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CLIMATE CHANGE

Politicians must heed health effects of climate change

The report on climate change and health commissioned by University College London and the *Lancet* concludes: "Climate change is the biggest global health threat of the 21st century."¹ In this report, the authors emphasise not only the immediacy and gravity of this threat but also the directness: while the poorest in the world will be the first affected, none will be spared. The escalating carbon footprint of the developed world has led to the present situation, but the rapid impact on developing countries such as the encroaching deserts in Africa is the immediate price.

This is one reason why doctors must take a lead in speaking out. Another is that there are important co-benefits of tackling climate change for those with long term conditions in the developed world, such as those that come from more exercise with less use of cars and dietary change with reduced meat consumption. In December this year, world governments meet in Copenhagen, Denmark, to negotiate a new UN Framework Convention on Climate Change. There is a real danger that politicians will be indecisive, especially in such turbulent economic times as these. Should their response be weak, the results for international health could be catastrophic. Doctors are still seen as respected and independent, largely trusted by their patients and the societies in which they practise. As leaders of physicians across many countries, we call on doctors to demand that their politicians listen to the clear facts that have been identified in relation to climate change and act now to implement strategies that will benefit the health of communities worldwide.

This letter is published simultaneously in the *Lancet*.

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1 Mayor S. Climate change will have greatest health impact on poor, report warns. *BMJ* 2009;338:b2024. (19 May.)

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NHS organisations, let's all sign up to the 10:10 campaign



We have joined the 10:10 campaign to cut our carbon dioxide emissions by at least 10% during 2010.¹

The business reasons for joining are compelling:

- We must reduce our dependence on oil, with its fluctuating and increasing prices, if we are to deliver

- high quality care in the medium and long term
- Commitment to 10:10 is a positive investment in all our futures, benefiting staff morale, recruitment, and retention and increasing patients' engagement with their health service
- Legislation and regulation such as the UK government's carbon reduction commitment will increasingly penalise organisations that do not take bold steps to cut their emissions and become more environmentally sustainable
- Cutting energy costs is one way to increase the NHS's productivity and efficiency. The social reasons are equally compelling:
- With its responsibility to care for the health of the population, the NHS should reduce its contribution to climate change, "the biggest

global health threat of the 21st century"²

- If we are serious about tackling health inequalities we should be taking bolder action on climate change, which already hits the poorest hardest
- As the largest organisation in the UK, the largest employer in Europe, and one of the largest employers in the world, the NHS must demonstrate leadership at this critical time. If we can deliver a 10% cut in our emissions in 2010 so can other organisations worldwide.

The 10:10 campaign takes positive, exemplary, and inspiring action on climate change (www.1010uk.org, health@1010uk.org). Early commitment to 10:10 can influence the climate change talks in Copenhagen in December of this year and make urgent cuts in global emissions a reality. We urge you to join and be part of the solution, so that we can all reap the rewards of a low carbon health service.

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Competing interests: 10:10 Health is coordinated by the Campaign for Greener Healthcare.

1 In brief. *BMJ* 2009;338:b1214. (25 March.)

2 Mayor S. Climate change will have greatest health impact on poor, report warns. *BMJ* 2009;338:b2024. (19 May.)

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See also **EDITORIAL**, p 645, **FEATURE**, p 660, and **PERSONAL VIEW**, p 697

ASSISTED DYING DEBATE

A baroness replies

Delamothe is right about one thing: we should not equate disability with terminal illness.¹ Not all disabled people are terminally ill, though many terminally ill people are disabled by their illness. The vulnerability of disabled people to collateral harm from the legalisation of assisted dying depends on the impact of their illness, their degree of dependence on others, and the

beliefs of some that their lives are less worth living. Many disabled people are more vulnerable than most, as Delamothe seems to recognise, albeit somewhat grudgingly.

