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Our survey showed that over half (218) of the doctors interviewed had withdrawn life sustaining treatments or practised active euthanasia, or both.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 Van der Maas PJ, van der Wal G, Haverkate I, Carmen M, Kester JGC, Bregje D, 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.

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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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.

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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1 Suchard MA, Adamson S, Kennedy S. Netpoints: piloting patient attitudinal surveys on the web. *BMJ* 1997;315:529. (30 August.)

2 Batinic B. How to make an internet based survey. www.psychol.uni-giessen.de/~Batinic/survey/faq_sof.htm [accessed 26.9.97].

3 Bell DS, Kahn-CE Jr. Health status assessment via the world wide web. Proceedings of the American Medical Informatics Association annual fall symposium, Washington, DC. 1996:33-42.

4 www.derma.med.uni-erlangen.de/cgi-bin/atopiefrage/erster-e.asp

5 Diepgen TL, Sauerbrei W, Fartasch M. Development and validation of diagnostic scores for atopic dermatitis incorporating criteria of data quality and practical usefulness. *J Clin Epidemiol* 1996;49:1031-8.

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