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LETTERS



MARK THOMAS

CONTINUOUS DEEP SEDATION

Please, don't forget ethical responsibilities

A caveat to the assumption that terminal or palliative sedation can be accepted as the norm by healthcare professionals is that patients and their relatives should be contacted and their wishes, where possible, properly obtained.¹ This is not as straightforward as it sounds.

My own, previously well and robust, 92 year old father was admitted as a medical emergency with rectal haemorrhage. He had moved to live in a rest home three weeks earlier because of deteriorating health of uncertain cause, having spent all of his life living independently and in robust health (and fully lucid). On admission his haemoglobin was about 60 g/l, and initial resuscitation, blood transfusion, was successful. However, an urgent abdominal computed tomography scan showed a locally invading colonic carcinoma at the splenic flexure—with little chance he might survive surgery or, at least, long after it, and terminal sedation was decided on. Neither he (I later discovered) nor any of his close family was consulted before such a decision, and treatment was implemented immediately. My brother and I, his only first degree relatives, were both overseas and returned to the United Kingdom to be with him. My brother arrived the next day only to discover he was deeply unconscious. He lived three days in total until two hours after I arrived at the hospital. At this point he was warm, well perfused with a good cardiovascular output—so hardly haemorrhaging to death. After a 36 hour shuttle across the world having learnt he was sitting up, chatting, and vowing to recover (admittedly pre-diagnosis), to find him close to death was a little distressing. No drip, heavy sedation increasingly infused. Protocol

successful; patient died quietly with his family. No goodbyes.

I was quite upset to learn that my father had no knowledge of his fate and I therefore investigated his care in more detail. I was then able to confirm that he had never consented to terminal sedation, and, although he knew his condition was not curable (not documented), he was certainly not aware that he would shortly die as was evidenced by the statements he made to friends. And as his sons were flying to his side surely he would have wanted to see and talk to us before he died. Isn't that obvious? Obviously not. Of course, once the facts were established, I received a profound and honest apology from the hospital, but I only received this after they had initially incorrectly made a statement in writing that he had received terminal sedation because he was "distressed" and "in pain." Not only was this refuted by visitors but the notes made no reference to pain or distress, whatsoever. By all accounts he was actually feeling quite well. So was this terminal euthanasia in another guise—or was this worse?

Terminal sedation is not simply to expedite demise in order to free up costly specialist facilities. Far better to discharge such patients to hospice care where caring for the terminally ill is done with greater expertise and sensitivity. I only discovered these facts because I am a doctor and had the "brass neck" to ask. I am quite concerned what could well be going on out there in the name of caring and terminal sedation.

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Competing interests: PJH's father was subjected to terminal sedation courtesy of medical and nursing team.

1 Murray SA, Boyd K, Byock I. Continuous deep sedation in patients nearing death. *BMJ* 2008;336:781-2. (12 April).

Good care at the end of life, not hastening death

Treloar misunderstands the fundamental premise of the Liverpool care pathway (LCP).¹ A patient is put on the pathway only once it is recognised they are dying imminently, within hours to a few days.² The evidence does not support that artificial hydration or nutrition has a role to ease symptoms and suffering and may, in fact, add to it.³

Deep sedation is not recommended as part of the Liverpool care pathway and is not usual practice in UK palliative care teaching. Sedation

can be a feature of symptom management but is not the prime aim. Morphine will be used to treat pain or breathlessness, glycopyrronium to treat bubbly secretions, haloperidol to treat nausea or agitation and delirium, midazolam to treat distress, etc. Most patients do not need large doses of these medications to achieve the necessary symptom control. In a study from St Christopher's Hospice, dose increases in sedative medication at the end of life were not associated with a shortened survival.⁴

The key assessment is the identification of dying. The focus of care is then clarified, and the pathway provides a structured format to achieve this. It is unhelpful to raise concerns about hastening death by deep sedation or denying hydration and only fuels misunderstanding and fear. The introduction of the pathway must be supported by a comprehensive teaching programme, and the structure of the tool supports regular evaluation and audit.

The pathway is not a *fait accompli* to dying and occasionally patients get better and come off the pathway. In the acute general hospital I work in, where we have supported over 300 patients on the LCP, this has occurred on 14 occasions.

This is an essential time to be effective clinicians. Poor experiences of dying will resonate in relatives' memories. The Liverpool care pathway supports clinicians to get it right.

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Competing interests: None declared.

- 1 Treloar AJ. Dutch research reflects problems with the Liverpool care pathway. *BMJ* 2008;336:905. (26 April.)
- 2 Marie Curie Palliative Care Institute. Liverpool care pathway for the dying patient (LCP), 2008. www.mcpcil.org.uk/liverpool_care_pathway
- 3 Campbell C, R Partridge. *Artificial nutrition and hydration. Guidance in end of life care for adults.* National Council for Palliative Care, 2007.
- 4 Sykes N, Thorns A. The use of opioids and sedatives at the end of life. *Lancet Oncol* 2003;4:312-8.