The strident campaign to legalise assisted suicide for the terminally ill is being built around someone who is disabled and chronically rather than terminally ill. Many disabled people are like this. Therefore it is not surprising that they are concerned about the underlying message: if you have a disabling and degenerative illness the way should be cleared for you to have assisted suicide.

One hopes that the supporters of an assisted dying law would see it as providing a narrowly defined facility to be exercised under wholly exceptional circumstances. Simply limiting it to “terminally ill adults of sound mind who want to die” is not nearly sufficient to meet this requirement.

I argued in the *Lancet* article that Delamothe cites that if assisted dying is being justified on grounds of personal choice and control rather than unrelievable suffering, it has effectively lost its link with terminal illness and is therefore more open to drift to encompass people who are not terminally ill. Delamothe underestimates the pressures that a change in the law would place on disabled people.

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Competing interests: IGF wrote one of the papers commented on.

1 Delamothe T. Assisted dying: what's disability got to do with it? *BMJ* 2009;339:b3446. (26 August.)

Cite this as: *BMJ* 2009;339:b3762

Doctors' attitudes surveyed

Delamothe argues that it is “time for a carefully worded secret ballot” of UK doctors, having reported that 79% of the general public in a Harris poll believe in a “right to die” for the terminally ill.¹

The need to clarify medical views on this subject was the motivation for my recently published survey of a large representative sample of UK doctors.² I used the same questions as those used in surveys of the general public in British social attitudes surveys, which, like the Harris poll, have shown substantial public support for the legalisation of assisted dying.

The survey showed that the majority of UK doctors are opposed to the legalisation of euthanasia or physician assisted dying, whether in cases of terminal illness or not. There are some variations between different groups of doctors, the most significant being whether a doctor is religious. Doctors specialising in palliative medicine are the most opposed, with doctors

specialising in care of the elderly being the next most opposed.

These findings are consistent with studies comparing medical and public opinion in several other countries.

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Competing interests: None declared.

- 1 Delamothe T. Assisted dying: what's disability got to do with it? *BMJ* 2009;339:b3446. (26 August.)
- 2 Seale C. Legalisation of euthanasia or physician-assisted suicide: survey of doctors' attitudes. *Palliat Med* 2009;23:205-12.

Cite this as: *BMJ* 2009;339:b3761



JOHN STILLWELL/JPA

Life is a terminal condition

Lord Carlile's views are well known,^{1,2} but many can envisage differing thresholds and circumstances that are worse than death and not restricted to terminal illness. Since life itself is a terminal condition, there is a refreshing sense of realism in the possibility under Swiss law of assisted suicide in cases of unbearable suffering that is not the result of a terminal illness.

The attack on the World Trade Centre evidently led to some people committing suicide by leaping from the windows rather than suffer prolonged injury and death from the fire. Following these terrible circumstances, some people with religious convictions found comfort in knowing that the death of a relative had arisen from the unfolding alternatives rather than a deliberate act of suicide.³ In the current and different context should one be constrained to the alternatives for the religious reasons of others, or by the concerns of those who would not commit suicide given similar disabilities whether terminal or not?

Traditionally a doctor's prime responsibility has been towards an individual patient, while not entirely neglecting wider considerations. Surely this should have resonance in how society responds, particularly when that patient, having reached a personal threshold, is seeking control over what remains of life and the departure from life.

The risk of exploitation is given prominence by those opposed to changes in the law, but these views seem to be detached from the everyday clinical reality of cases that are likely to occur.

If approached carefully and with consultation with other professionals and relatives these cases could be dealt with sensitively and appropriately—and more safely.

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Competing interests: MB is a subscriber to Dignity in Dying.

- 1 Carlile A. The law as it stands on assisted suicide could not be clearer. *BMJ* 2009;339:b3169. (5 August.)
- 2 Lord Carlile of Berriew. Getting away with murder. *BMA News* 2006 December 9.
- 3 Channel 4. *The falling man*. 16 March 2006.

