may admit sympathy for the view that in severe and persistent depressive illness, when all appropriate physical treatments, including polypharmacy, electroconvulsive therapy, and psychosurgery,^{12,13} have apparently been exhausted, voluntary euthanasia may sometimes seem to be as justifiable an option as it does in intractable physical illness. This, however, is not necessarily to condone it for either.

The particular problem that is raised by "psychiatric euthanasia" is the dubious boundary between psychiatric illness and understandable unhappiness. Now that this judgment apparently accepts the precedent of assisted suicide for depressed patients as being morally justifiable if not actually lawful, it is difficult to imagine how the progression to a test case regarding psychic suffering in a person who is not mentally ill can be avoided.

However psychiatrists respond to this dilemma, campaigners against euthanasia will point, perhaps with good reason, to cases such as Chabot's as evidence that the slippery slope they feared already exists. It has long been argued that if euthanasia and assisted suicide become acceptable, as they now have in some countries, for "core cases"—people who are terminally ill with physical symptoms, especially pain, which cannot be relieved by other measures but who remain psychiatrically well and fully competent—then it may be impossible to restrict the scope of these new medical interventions.^{14,15} However well any legislation is hedged about with guidelines and protections against abuse, the slippery slope predicts an inevitable extension of these practices to other, more vulnerable, groups, such as those who are demented, mentally ill, chronically disabled, frail, dependent, and elderly—and perhaps even simply unhappy.

We hope that the implications of this judgment will be

carefully considered in the Netherlands, Britain, and elsewhere. Finally, we are left with a quotation from George Annas, professor of health law at Boston University: "If you're worried about the slippery slope, this case is as far down as you can get."⁴ We are not so sure.¹⁶

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Are H₂ receptor antagonists safe over the counter drugs?

Five years' experience in Denmark suggests that they are

Several factors are driving the move to make medicines that were previously obtainable only on prescription available over the counter from pharmacies.¹ One factor is the decline of paternalism and the consumerist belief that the populations of highly developed societies are educated enough to be able to treat themselves without the need to consult a doctor. Another is governments' interest in controlling expenditure on health care. A drug bought over the counter at a pharmacy not only saves the costs of any subventions given to prescribed drugs but also eliminates the cost of a consultation to obtain the prescription. Finally, the pharmaceutical industry also has an interest in increasing the sales of generic products and sees scope for doing so through advertising directed at patients who make their own decisions.² These forces may be irresistible. The question then becomes where to set the threshold to ensure an acceptable risk in relation to the benefits.

Danish experience may be instructive since the two H₂ receptor antagonists cimetidine and ranitidine became over the counter drugs (limited to pharmacies) more than five years ago. The decision was the result of a request from the government to the Licensing Committee for New Drugs, comparable to Britain's Committee on Safety of Medicines, to advise on major groups of medicines suitable

for transfer to over the counter sales. Among others, the committee proposed the anti-ulcer drugs in view of their low toxicity, their rare and relatively harmless adverse reactions, and their extensive use. The economic gains were expected to be reduced costs for the government, because general practitioners' income would be reduced, and increased spending on medicines by consumers.^{3,4}

The licensing committee added the condition that the safety consequences of this change should be monitored. Special research programmes were therefore set up to look for possible changes in the pattern, frequency, and seriousness of adverse drug reactions, in the need for admission to hospital because of complications of ulcer disease, and in the total use of the medicines.

Several problem areas were identified and examined, such as the risk of interactions with other drugs (particularly for cimetidine), the possible interaction with alcohol, and the possibility of mistreatment of other non-responsive gastrointestinal disorders. The greatest fear was of delayed diagnosis and treatment of gastric cancer. The risk of treating the early symptoms of gastric cancer exists with analgesics, antacids, and H₂ antagonists, but the failure of continued pain relief should prevent an extended delay in diagnosis and treatment. The over the counter prepara-

tions are labelled with a warning that patients should see a doctor if pain remains after four weeks. There is a further warning against the possible increase in blood alcohol concentration after drinking when cimetidine is taken at the same time, and there are instructions never to start self treatment if other medicines are being taken or when the person is aged over 65.

