LETTERS

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ASSISTED DYING BILL

Why *The BMJ* should not declare a stance on assisted dying

Assisted dying is a topical, contentious, and heavily debated subject and I am surprised that a respected and peer reviewed journal has declared its stance on the basis of the (current) editors' opinions.[1]

This creates a future publication bias for *The BMJ* because authors of further non-commissioned articles against assisted dying are less likely to submit to *The BMJ* for peer review. How will this affect the journal's credibility as an independent and peer reviewed publication, and will the journal continue to declare an outright stance on further controversial subjects?

I also wasn't clear who was expressing the opinion here. The editorial said, "*The BMJ* hopes that this bill will eventually become law," but who did this cover—the current editors, the full editorial board, its readership, or just a straw poll around the publication office?

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Competing interests: None declared.

1 Delamothe T, Snow R, Godlee F. Why the Assisted Dying Bill should become law in England and Wales. *BMJ* 2014;349:g4349. (2 July.)

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Editors' reply

From time to time, *The BMJ* declares its outright opinion on topical, contentious, and heavily debated areas, and under its current editorship this is unlikely to change. Examples include our support for the rights of Northern Irish women to abortion,[1] and our opposition to the Health and Social Care Bill.[2]

While we respect their choice, it would nevertheless be a shame if some authors were less likely to submit articles that oppose assisted dying to *The BMJ*. The debate is far from over, and we would like it to be reflected in our pages.

To that end, in the run up to the second reading of the Assisted Dying Bill in the House of Lords, we published a critical Observation from Rob George,[3] and in response to our editorial, Margaret McCartney used her weekly column to argue that "*The BMJ* is wrong: doctor assisted dying would overmedicalise death."[4] Less than a month before the Lords debate, Ilora Finlay, vocal opponent of assisted dying, was the subject of a BMJ Confidential article.[5]

We hope that this provides sufficient reassurance that the journal hasn't closed its mind to opposing points of view.

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Rosamund Snow patient editor
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Competing interests: We are the authors of the editorial that Dr Harris objects to. For the past five years, TD has been publicly declaring his support for a legal option for terminally ill adults of sound mind who want to die.

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4 McCartney M. *The BMJ* is wrong: doctor assisted dying would overmedicalise death. *BMJ* 2014;349:g4502. (8 July.)
5 Ilora Finlay: Hooked on Candy Crush. *BMJ* 2014:348:g3956. (18 June.)

Cite this as: ***BMJ* 2014;349:g4949**

ANNABEL WRIGHT/HEART

No man is an island

Delamothe and colleagues' recent editorial on why the Assisted Dying Bill should become law in England and Wales claims that autonomy is the cardinal principle of medical ethics that justifies the legalisation of assisted dying.[1] However, autonomy is a relational concept that involves people considering the effect of their choices on the autonomy of others. As Donne stated, "no man is an island"—our autonomy is defined in our relationships with other people.[2]

The choice for assisted dying must involve many others including family, doctors, nurses, pharmacists, and other vulnerable patients. Respect for autonomy has to be balanced against other ethical principles, such as the duty of beneficence and the primacy of not causing harm and of being fair to others. The "four principle approach" is only one of many ways of looking at ethical dilemmas. Virtue ethics considers what the good doctor would choose to do. Currently, doctors are in no doubt of the absolute prohibition on helping to hasten a patient's death. Intuition ethics accounts for the "gut feeling" that most doctors have that they should not be involved in hastening a patient's death.

The editorial takes no account of the reality and complexity of end of life care at the bedside.[3] It is naive to assume that it is straightforward to assess mental capacity in a dying patient. Depression can be difficult to identify, and if the diagnosis is missed all "safeguards" disappear.[4] In 2013, of the 71 patients who committed suicide under the Death with Dignity Act in Oregon, only two were referred for formal psychological or psychiatric assessment.[5] The prescribing doctor was present at the death in only 11.4% of the patients who committed suicide—a lonely choice indeed.[5]

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Competing interests: I am a patron of Living and Dying Well.

Full response at: www.bmj.com/content/349/bmj.g4349/rr/759945.

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Assisting suicide goes against why most of us became doctors

In their editorial on why the Assisted Dying Bill should become law in England and Wales Delamothe and colleagues put aside concerns about the difficulty in forecasting the end of life by citing a study which found that doctors often overestimate prognosis.[1] Yet they fail to highlight that this study looked at prognosis only in those with advanced cancer, not those with incurable chronic illness. Many studies show how difficult it is to forecast end of life—establishing a six month prognosis is fraught with error.[2 3]

What exactly is the capacity to decide to end one's own life? When doctors assess capacity, it is to protect patients from harm, not facilitate their suicide. Proper assessment of capacity is complex. Capacity can fluctuate rapidly and is often impaired in those who are seriously ill. What is a "clear and settled intention?" I have seen many patients change their minds about care preferences as they approach the end of life. And how can a doctor be sure a patient has not been influenced or coerced? In today's economic climate, patients already worry about being a burden,[4] and most doctors know little about the presence of coercion in patients' personal lives.