Cite this as: *BMJ* 2009;339:b3682

Doctors, steer entirely clear

Cumberlege urges doctors to steer clear of assisted suicide and preserve their place in society as a profession with a clear purpose: to treat, cure, and care for sick and disabled people (to which I would add “and improve the health of the population”).¹

If this is the right position for the medical profession, surely it also follows that since this position is based on professional self interest, society and the media should pay no attention whatsoever to our views on assisted suicide.

The medical profession would do well not just to steer clear of assisted suicide but to make it clear that it is not for us to influence the opinion of society at large.

If assisted suicide were ever to become legal then the position of the medical profession should be to have nothing to do with it. Yet that does not mean that society cannot press ahead and find another professional group to help with implementation.

Let us not just steer clear. Let's steer entirely clear, routinely stating that this subject is very clearly outside our remit.

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Competing interests: None declared.

- 1 Cumberlege J. Doctors, steer clear. *BMJ* 2009;339:b3422. (5 September.)

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END OF LIFE DECISIONS

Authors respond to editorial

In the editorial accompanying our study, Byock says that we focus on practices that rarely occur at the end of life, such as euthanasia and physician assisted suicide, and pay little attention to more common decisions.^{1,2} However, detailed empirical reporting is necessary because of the intense societal, legal, and ethical debates about these decisions. Additionally, although some decisions such as life ending drug use without explicit patient request and palliative sedation are not common in palliative care overall, they are more common than outside palliative care.

The classification system we used has been validated and used extensively in international research.^{3,4} It distinguishes specifically between distinct actions and intentions, as described in detail in the methods section.

“Principles do not depend on empirical data,”¹ but our study provides empirical data on a subject that has been dominated by emotional unproved arguments. Although many people believe that euthanasia requests follow a lack of access to palliative care and that delivery of palliative care will resolve any euthanasia request, our data showed that euthanasia or physician assisted suicide was not disproportionately chosen by patients not accessing palliative care. This is an important message for policy makers and palliative care associations and should be taken into account when discussing the future role of palliative care.

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Competing interests: None declared.

- 1 Byock I. End of life decisions and quality of care before death. *BMJ* 2009;339:b2730. (30 July.)
- 2 Van den Block L, Deschepper R, Bilsen J, Bossuyt N, Van Casteren V, Deliens L. Euthanasia and other end of life decisions and care provided in final three months of life: nationwide retrospective study in Belgium. *BMJ* 2009;339:b2772. (30 July.)
- 3 Van der Heide A, Deliens L, Faisst K, Nilstun T, Norup M, Paci E, et al. End-of-life decision-making in six European countries: descriptive study. *Lancet* 2003;362:345-50.
- 4 Van der Maas PJ, van der Wal G, Haverkate I, de Graaff CL, Kester JG, Onwuteaka-Philipsen BD, et al. Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990-1995. *N Engl J Med* 1996;335:1699-705.

Cite this as: *BMJ* 2009;339:b3687

Doctors can be trusted

Van den Block and colleagues' survey in Belgium found that high use of palliative care is associated with more medical decisions to hasten death.¹ This may be because the quality of palliative care is insufficient or because palliative care is limited in addressing suffering at the end of life.



JOANNE CIBRENI/PHOTOFUSION/ALAMY

Byock states that proponents of legalising euthanasia and physician assisted suicide and right to life advocates share “a deep distrust of doctors and the institutions in which they practice.”² This claim cannot be universally upheld. The system that legally allows physician assistance in dying in the Netherlands is rightly based on trust in doctors, as proved by the regular monitoring of their actions.^{3,4}

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- 1 Van den Block L, Deschepper R, Bilsen J, Bossuyt N, Van Casteren V, Deliens L. Euthanasia and other end-of-life decisions and care provided in the last three months of life: nationwide retrospective study in Belgium. *BMJ* 2009;339:b2772. (30 July.)
- 2 Byock I. End of life decisions and quality of care before death. *BMJ* 2009;339:b2730. (30 July.)
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- 4 Regionale toetsingscommissies euthanasie. Jaarverslag 2008. [Annual report 2008 of the euthanasia review committees.]

