patients? Would another church support a member who withheld lifesaving treatment from a Jehovah's Witness? This was not a balanced treatment of an issue clearly introduced in the journal as an ethical dilemma.

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1 Finfer S, Howell S, Miller J, Willett K, Wilson-MacDonald J, Wilson DH, *et al.* Managing patients who refuse blood transfusions: an ethical dilemma. *BMJ* 1994;308:1423-6. (28 May.)

****When we ask people to comment on a case we try to select a range of relevant people—in this case an ethical expert, a lawyer, and a Jehovah's Witness—but we do not seek to know in advance what line they will take. We think that it is right to try to seek opinions from a range of disciplines and specialties but wrong to expect people to follow a particular line. The letters columns are open to those who want to take a different view.—ED, *BMJ***

Use of resources needs to be addressed

EDITOR,—Simon Finfer and colleagues' article and the accompanying responses seem to raise two distinct issues, which in my view should be kept separate: the wishes of the patient (and issues concerning consent) and the "moral" issue of use of resources. The only respondent who seems to have tackled the issue of use of resources is Michael A Jones; doctors need to consider this increasingly relevant question in the world of the internal market.

Had Finfer and colleagues' other patients been denied the use of resources required by the authors' first (surviving) patient, and had one of those patients or his or her representative chosen to sue for lack of adequate care, it would, presumably, in the first instance, be the health authority or trust, not Finfer and colleagues. It is interesting to conjecture how a trust might have chosen to respond. It could have argued that it was up to the medical staff to dispose of clinical resources more efficiently and thereby have implied that responsibility rested with its employees (as Jones, in his final paragraph, also seems to suggest the courts may imply). It could have accepted full responsibility for the lack of resources. Or it could have argued that the contract it held with its local purchaser was cash limited and that some responsibility lay with the purchaser or its contracts managers for not having built in sufficient flexibility to allow for this kind of situation. The purchaser could, of course, in turn argue that responsibility lay with central government for having cash limited its budget.

There are doubtless many other alternatives, but I am left wondering who does bear the moral responsibility so readily and bravely shouldered by Finfer and colleagues.

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Chemotherapy for haematological malignancies can be fatal

EDITOR,—Those of us who treat haematological malignancies are sometimes faced with equivalent dilemmas to that discussed by Simon Finfer and colleagues, although the time scale is different from that in acute trauma.¹ A few years ago I

attempted chemotherapy in a 19 year old woman who was a practising Jehovah's Witness. The implications of chemotherapy without the support of blood and blood products were fully discussed with her and her family. All remained steadfast in their refusal to accept any form of red cell transfusion. The patient received chemotherapy but, almost inevitably, died.

Managing such a patient proved difficult for all the staff concerned with the case. Nevertheless, the beliefs of the patient and her family were respected. It was therefore some comfort to the staff that the family wrote to the unit specifically to thank the staff for the way in which they had handled the difficult situation. The letter clearly gave the impression that the family had come to terms with the death in their own way, doubtless sustained by their faith.

Experience of this case leads me to agree strongly with the view expressed by David H Wilson²: that we must continue to inform such patients adequately about the consequences of their refusal to accept blood transfusion, but, equally, that we must respect their right to refuse this supportive treatment even if the consequence is likely to mean their death. In certain respects the death of this young Jehovah's Witness with malignant disease ultimately proved easier for staff to cope with than the deaths of other young patients with leukaemia in families with no particular religious or other faith enabling them to prepare for or accept death.

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Register of willing consultants is needed

EDITOR,—We agree with Simon Finfer that every hospital should maintain a list of consultants who are prepared to treat Jehovah's Witnesses.¹ These data could easily be collated with regional and national registers. The royal colleges might wish to have a role. Our recent experience of managing a Jehovah's Witness who required elective radical surgery is relevant.