Doctors will be expected to provide assisted suicide. Yet most doctors don't want anything to do with it. Despite the clause on conscientious objection, it will be impossible for doctors to be free of involvement. I can see why Lord Falconer wants to embed his ideas in the highly respected and trusted profession of medicine, but there is a serious question over whether assisting suicide is a proper part of clinical practice. It goes against why most of us became doctors.

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Full response at: www.bmj.com/content/349/bmj.g4349/rr/759865.

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Data to support assisted dying

The editors of *The BMJ* have taken an important stand in the assisted death debate in the UK.[1] In Canada, we are also coming to terms with this issue. Quebec province has legalised it, and our supreme court is set to hear a case that could strike down the federal laws that prohibit it.[2]

In Canada, about 80% of the public supports the legalisation of assisted death. Twenty years ago, our supreme court upheld the ban by only a 5-4 vote, mainly because of concerns about risks to the vulnerable. Since then, reassuring data from the Netherlands suggest that involuntary euthanasia became less common after assisted death was legalised, and data from Switzerland and the US show that vulnerable populations are less likely to receive assisted death than the general population.

Palliative care physicians worry that the demand for assisted death is the result of poor palliative care or that legalising assisted death might erode palliative care services. Again, the data are reassuring. In the US, the three states that have legalised assisted death are in the top eight in terms of availability of palliative care,[4] and Oregon is a leader in opioid prescriptions and hospice referral rates.[5] In the Netherlands, palliative care received a dramatic increase in funding after assisted death was legalised.[6] Clearly, improving palliative care will not remove the need to legalise assisted death and legalisation need not harm palliative care.

As you eloquently stated, it is right to legalise assisted death and most people want it. Doctors everywhere need to listen to our patients and realise that our fears for the vulnerable and for palliative care have not materialised. If we have any claim to being patient advocates or scientists, we must support the legalisation of assisted death.

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Competing interests: All three authors are members of the Advisory Council of Physicians for Dying with Dignity, which advocates for improved end of life care, including legalisation of assisted death.

Full response with references at: www.bmj.com/content/349/bmj.g4349/rr/760260.

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WHO IS PAYING YOUR DOCTOR?

Eliminate gifts and benefits that lead to conflicts of interest

More public information on which doctors benefit from drug industry sponsorship and consultancy fees seems unlikely to deal with the problem of conflict of interest.[1]

Prominent practice guidelines like those on venous thromboembolism from the American College of Chest Physicians are still written by those declaring relevant conflicts of interest. The authors just stare down any implicit or explicit criticism of this problem, and pharma keeps paying the next generation of authors.

So how can patients use knowledge of their doctor's conflicts of interest to make up their own minds? There's not much research to provide an answer, but one experimental study found that people given such disclosures made poorer judgments than those not given them.[2]

So, trying to account for the effect of the conflict of interest is probably a waste of time. Patients could completely disregard everything the doctor says on the topic, but that won't work unless they choose another doctor. So what we're left with is little different from not knowing at all.

A reason disclosures are becoming more prevalent is that they offer little threat to pharma, or the industry would be trying harder to get around them.

The best approach might be to concentrate our efforts on eliminating the gifts and benefits that lead to conflicts of interest.

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Competing interests: None declared.

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Eradicate commercial interests from official medical education

Dyer describes international initiatives to promote public disclosure of payments from industry to doctors, thereby enabling patients to tell whether their treatment might be influenced by commercial interests.[1] Coombes suggests that messages from key opinion leaders paid by drug companies to advise on marketing strategies, present at conferences, or write in medical journals may be biased.[2]

It is important to uncover these links between industry and individual doctors, but the problem is broader and other stakeholders play a role. These include academic institutions that obtain industry funding, medical journals that gain from advertising and selling of reprints, patient organisations that receive support from drug companies,[3] and scientific societies that depend on industry for organising their meetings. In such a globally distorted system, patients may be unable to orientate themselves despite individual disclosures. Because connivance is so pervasive, disclosure should not remain a stand alone measure, otherwise its effect on bias mitigation would be uncertain.[4]

Our ultimate goal should be the eradication of commercial interests from official medical education.[5] Scientific societies, editorial boards, and conference organising committees should be free of conflicting interests. Improvement in quality of information would more than compensate for a likely reduction in quantity. Medical schools should select tutors, lecturers, and professors with no competing interests. Classes on ethics and relations with industry should be an integral part of students' training. Primary prevention through educating younger generations of doctors according to the highest ethical standards could be the best way to combat influence and bias.