Cite this as: *BMJ* 2009;339:b3685

Counting end of life decisions

In the editorial accompanying the report from Van den Block and colleagues, Byock points out that only 22 cases of euthanasia or physician assisted suicide occurred (1.3% of all 1690 non-sudden deaths).^{1,2} But if the 26 cases of “life ending without a patient request” are included (unfortunately translated as “involuntary euthanasia” in early Dutch reports of studies using this questionnaire³) the proportion of cases of assisted dying rises to 2.8%. All of these end of life decisions entail doctors saying yes when asked, “Was death caused by the use of a drug prescribed, supplied, or administered by you or a colleague with the explicit intention of hastening the end of life (or of enabling the patient to end his or her own life)?”

In the United Kingdom, use of the same questions with a nationally representative sample of doctors reporting on 2869 deaths (including sudden deaths) has produced figures of 0.21% for euthanasia, 0.00% for physician assisted suicide, and 0.30% for life ending without a patient request.⁴ An earlier survey using these questions, of 629 deaths in the UK in 2004, produced figures (excluding sudden deaths) of 0.17%, 0.00%, and 0.36%.⁵

Van den Block and colleagues also report the proportions of deaths in which actions were taken that entailed either an expectation or a partial intention that these would contribute to a hastened death. The wordings of the questions that produce these statistics are

controversial, and reworded questions have produced lower estimates.⁴

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- 1 Byock I. End of life decisions and quality of care before death. *BMJ* 2009;339:b2730. (30 July.)
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Cite this as: *BMJ* 2009;339:b3690

OSTEOARTHRITIS OF THE KNEE

Precise diagnosis and treatment

The more knees wear out the more they hurt—this is the message from a clinical epidemiology group in Boston.¹ But that is not the whole story. The radiographic paper published by the same group last year shows that this progressive wear remains confined to the single compartment initially affected.²

By calling the condition osteoarthritis of the knee, the authors continue a sophistry that suggests that the knee is an organ like the pancreas, where inflammation is the key process, and total excision the final solution. However, treating unicompartamental wear by unicompartamental knee replacement effectively restores function and prevents disease progression over decades.^{3,4} Partial replacement, whether of the medial or lateral tibiofemoral joint or of the patellofemoral joint, is not only more functional but also much more cost effective than total knee replacement driven by a diagnosis of osteoarthritis of the knee. It could save the NHS over £50m a year.⁵

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Competing interests: None declared.

- 1 Neogi T, Felson D, Niu J, Nevitt M, Lewis CE, Aliabadi P, et al. Association between radiographic features of knee osteoarthritis and pain: results from two cohort studies. *BMJ* 2009;339:b2844. (21 August.)
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Cite this as: *BMJ* 2009;339:b3747

HERPES ZOSTER OPHTHALMICUS

Don't forget HIV

Lam and colleagues did not mention possible HIV infection in their 10-minute consultation on herpes zoster ophthalmicus.¹ Herpes zoster may occur at any stage of HIV infection and be its first clinical presentation. In one study it was significantly higher among HIV positive men than HIV negative men (29.4 v 2.0 per 1000 person years),² and the risk of developing herpes zoster was not associated with duration of HIV infection or rapid progression to AIDS.

HIV infection should always be considered in patients under 65 with herpes zoster. Awareness of herpes zoster in HIV may help to reduce the incidence of people presenting late with HIV infection (M Sethupathi et al, BASHH-ASTDA conference, New York, May 2008).

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Competing interests: None declared.

