to request or consent to it, and 162 already practised it.

Our survey showed that over half (218) of the doctors interviewed had withdrawn life sustaining treatments or practised active euthanasia, or both. This proportion is similar to the 53% of Dutch doctors who admitted in a recent study that they had taken active steps to end a patient's life.²

Although doctors in Argentina are known to practise different types of physician assisted death, this subject has rarely been explored and official data are lacking. We consider that there is an urgent need to open the debate in our community.

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- 1 Churchill LR, King NMP. Physician assisted suicide, euthanasia, or withdrawal of treatment. *BMJ* 1997;315:137-8. (19 July.)
- 2 Washington v Glucksberg, No 96-110 (US June 26, 1997).
- 3 Watt H. Killing and letting die. *Update* 1997;52:833.
- 4 Steinbock B. *Killing and letting die*. Englewood Cliff, NJ: Prentice-Hall, 1980.

Euphemisms must be avoided

EDITOR—To advance the discussion relating to euthanasia we need to stop using euphemisms such as "physician assisted suicide" and "withdrawal of treatment" as this simply clouds the fundamental moral arguments.¹ The key issue, as Chief Justice Rehnquist pointed out in the United States, is intent and outcome.² This is best demonstrated by exploring the case of a patient dying of lung cancer and acquiring pneumococcal pneumonia. There are three fundamental medical ways of "allowing" the patient to die: withholding penicillin; gradually increasing the dose of morphine for pain relief, which results in respiratory suppression; and giving a lethal injection of intravenous potassium. The first two options are commonly practised and are completely legal while the third is deemed to be murder. Philosophically speaking, the intent and the outcome in all three cases is the same—the hastening of the patient's death. The logical extension of this is that the three options are morally identical; only the method is different.³

When the intent is clearly agreed between the patient and the doctor, the methods become secondary in the debate.⁴ Using euphemisms simply appeases the antieuthanasia lobby and clouds the honest dialogue between the patient and the doctor. Such clouding of the dialogue happened in the past when euphemisms, such as "growths" or "lumps," were used to describe malignant cancers. The euphemisms simply resulted in misinformation and left patients unable to determine their own outcome. There is a risk of a similar situation developing if the medical and legal professions continue to use euphemisms relating to the method of death rather than explicitly discussing intent and outcome. From the patients' point of view the crucial time is

when they decide that they do not want to live any more and suffer the consequences of terminal illness. That is when the decision about the intent to die is made. The method, be it by morphine or intravenous potassium, is irrelevant. To get to the heart of the matter the doctor and the patient need an honest discussion about the validity of the intent rather than distortion of the issue by using euphemisms relating to the method.

Society needs to discuss this crucial point honestly and make a judgment about the validity of intent and apply safeguards in securing an acceptable notion of intent to prevent the "slippery slope."

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Epidemiological data can be gathered with world wide web

EDITOR—In their note, "Piloting patient attitudinal surveys on the web" Suchard et al rightly point out that the web is a powerful resource to use in developing surveys quickly and effectively.¹ But the power of the web goes far beyond that. Psychologists and sociologists are already using the web for surveys,² and there has also been a recent experiment to collect health status information for medical outcomes research with a web based questionnaire.³

The web may further become a new means of gathering data from patients for studies of quality of life and epidemiological research, as it allows questionnaires to reach a worldwide population of patients and healthy controls with a minimum of cost and time. Researchers may rapidly explore various hypotheses—for example, about relations between a disease and its symptoms, predisposing factors, patients' demographic data, and associations with other diseases.

In an experiment with a web based questionnaire about atopic eczema we are making use of the fact that dermatological patients, especially those with chronic diseases, are usually well informed about their disease and may therefore answer questions about their symptoms precisely. We developed a web based patient information system about atopic eczema to attract patients to our website and provide an electronic questionnaire to explore the relation between atopic stigmata and symptoms, demographic data, and environmental factors.⁴ As an incentive for filling in the questionnaire, an atopy score is calculated⁵ and presented to the user. Answers of all users are stored anonymously in our database for further analysis. At present, each month about 240 patients and healthy

web surfers as controls complete the questionnaire.

With Internet questionnaires one may obtain data from an entirely different population of patients to those seen in a clinical setting. For example, minimal variants of atopic eczema are not severe enough for patients to see their doctor, so patients taking part in a questionnaire study on the world wide web are different from the population seen at university hospitals. It will therefore be interesting to compare data obtained via the world wide web with published data obtained by traditional questionnaires.

Obviously, the web community is not a representative sample of the whole population, and results obtained with questionnaires on the web are biased towards self selection; thus they must be interpreted with care and verified in an unbiased population.

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Paper in *BMJ* influenced prescribing of minocycline

EDITOR—In January 1996, Gough et al reported the potential adverse effects of minocycline¹; an editorial in the same issue amplified the position.² Their paper highlighted the fact that minocycline is the most widely prescribed systemic antibiotic for acne, and one for which no resistance has yet been described. They noted, however, reports of 11 cases of systemic lupus erythematosus induced by minocycline and 16 cases of autoimmune hepatitis due to the drug. Seven further cases had also been reported. The editorial suggested that use of tetracycline or oxytetracycline was a safer and cheaper first line treatment, with minocycline being reserved for patients not responding to other tetracyclines.

