checklist below (adapted from Jolles and Hughes[4]) summarises the general considerations prior to the commencement of hdIVIG.

Physician's checklist for high dose IVIg:

1. Liver function, renal function, full blood count, and hepatitis screen (avoid hdIVIG in rapidly progressive renal disease).
2. Immunoglobulin levels to exclude IgA deficiency. If no IgA present (<0.05g/l), measure anti-IgA antibodies.
3. Exclude high titre rheumatoid factor and cryoglobulinaemia.
4. Preferably ensure that a sufficient supply of a single product and batch of IVIG is available to expose the patient to a minimum number of donors and to avoid unnecessary product changes.
5. Take any baseline specimens, examination findings, or photographs required in order to later document any objective response.
6. Follow manufacturer's guidelines regarding reconstitution and rate of infusion (and maintain good hydration and fluid intake).
7. Provide patient information regarding high-dose IVIG therapy and consent.
8. Store a sample of serum so that any future research questions or matters relating to transmission of infective agents may be addressed.

If anti-IgA antibodies are detected and are at high titre it may well still be possible to use an IVIg product low in IgA (see Table 1: Properties of IVIg preparations currently available in the UK, in our original article) starting the infusion at a slow rate and, if tolerated, gradually being increased under the supervision of experienced staff and in a setting where full resuscitation facilities are available. The current generation of IVIg products are generally lower in IgA than has previously been the case. Premedication such as antihistamine, paracetamol and hydrocortisone may also be used at initiation of IVIg or during change of product. This is not generally needed for subsequent infusions. Consideration may also be given to a medic alert bracelet documenting the high titre anti-IgA antibodies should the patient require blood products in the future.

Reassuringly, the incidence of serious reactions to IVIG is low and usually due to concurrent infection or over-rapid administration. A prospective study of 459 antibody deficient patients established on IVIG showed that no serious reactions occurred in over 13,000 infusions across twelve centres and using six different IVIG products. The rate of milder reactions was 0.8%.[5] In the UK, primary immunodeficiency patients who infuse at home no longer require the automatic prescription of adrenaline auto-injectors even though incidence of complete IgA deficiency with anti-IgA antibodies is higher in antibody deficient patients (especially IgAD with IgG subclass deficiency) than the general population. Furthermore a large study demonstrated that far fewer individuals with IgAD and anti-IgA antibodies than would be expected developed transfusion reactions[6].

The diagnosis of IgAD and measurement of anti-IgA antibodies is therefore useful in defining patients at increased risk of reactions to IVIg but the presence of even high titre anti-IgA antibodies may not preclude the use of an IVIg product low in IgA where the risk–benefit ratio merits it.

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Systematic review of systematic reviews of acupuncture

Editor – Derry *et al* (*Clin Med* July/August 2006 pp 381–6) have advanced acupuncture research significantly by their review of 35 systematic reviews. Since I am an author of 14 of these articles, I feel I should comment. The analyses by Derry *et al* imply that the authors of many reviews were too 'optimistic' regarding the value of acupuncture mainly because they often based their conclusions on biased data. I think that this may well be true. We need to be more, not less, critical when assessing complementary/alternative medicine (CAM). Ironically, many CAM enthusiasts believe that the work of my team is already too critical.

Believers in acupuncture will probably point towards a range of weaknesses in the analyses by Derry *et al*. The article has, of course, several limitations but these should not distract us from its provocative conclusion: there is 'no robust evidence that acupuncture works for any indication.' Using an entirely different approach, which included a review of those trials which control for placebo effects through the use of the new non-penetrating sham devices, I recently arrived at a strikingly similar overall verdict: 'Acupuncture remains steeped in controversy. Some findings are encouraging but others suggest that its clinical effects mainly depend on a placebo response.'[1] Critical assessment like this of Derry *et al* is a very rare thing in CAM. But CAM researchers should remember that it is mainly this approach which advances healthcare.

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1 Ernst E. Acupuncture – a critical analysis. *J Int Med* 2006;259:125–37.