- 1 Lam FC, Law A, Wykes W. Herpes zoster ophthalmicus. *BMJ* 2009;339:b2624. (13 August.)
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Cite this as: *BMJ* 2009;339:b3621

A/H1N1 FLU PANDEMIC

Roche responds

The use of oseltamivir (Tamiflu) in children and the development of resistance from widespread usage have been much debated.¹

Antiviral treatments are currently the only available therapeutic option to prevent and treat infection with the A/H1N1 flu virus. The product summary for oseltamivir shows that it is effective and well tolerated in children.

The European Medicines Agency approves oseltamivir to treat and prevent flu in those aged 1 year and over on the basis of a positive benefit and risk assessment. The product summary shows that in otherwise healthy children (under 12s) who had fever with either cough or coryza, treatment started within 48 hours of the onset of symptoms significantly reduces the time to alleviation of illness by 1.5 days compared with placebo. The incidence of acute otitis media was reduced from 26.5% in the placebo group to 16% in the oseltamivir group. In a group of asthmatic children, the median duration of illness was not reduced significantly in those treated with oseltamivir, although by day 6 of treatment forced expiratory volume had increased by 10.8% in the oseltamivir group compared with 4.7% in the placebo group.

Ongoing testing shows that the currently circulating pandemic virus remains susceptible

to oseltamivir.²⁻⁴ Roche takes the issue of resistance seriously and is monitoring the situation in collaboration with established surveillance groups from around the world. Data on file at Roche show resistance to oseltamivir in 13 isolated cases. This is in the context of testing for resistance in more than 2000 virus isolates from 119 countries and 180 clinical specimens from the United States.⁵

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Competing interests: Roche manufactures Tamiflu.

- 1 Godlee F. Pandemic flu: will there be a second wave? *BMJ* 2009;339:b3394. (20 August.)
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Cite this as: *BMJ* 2009;339:b3758

Should flu have at least one respiratory symptom?

The algorithms for A/H1N1 flu currently used by the UK population do not seem to need any respiratory symptoms.¹ Although information on various symptoms in proved A/H1N1 flu is lacking, the total absence of cough, coryza, or sore throat implies that an alternative diagnosis is worth considering, and the protocol should be modified to redirect patients to a clinician. We have seen proved gastrointestinal infection treated as A/H1N1 flu.

The automatic assumption that children with symptoms that could arise from any infection should be treated without clinical assessment is worrying. All children deserve a conversation with a clinician.

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Competing interests: None declared.

- 1 Bourke TW, Shields MD. Misdiagnosis in the time of meningitis. *BMJ* 2009;339:b3423. (25 August.)

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MESOTHELIOMA PATIENT JOURNEY

Researching the small things that matter

Two general practitioner academics who spent their professional lives researching the patient experience are facing terminal illness.^{1,2} Sweeney's comment that "the more junior ranks of ancillary health



professionals are simply unable to conceal the pleasure of the deployment of their authority" deserves to be systematically researched.

Managing serious illness requires collaboration between multiple professionals and, importantly, non-professionals.³ Seemingly small things—an ill-chosen phrase, lack of eye contact, a gaping hospital gown, and miscommunication about the diagnosis—came together to erode Sweeney's sense of dignity and his trust in the wider system of care.¹

We should revisit the work of Garfinkel to develop a research agenda into the small things that matter.⁴ Much research on organisational work focuses on standard operating procedures. Garfinkel, in contrast, argued that work is irreducibly situated and contingent; medical work is characterised by a high degree of exceptionality; and the key research question is how, from moment to moment, staff attend to subtle cues from the patient, other staff, and the medical record, and adapt their actions and utterances accordingly.

My team showed that low status general practice staff such as receptionists have enormous power to shape organisational routines to provide interpreters for people with limited English.⁵ The difference between a good and disastrous patient experience was linked to such things as identity, mindfulness, and autonomy in the most junior members of the organisation. The agenda raised by our dying colleagues demands more theory driven research studies into how frontline administrative and ancillary work supports, or undermines, the high ideals of patient centred medicine.

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Competing interests: None declared.

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