We have examined national PACT (prescribing analysis and cost) data to see what, if any, effects resulted from this reporting. Up to March 1995, use of the drug (in terms of defined daily doses) had been increasing (figure). For the rest of 1995, use levelled off or showed a small decrease. In the quarter to March 1996, however, there was a marked drop to less than 70% of the previous quarter (and the spring quarter was previously

Trends in use of minocycline in United Kingdom, 1992-7

always the largest). Use in subsequent quarters fell further to 62% of the level before the paper was published. This lower level has now been maintained for 15 months. Since the quarter to June 1996 the use of oxytetracycline has increased slightly. This seems partially to replace the reduction in prescriptions of minocycline. The average length of treatment per prescription for minocycline remained at nearly 26 days.

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Experience of clinical risk management in obstetrics in Oxford

EDITOR—We agree with Charles Vincent that clinical risk management should be integrated with other quality assurance programmes and that its aim should be more ambitious than simply avoiding litigation.¹ Indeed, evidence that clinical risk management can reduce litigation is limited,² so continued justification for the approach may depend on its ability to improve patient safety.

We introduced a clinical risk management programme in obstetrics in Oxford in September 1994. The cornerstone of the programme was an early warning system for adverse events. Our definition of an adverse event was any unexpected event or outcome of pregnancy that has (or might have) a significant short or long term detrimental effect on either mother or infant. All clinical staff were encouraged to report such events to a perinatal risk coordinator, who was a

midwife. In addition, the perinatal risk coordinator screened the birth registers of delivery suites for possible adverse events.

Over one year 423 adverse events were identified, which is the equivalent of one for every 15 deliveries. Fourteen of the events were assessed as carrying some risk of litigation. In these cases, written statements were taken if appropriate from relevant clinical staff and the trust's solicitors were contacted at the discretion of the trust's legal department. Staff were encouraged to discuss what had happened with the family. A multidisciplinary clinical risk management group met every fortnight to review contemporary adverse events and make recommendations for clinical practice and service development. Between September 1994 and December 1996 six claims were made against the unit that related to obstetric care over these 28 months. Only three of these claims had been identified prospectively by the early warning system. However, the average time lag from incident to claim is five years, so further claims are likely to arise.³

Our initial experience is that an adverse event detection system is neither sensitive nor specific for possible medical negligence claims. The Harvard medical practice study reached similar conclusions.⁴ Thus, an early warning system for adverse events is likely to have only a limited impact on the direct costs of medical negligence litigation relating to such events since it will identify only some of those that will lead to claims. Clinical risk management may have only a limited impact on medical negligence litigation, but it might have potential in improving patient safety.¹ Formal evaluations of clinical risk management in this role should be performed.

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Compensation for victims of medical accidents

One particular case recently took five years to be settled

EDITOR—I am outraged that Harris thinks that victims of medical accidents should wait for their compensation after it has been agreed by their lawyers or decided by a court.¹ Most victims have already waited five to seven

years for the case either to come to court or be settled. It does not seem to have occurred to Harris that plaintiffs have already done more than their share of waiting.

I am one such plaintiff. In April 1992 I went into hospital for an elective endometrial resection. I awoke to find that I had had an "elective" (non-emergency) hysterectomy for benign disease and that my still-ovulating ovaries had been "prophylactically" removed to prevent the possibility of ovarian cancer. This was not something made necessary as a result of an accident or mishap but was a decision by the surgeon. I had no say in it. I was, and still am, distraught.

After a decision by the Crown Prosecution Service not to bring charges—a decision which, I might add, had a lot to do with witnesses being unwilling to "remember" my expressed aversion to hysterectomy or recall what had taken place in the operating theatre—I brought an action for negligence, and battery or trespass to the person, against the surgeon and the health authority. It took over five years for the case to be settled out of court, even though the defendants knew that I was dying of lymphoma. My career as a medical journalist suffered. I lived in straitened circumstances on borrowed money while the lawyers slugged it out in a desultory fashion.

Were I the defendants I hope I would have had the decency to admit having been at fault and pay up. This would have had the additional advantage of saving huge legal fees, unofficially estimated at £100 000, which were paid jointly by the Medical Defence Union and the NHS. As it is, if the NHS wants to save money it could stop doing expensive and unnecessary operations on people who don't want them, and stop paying expensive law firms huge sums of money to defend the indefensible.

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- 1 Harris J. The injustice of compensation for victims of medical accidents. *BMJ* 1997;314:1821-3. (21 June.)

Victims do not always take precedence

EDITOR—Harris correctly points out that it is not obvious why victims of medical accidents should always have first call on scarce resources made available for health care.¹ Certainly a case can be made in favour of integrating the consideration of victims into an overall assessment of priorities for the commitment of funds, in total and at the margin.

It is unlikely, however, that victims in general do always take precedence, although the courts or NHS organisations themselves may decide that some of them do sometimes; court awards are only a fraction of total NHS expenditure on negligence claims. It is also not obvious that any part of the NHS should always decide on the relative priorities, especially if an NHS defence against a claim of negligence has been unsuccessful in the courts.

The NHS Executive asked that providers take all possible steps to reduce claims for