After five years' availability of cimetidine and ranitidine, over the counter monitoring of adverse drug reactions shows no reason to change the view that these drugs pose no major safety problems.^{4,5} There has also been no appreciable increase in consumption of the drugs, although a slight increase was seen intermittently in 1991, and the pattern of admissions to hospital for complications of ulcer disease has not changed.⁴

A major problem—particularly with gastro-oesophageal reflux disease—is that some patients may prefer medication and relief of symptoms to changing their lifestyle and avoiding provoking factors such as alcohol and cigarette smoking.^{4,6} This problem would not, however, be eliminated if the availability of these drugs was restricted to prescription only.

When over the counter status was recommended five years ago the therapeutic strategy for diseases related to gastric acid was somewhat different from that today. The proton pump inhibitors, which have now become more widely used, are still prescription only drugs, with an automatic subvention. We believe that only a small proportion (around 5%) of H₂ blockers are sold over the counter because the costs are subsidised when these drugs are prescribed by a doctor. In this way confounding factors make drawing conclusions more difficult.

Another important change is our knowledge of *Helicobacter pylori* as the cause of recurrent duodenal ulcers and of some gastric ulcers.⁷ The recommended strategy is now to treat these conditions with antibiotics in combination with proton pump inhibitors or H₂ blockers after diagnosis by endoscopy and tests for the presence of

Helicobacter. This approach flies in the face of symptomatic use of H₂ blockers.

The possible consequences of making H₂ antagonists available over the counter in the United States have been analysed in a model that used decision analysis; the conclusion was that the drugs could be a relatively safe and effective means of self treatment that might reduce the number of patients who seek professional care.⁸ In Britain cimetidine and famotidine were released from prescription control in January this year for short term (a maximum of two weeks) treatment of dyspepsia.⁹ This period is not sufficient to ensure healing of ulcers. In Denmark the duration of treatment for over the counter products is not limited and the full dose is recommended.

Our conclusion is that diseases related to gastric acid should ideally be diagnosed and treated by experts. But from a safety point of view it is still reasonable to keep the H₂ blocking agents available over the counter.

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Prescribing exercise in general practice

Look before you leap

Exercise is good for us, especially as we get older.^{1,2} People who are regularly active enjoy a lower risk of osteoporosis and a much reduced risk of coronary heart disease (the vigorously active have about half the risk of the inactive). Most people in Britain are not taking enough exercise to achieve these health benefits.^{3,4}

If primary health care teams could increase their practice populations' physical activity then many benefits might follow, including lower rates of cardiovascular disease, fewer fractured hips, reduced depression and anxiety, and improved functional ability in elderly people. Although this list makes promotion of healthy exercise look tempting, primary health care teams, and the policymakers who determine allocation of resources, should look carefully before they leap.

Very little is known about the effectiveness of exercise programmes and other initiatives designed to increase non-athletes' activity levels. The question of effectiveness should be answered by randomised controlled trials, although these are difficult to conduct in the community.⁵

After an extensive search we identified only 12 such trials,* none of them conducted in Britain, with few including those subjects with most to gain from increased exercise—middle aged and elderly people.

Moreover, the results of these trials are not particularly encouraging. The increase in activity is not great and, in so far as a sustained increase is observed, subjects seemed to prefer home based, self monitored exercise programmes rather than the programmes carried out at sports facilities that are currently popular "on prescription." In this discussion we should not forget that physical fitness and health status are interrelated but not synonymous, and improving fitness may not reduce the consequences of disease.⁶

Thus before investing time and resources in prescribing exercise general practitioners need to answer four questions. Can people who do not exercise be recruited to an exercise programme by their doctors? Does a short term

*Details of these trials are available from Margaret Thorogood.