabn.org/education/publications.html.

Bioterrorism: the need to be prepared

Editor – Colonel Michael J World reviews the steps necessary to minimise the probability of a successful terrorist attack with biological weapons (BW), mentioning that, when possible, effective interventions should be preventive, but he does not discuss this aspect further (*Clin Med* March/April 2004, pp 161–4).

Previous attempts by non-state actors to use BW have had limited success. The Rajneeshee sect contaminated salad bars in restaurants in Oregon in 1984 with *Salmonella typhimurium*, making 750 people ill but with no fatalities. The Japanese Aum Shinrikyo cult, responsible for 17 deaths from the nerve gas sarin in the Tokyo subway in 1995, attempted to develop anthrax, Q fever and the ebola virus as BW, but failed despite having skilled scientists among its members.¹ Thus, state sponsoring might be needed for

the preparation and dispersal of BW for the type of attack described. The person responsible for the postal distribution of weapons-grade anthrax in the USA may have had access to its BW programme.

State use of BW is illegal under the 1925 Geneva Convention, and 150 states are party to the 1972 Biological and Toxin Weapons Convention (BTWC) and have formally renounced the use of BW. A further 16 have signed but not ratified, but some states capable of a BW programme and accused of terrorist links are non-signatories. Unlike the 1996 Chemical Weapons Convention, the BTWC has no verification protocol.

However, progress on a protocol was well advanced by the November–December 2001 5th Review Conference of the BTWC, but was blocked by the United States, despite an adjournment of the conference to November 2002. The reasons adduced – that the proposed protocol would be ineffective and would affect the commercial confidentiality of the US biotechnology industry – seem contradictory.

Immediate progress on a verification protocol for the BTWC seems unlikely in view of the attitude of the current US administration to international arms control. But, pressure by sympathetic countries, and by civil society including medical organisations such as our College, could eventually lead to a near-universal and verifiable BTWC² – a major contribution to the primary prevention of bioterrorism.

References

- 1 British Medical Association. *Biotechnology, weapons and humanity*. Amsterdam: Harwood Academic, 1999.
- 2 Millett PD. Proliferation of biological weapons: challenges and responses. *Med Confl Surviv* 2004;20:4–18.

DOUGLAS HOLDSTOCK
Editor, *Medicine, Conflict and Survival*
London

In response

Editor – Dr Holdstock's letter appears to contain three related ideas:

- a) to be successful, an attack with a biological weapon must result in fatalities
- b) manufacture and storage of lethal biological weapons requires resources of a magnitude of which only governments are capable
- c) development of an international convention, incorporating verification protocols, where signatory governments agree not to develop biological weapons, will minimise the risk of terrorists attacking with biological agents.

I support wholeheartedly any measure that limits the availability of any unconventional weapon, including biological agents. In my article, the paragraph headed 'Factors facilitating attack' was an editorial distillate of several paragraphs in the original submission where many interventions to minimise the risk of a successful attack, not just production and storage facilities, were considered in detail. However, I believe that a successful attack with a biological agent does not necessarily have to result in fatalities: severe economic disruption may be a sufficient outcome. In consequence, the facilities for safe manufacture and containment before dispersal might not be that dependent on enormous resources. Therefore, it would be false to assume that an international convention would necessarily provide adequate protection.

The whole thrust of my article was that, sadly, it is necessary to contemplate that an attack with a biological weapon could be successful and that measures must be in place to minimise the distress, disruption and economic consequences. While I agree that the College should encourage any measure to limit availability of biological weapons, it should also assume the responsibility to ensure adequate education of civilian physicians so that the capability exists to deal with an attack by terrorists on the population in a competent and professional manner.

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