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 sent by email to: Clinicalmedicine@rcplondon.ac.uk

Committee for Ethical Issues in Medicine

Editor – The excellent paper by John Saunders (*Clin Med* October 2008 pp 508–11), outlining the role of the Committee for Ethical Issues in Medicine (CEIM), Royal College of Physicians (RCP), describes the role the RCP played in the recent euthanasia debate. It demonstrates with great clarity why I feel that the many RCP members who support euthanasia have been let down by the College.

The function of any ethics committee is to debate the ethical issues involved in a topic and give a reasoned view on what could be considered ethical and what is not. Questions to be considered in the euthanasia debate include: can euthanasia be considered ethical per se? Can euthanasia be delivered ethically within a legal framework? Is it ethical to withhold the option of euthanasia from competent autonomous terminally ill adults? Any ethics committee, including the CEIM, should provide a commentary and a view on these and allied questions to inform the debate. Rarely, if ever, can a yes/no answer be given. Yet this is what CEIM has done.

By using one simple binary question, a complex topic has been distilled into a single yes/no answer which has informed the RCP response. I would expect the RCP to take a more sophisticated approach that takes into account all shades of ethical and pragmatic opinion. The response should include a discussion of the ethics of the many issues involved, describing what it considers acceptable and unacceptable. The views of the Fellows and Members have a place, though I would like a more extensive and unbiased set of questions. The views of all Fellows and Members should be represented without the editorial comment of the CEIM or the College Officers.

Democracy requires rule by the majority with reference to, and respect for, the views of the minority. It is frequently possible to have the views of many groups catered for. The bill that was being considered would not have made euthanasia compulsory. It would have made it possible for those who wished to treat and be treated. Those doctors and patients opposed to euthanasia need not get involved. By rejecting this bill, those opposed to euthanasia, possibly the majority of Fellows and Members of the RCP, have imposed their will on those who support and welcome it. Supporters of euthanasia do not, however, want to impose our will on its opponents.

The CEIM have played a part in denying a section of society an option that they feel is ethically justifiable and legally controllable. They have done so without a clear and full discussion of the issues but by opinion poll politics.

MAURICE BUCHALTER
Consultant Cardiologist
South Wales

In response

Despite a large amount of information in *Clinical Medicine*, *College Commentary* and *Newsletter*, Maurice Buchalter does not appreciate the different roles of the RCP's Committee for Ethical Issues in Medicine (CEIM), College Council, senior College officers or the (independent) editor of *Clinical Medicine* in RCP debates around euthanasia. Any 'editorial comment' in the recent analysis[1] of 2,143 free-text comments from the 2006 consultation is mine, not the CEIM's or RCP officers'. A decision to change the law – not a specific question about Lord Joffe's Third Bill, which was not about euthanasia anyway – is necessarily a binary decision, whatever the complexities of the debate. As regards provision of commentary, several pieces have directly[1–4] or indirectly[5] informed Fellows and Members on these issues.

We have striven throughout to ensure that both minority and majority views have been encouraged and respected. As the post-consultation statement says, 'Council acknowledges that a significant minority of its Fellowship and Collegiate Membership support a change in the law…encouraging its Fellows and Members *in their diversity of views* [emphasis added by author] to play an informed role in continuing debate'. As I wrote elsewhere, a 26% minority view is important: 'No triumphalism here. The RCP has tried to avoid the elective dictatorship we see in political life. Nowhere is this more important than in ethical issues where division can be sincere, well argued and deeply felt'.[6]

I'm sorry Maurice Buchalter didn't like the consultation outcome but his view of opponents unfairly imposing their will while supporters don't is naive. Regardless of his personal position, surely he can acknowledge that opponents of euthanasia – or animal experimentation or abortion or a host of other issues – think it is wrong and should not be permitted in our society. It's about ethics, not etiquette or personal taste.

Finally, I agree with him that, with a return rate of around 35%, most Fellows and Members are probably opposed. As Council's statement says, 'in view of the strong majority view…a reasonable opinion of the overall opinion of its Fellowship and Collegiate Membership can be drawn'. Given the sustained press campaign since then it may, of course, have changed.