Assisted dying

Editor – Though I do not for a moment question his *bona fides*, I believe that Stephenson (*Clin Med* July/August 2006 pp 374–7) is profoundly mistaken and, indeed, that he condemns his position with his own arguments. He says that 'in *most* cases [my emphasis] the physical symptoms of terminal illness can be relieved' and that even where patients have complex symptoms 'they can *usually* [my emphasis again] be alleviated.' These statements are obviously correct but are, frankly, irrelevant: as Stephenson himself agrees, those who advocate the availability of assisted dying do so in relation to an 'extremely small proportion [of terminally ill people]'; however small that proportion may be, the fact is that such people exist, as is eloquently demonstrated by another author in the same issue.[1] There are people who are resistant to opiates or who find their side effects intolerable and the same goes for the most commonly used anti-emetic drugs. What are we going to provide for these people?

No one would suggest that assisted dying is an easy matter on which to legislate, but with sufficient determination it is possible to set aside absolutist arguments and to provide for the needs of vulnerable people even in contentious areas, as the 1967 Abortion Act showed. I would remind Stephenson, incidentally, that the Hippocratic oath also forbids abortion, yet many doctors are content to terminate pregnancies under appropriate circumstances.

Stephenson's attempt to raise a series of moral absolutes in opposition to assisted dying is honourable but ultimately illogical: for example, to say that some doctors will 'kill or facilitate the killing' of their patients is an emotive statement which bears no relation to the reality of what is being discussed. In the days of surgery before asepsis and proper anaesthesia, operative and post-operative mortality was high, yet it would have been wrong to have described surgeons as 'wounding or facilitating the wounding' of their patients.

Whilst it may well be the case that the general public's understanding of this area is inadequate, I firmly believe that they have got hold of a truth which many professionals are trying to deny, namely that the choice of the time of one's death is a fundamental human right and that it is not the place of legislators or health professionals to deny that right.

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Reference

1 Anonymous. A personal view of assisted dying. *Clin Med* 2006;6:412–7.

In response to Fisken

My statements about what can be achieved by palliative care are hardly irrelevant as it is important to establish the benchmark for what is possible. The appalling care highlighted by the author in the same issue, to whom Fisken refers, although tragically all too common is nonetheless suboptimal.[1] Palliative care is certainly not a panacea for all end-of-life ills, but whatever the limitations there is always something that can be done to bring a measure of relief.

There will always remain some people who would like the option of assisted dying. However, at what cost to others do we elevate their autonomy above other concerns? Fisken's faith in our legislators is admirable, but I'm afraid that I have rather less faith in human nature. He does his cause little favour by making the comparison with the 1967 Abortion Act. I doubt those who framed that legislation would have had any idea that the result would be abortion on demand, with only a tiny fraction of these being for foetal abnormality. Furthermore, while some may argue that there is scope for debate over viability of life or personhood of an embryo, there is absolutely no doubt that assisted dying involves ending a life.

While 'kill' and 'facilitating the killing' may be emotive terms, I'm afraid they do accurately represent the reality of what is being discussed. Euphemisms cannot hide the fact that the intention in assisted dying is to unnaturally end a life, and there is a world of difference between this and death resulting as a complication from surgery in which the intention is to save life.

On his final point, we will simply have to disagree. We hear much about supposed human rights, and very little about responsibilities. I do not accept that the choice of the time of one's death is a fundamental human right, and I would be interested to know the premise on which this assertion is made. If Fisken really believes this, and if this 'right' is not to be denied to people by legislators and health professionals, then presumably he would advocate that assisted dying be available to anyone who asks, of whatever age and whatever condition of health? A slippery slope indeed.

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Reference

1 Anonymous. A personal view of assisted dying. *Clin Med* 2006;6:412–7.

Assisted dying

Editor – While I share some of Dr Jeffrey Stephenson's concerns regarding assisted dying, I feel that several of the points raised need further attention. Firstly, I think it is presumptive to state that most of us working with the terminally ill are strongly against a change in the current law. Those physicians working in palliative medicine who have spoken out on this subject tend to be strongly against assisted dying. I'm sure that there must be other workers in palliative medicine, however, who have been examining the moral issues involved and feel that they cannot dismiss the idea without further discussion and thought.

Secondly, I have worked with patients who had symptoms that could not be alleviated through palliative care. These have included patients with progressive neurological disease who were profoundly disabled, but who had no remedial symptoms such as pain or nausea, and cancer patients who have had symptoms such as fatigue and weakness, which we have been unable to reverse. There may be a very small proportion of our patients who, whatever we do, wish to end their lives, and this should be acknowledged.

With regards to violation of the Hippocratic oath, a longstanding tradition