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Competing interests: None declared.

Full response at: www.bmj.com/content/349/bmj.g4601/rr/761036.

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Disclosure should strengthen governance at multiple points

When politicians are held to higher standards than doctors, tighter regulation of our conflicts of interest is surely overdue.[1] Progress has been slow because it has relied on self regulation—itself a conflict of interest. Moves by the drug industry are welcome, but the General Medical Council should recognise the need to target regulation across the drug industry-doctor-publishing complex.

Information on financial ties should not only be published on a central register but be actively used to strengthen governance. Appraisal of probity should specify disclosure of conflicts of interest and be a prerequisite for revalidation. The sums of money and the number of ties should be visible to patients at the point of care.

Mandatory disclosure is needed for all research outputs because academic regulation is weak and the for-profit publishing industry profits from the status quo. Journals do not rigorously enforce disclosure of interests and benefit from large reprint orders bought for promotional purposes, including guidelines statements.[2] Developed by key opinion leaders in special interest groups, these may be bulk purchased and distributed by drug companies, delivering profits for them, publishers, and societies, while concealing the financial links to the opinion leaders.

Self regulation allows professional corruption to fester, particularly when the financial sums involved may approach or exceed doctors' NHS salaries. Yet those with industry ties have long enjoyed less accountability under the GMC than under the Inland Revenue. The GMC should consider all options to strengthen governance and not underestimate the repercussions for medicine and public trust.

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Cite this as: *BMJ* **2014;349:g4975**

NUMBERS NEEDED TO TREAT FOR STATINS

Statins: numbers needed to treat and personal decision making

As a South Asian in Scotland I am at risk for coronary heart disease (CHD) according to the Scottish Health and Ethnicity Linkage Study.[1 2] Cardiologist friends and colleagues have advised statins. So I looked for numbers needed to treat (NNTs) to guide me, as called for by Tresidder,[3] and found them in a review by Enas.[4] These numbers have helped me make a difficult decision—as a medical professor of public health specialising in the prevention of cardiovascular disease and diabetes, especially in South Asian populations, I need to get it right for reputational reasons as well as health.

Enas derived his numbers using a 2013 Cochrane review. He reports an NNT of 167 for low risk (<1% annually) and 67 for intermediate risk (1-2%) people. He states that 1000 low risk people would need treatment for five years to prevent six major cardiovascular events. He notes the increased risk of type 2 diabetes and estimates that 10% of those treated would have myopathy (that the same occurs with placebo is irrelevant because I would not take placebo). Enas judged that the benefits of treatment in low risk people far outweigh the hazards and concluded that statins could curtail the epidemic of CHD among Indians.

My established cardiovascular risk factors are Indian background, family history of CHD, and age (61 years). The Q-risk calculator (www.qrisk.org/lifetime/index.php) estimates that I have a 13% risk over 10 years, ignoring family history, and 22% with it. Another 11 calculators gave variable results, and some calculated NNTs of 22-40. On reflection, I decided against taking statins at present.

Even with NNTs, medical qualifications, study of the subject, and advice from cardiologist friends I found the decision difficult. The values and beliefs of the medical profession will probably determine the public's decisions more than the evidence.

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Competing interests: None declared.

Full response at: www.bmj.com/content/348/bmj.g3458/rr/761453.

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WEIGHT LOSS SURGERY

The safety and transformative power of bariatric surgery

LIFE IN VIEW/SPL

Bariatric surgeons realise that the zeal for performing what we see as life transforming surgery is not shared outside the specialty. Non-surgeons often perceive such operations as "drastic" or "barbaric." *The BMJ*'s choice of a blood and guts photo of open abdominal surgery to accompany the news story on the National Institute for Health and Care Excellence's recommendation to increase access to gastric bypasses for type 2 diabetics was therefore unhelpful and served to reinforce a negative stereotype.[1]

Technical advances over the past 15 years mean that more than 99% of bariatric surgery in the UK is carried out using keyhole (laparoscopic) techniques, even in patients with a body mass index over 100. The enhanced recovery resulting from this seismic change in surgical practice has made even complex procedures, such as the gastric bypass, one of the safest forms of major elective gastrointestinal surgery, with a UK mortality of 0.2%,[2] less than that for laparoscopic cholecystectomy.[3 4]

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Competing interests: I am a practising bariatric surgeon and managing director of Phoenix Health, a sub-contractor to NHS bariatric surgery in north west England.

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