JOHN SAUNDERS
Chair, Committee for Ethical Issues in Medicine
Royal College of Physicians

References

1 Saunders J. What do physicians think about euthanasia and physician assisted suicide? *Clin Med* 2008;8:243–5.
2 Tallis R, Saunders J. The Assisted Dying for the Terminally Ill Bill 2004. *Clin Med* 2004; 4:534–40.
3 Saunders J. Assisted dying: considerations in the continuing debate. *Clin Med* 2005; 5:543–7.
4 Hoffenberg R. Assisted dying. *Clin Med* 2006;6:72–4.
5 Saunders J. Ethical decision making in

professional bodies. *Clin Med* 2006;6:13–5.
6 Saunders J. Institutional ethics committees: lessons from the Royal College of Physicians? *Clin Ethics* 2008;3:46–9.

Harveian Oration 2008

Editor – Sir Michael Rawlins' fascinating review of decision making in the use or approval of therapeutic interventions (*Clin Med* December 2008 pp 579–88) mentions the belief that the results of the GREAT trial of GP home thrombolysis were 'too good to be true'. Oddly, suspicions of biological implausibity are employed most often by statisticians, rather than doctors, to discount statistical hypotheses. Here, a delay of one or two hours immediately after an infarct could easily halve the benefit of thrombolysis, as was in fact observed in the study. To explain this away, an entirely imaginary prior scenario was introduced to 'pull back' the results to a more acceptable range. This example discredits rather than supports the use of Bayesian analysis. It reminds one of the bad old days when 'We set out to prove (or disprove)…' was tolerated as a preamble to a paper.

GH HALL
Retired Physician, Exeter

In response

The phrases 'pulled back' and 'too good to be true' were deliberately put in quotes and taken from the reference. They are therefore Stuart Pocock's and David Spiegelhalter's own words. David Spiegelhalter, the doyen of Bayesian statistics, has often used this himself, as an example of the 'appropriate' use of Bayesian statistics. Hence my use in the Oration!

MICHAEL RAWLINS
Chair, National Institute for Health and Clinical Excellence

The patient–doctor partnership

Editor – It was very interesting to read Dame Margaret Turner-Warwick's excellent paper (*Clin Med* December 2008 pp 573–5). She is absolutely right that the patient–doctor partnership 'should be the cornerstone in any healthcare service'.

Having practised as a clinical haematologist for 30 years, I realised that getting the partnership between myself and my patients right was by far the most important priority in my professional life. If the doctor is really at pains to see that the partnership is working, then everything else falls into place, and the patient receives the best care available. If the partnership is working, the doctor will see to it that their colleagues at every level are people the patients feel they can trust, and the patients are usually grateful whatever the clinical outcome. Furthermore, when mistakes are made, as unfortunately they are even in the best-run institutions, the patient is far more likely to be accepting and understanding than litigious and belligerent. The fact that nowadays patients are so much better informed enhances, rather than detracts from, the partnership.

I was fortunate to work in a specialty where many of the patients had medically (as opposed to surgically) the most treatable malignancies, but the above considerations apply equally to patients with non-malignant diseases. The patient–doctor partnership is of infinitely greater importance than, for example, the type of building we practise in, new or old, polyclinic or hospital. Dame Margaret's 'solution' in her final paragraph is entirely correct – the sooner changes can be brought about to achieve this, the better. If these issues were addressed, morale would improve automatically and many of the current problems would be solved.

TONY ROQUES
Retired Consultant Haematologist
Worthing Hospital

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.

The use of aspirin and dipyridamole in the treatment of acute ischaemic stroke/transient ischaemic attack: an audit-based discussion

The National Institute for Health and Clinical Excellence (NICE) recommends combination therapy (low dose aspirin plus modified-release dipyridamole) for all ischaemic strokes and transient ischaemic attacks (TIAs), for secondary prevention. Combination therapy is recommended for two years and thereafter low dose aspirin alone.[1]

The first such audit at Withybush General Hospital in Haverfordwest was carried out in 2007 and was published as a clinical letter in this journal.[2] The practice has since been re-audited.

In the re-audit, 108 inpatients were included and data were collected on a proforma.

Eighty-nine patients (82%) presented with a first episode and 19 (18%) with recurrence. Of the 89 patients, 47 (53%) were prescribed the combination therapy and 20 (22.5%) were given aspirin only. Twelve were on warfarin, three on aspirin + warfarin, four on aspirin + clopidogrel and two on clopidogrel only. In the 2007 audit, 12% had combination therapy and 71% aspirin alone.

In the recurrent disease group, seven (37%) were on combination therapy compared to 16 (62%) in 2007 while four (21%) were on aspirin alone. Six patients were on warfarin, one on aspirin + warfarin and one on aspirin + clopidogrel.

Only three out of 54 patients on combi-