In September 1993 a 45 year old Jehovah's Witness was diagnosed as having invasive vulval carcinoma. The gynaecologist under whose care the vulval biopsy was carried out declined to carry out radical vulvectomy (the preferred mode of management) because the patient refused blood transfusion. Instead he offered alternative management of radiotherapy and chemotherapy followed by simple vulvectomy. The patient received two pulses of chemotherapy but declined to continue with the rest of the chemotherapy and radiotherapy. At this stage, three months after diagnosis, her general practitioner referred her to our hospital for consideration for surgery.

Precautions were taken to minimise the perioperative blood loss. Radical vulvectomy with bilateral inguinofemoral lymphadenectomy was carried out by a team consisting of two consultant gynaecologists and two assistants. A cell saver autologous blood recovery system (Haemonetics Leeds) which is an acceptable method of conserving the blood lost, was used.² With this system blood lost was suctioned from the surgical field, anticoagulant was added, and tissue, clots, and debris were filtered out. The washed packed red cells were finally suspended in saline ready for reinfusion. As her preoperative haemoglobin concentration was 136 g/l and the estimated blood loss at surgery was only 500 ml, replacement was not required. Her postoperative period was uneventful except for minor wound infection.

The above case highlights the need for such regional or national registers so that referral and appropriate management can be undertaken. Two preconditions need to be met before the advantages of such a register can be fully exploited. Firstly, every health care provider should be willing to take cognisance of the religious beliefs of Jehovah's Witnesses; and, secondly, if surgeons are unwilling to operate on Jehovah's Witnesses themselves they should facilitate their referral to a surgeon who has the appropriate facilities and is willing to do so.

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1 Finfer S. Managing patients who refuse blood transfusions: an ethical dilemma: Author's views. *BMJ* 1994;308:1425-6. (28 May.)

2 Knonagel H, Karmann U. Autologous blood transfusions in interventions of the pelvis using the cell saver. *Helv Chir Acta* 1992;59:485-8.

Treatment of oesophageal cancer

Prognosis is not uniformly bad

EDITOR,—We agree with Seamus O'Reilly and Arlene Forastiere that surgery remains the standard treatment for resectable oesophageal cancer, but we do not agree that the outlook in such cases is almost hopeless.¹ The review of Earlam and Cunha-Melo spanned two decades of all types of practice, and the latest paper in that review was published 16 years ago. This review is now of only historic interest and should not be quoted as a reflection of modern practice. Nor do we agree that most patients have metastases by the time they present. The paper quoted in support of this statement was a necropsy study, which would have been biased in that direction.

Last year we saw 102 new patients with oesophageal cancer in our unit. Sixty two were secondary referrals from consultants and 40 were primary referrals from family doctors. Eighty eight patients were explored with a view to potentially curative resection, of whom 65 underwent successful resection (74% of those explored and 64% of the total). Twelve patients were considered to be unsuitable for surgery and had intubation as a primary procedure. Mortality at 30 days was 5% (three patients). Of the 40 patients referred by family doctors, 31 were explored and 27 underwent resection (87% of those explored and 68% of the total); nine patients (23%) were unsuitable for surgery and underwent primary intubation (as opposed to three patients (5%) in the group referred by consultants). Overall five year survival after surgery alone carried out in specialised units averages from 36%² to 58%,³ with higher rates for stage I disease.

Chemotherapy in various combinations with radiotherapy and surgery has been used over the past 20-30 years. The results are conflicting and the benefits unproved, as O'Reilly and Forastiere indicate. We agree that properly set up randomised trials are important to provide answers over the next decade. Because of the high toxicity of the available drugs, however, one should not be too optimistic about the outcome of such trials.

The treatment of cancer generally is patchy in Britain. It is encouraging that the government has recognised this and is trying to do something about it. Cancer of the oesophagus, like any other cancer, should be treated in specialised centres, where the patient stands the best chance of a cure. The future must lie in the development of agents that kill the tumours but spare the rest of the patient. Until