RAPID SCREENING FOR MRSA

Preventing infections from cannulas reduces MRSA

We have shown through bacteraemia surveillance (June 2003-December 2006) that 19 of 118 episodes (16.1%) of bacteraemia due to hospital acquired MRSA on medical and surgical wards were secondary to infected insertion sites of peripheral cannulas. In June 2007, King George Hospital, Barking, Havering

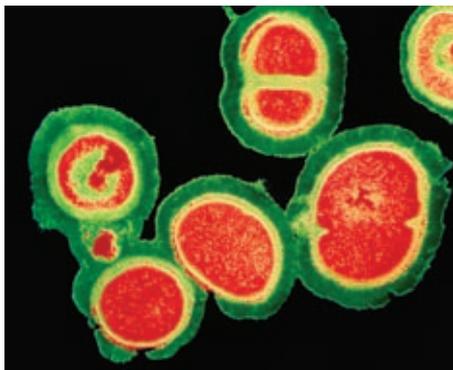
and Redbridge Trust implemented a programme aimed to reduce these infections. This followed guidance in the “Saving Lives” programme.¹ Skin decontamination devices (Chlorprep Single Swab Applicator) and venflon packs were supplied to all wards. Labels for date of insertion and removal for peripheral cannulas were provided together with Tegaderm to replace tape and gauze dressings. Junior doctors and nurses were trained to use these packs and, in particular, how to label and insert cannulas in an aseptic manner.

From June 2007 to March 2008, total episodes of MRSA bacteraemia trustwide fell from 56 to 32 (42.9%) compared with the preceding 10 months. Over this 20 month period, policies on the selective screening of high risk patients (critical care, neonates, elective orthopaedic surgery, frequent hospital reattenders, and patients from care homes) remained unchanged. Recently, we screened all patients on six medical and surgical wards and showed that MRSA is as prevalent in our trust (median prevalence rate 11.5%, range 7-23%), as St Thomas’s (median value 6.1%, range 2.7-19.7%).

Based on Jeyaratnam et al’s finding² and our own experience locally, we believe the government target of universal MRSA screening of elective inpatients, costing our trust £97 000/year, is unlikely to affect MRSA bacteraemia rates. By March 2011, the government aims to screen all hospital inpatients for MRSA, which would cost an additional £837 000/year. This amount would be five times more expensive if polymerase chain reaction assays were introduced. In contrast, enhanced bacteraemia surveillance and targeted interventions aimed at reducing infection at sites that cause MRSA bacteraemia is likely to be money well invested. Universal screening seems to be wasteful, and we believe the government’s strategy to reduce MRSA infections through universal screening requires a fundamental rethink.

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Competing interests: None declared.



KARLOUNATMA/SPL

- 1 Saving Lives: reducing infection, delivering clean and safe care. Peripheral intravenous cannula care bundle. www.clean-safe-care.nhs.uk
- 2 Jeyaratnam D, Whitty CJM, Phillips K, Liu D, Orezzi C, Ajoku U, et al. Impact of rapid screening tests on acquisition of methicillin resistant *Staphylococcus aureus*: cluster randomised crossover trial. *BMJ* 2008;336:927-30. (26 April.)

BLUNT ABDOMINAL TRAUMA

Note of caution on diagnostic peritoneal lavage

Jansen et al highlight the potential difficulty of diagnosing intraperitoneal bleeding and hollow viscus injuries in patients with blunt abdominal trauma.¹ Despite an increasing use of point of care focused assessment with sonography for trauma (FAST), diagnostic peritoneal lavage continues to be taught on advanced trauma life support courses² and can provide useful information that has the potential to alter patient management in appropriately selected cases. However, we wish to sound a cautionary note for physicians performing diagnostic peritoneal lavage.

Our department has previously surveyed a representative sample of 40 UK major trauma units regarding their ability to analyse fluid samples.³ During normal working hours (9 am-5 pm), only 29 of 40 haematology departments were able to provide this service, falling to nine of 40 outside these times. Fourteen departments stipulated that the lavage fluid should be collected in EDTA bottles, while the remainder had no container preference. We also detected variation in the returned volume of lavage fluid required for analysis, in the infusion fluid required, and in the time taken for sample analysis. Only five of 40 departments had guidelines in place. Given these findings we strongly recommend that prior to performing diagnostic peritoneal lavage, doctors confirm with their local laboratory service both the ability to analyse lavage fluid and any special requirements for sample handling. This seems particularly prudent outside of normal working hours.

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Competing interests: None declared.

- 1 Jansen JO, Yule SR, Loudon MA. Investigation of blunt abdominal trauma. *BMJ* 2008;336:938-42. (26 April.)
- 2 American College of Surgeons Committee on Trauma. *Advanced trauma life support program for doctors*. 7th ed. Chicago: American College of Surgeons, 2004.
- 3 Maxwell-Armstrong C, Brooks A, Field M, Hammond J, Abercrombie J. Diagnostic peritoneal lavage analysis: should trauma guidelines be revised? *Emerg Med J* 2002;19:524-5.

PLACEBO EFFECT

Reconceptualising placebo

The notion that placebo responses are responses that are evoked by nothing is nonsense. The study by Kaptchuk et al and the study by Waber et al in *JAMA* illustrate clearly that the “placebo” responses observed are in fact responses to things other than the thing to which we hypothesise a response.^{1,2} Therefore, placebo responses reflect the limitations of our experimental design, our appreciation of the contributors to a patient’s symptoms, and our appreciation of what might change those underpinning factors. The convincing placebo data concern symptoms—experiences reported by patients. That means that symptoms are outputs of the brain. That a placebo response occurs means that something has changed the brain’s evaluation of whether or not to evoke that symptom. This makes a placebo response not a response to nothing, but to something we haven’t identified or measured. Take pain for example: it emerges according to an implicit evaluation of the threat to body tissue and the need for action. It is sensible that anything that changes this implicit evaluation of threat should change pain.

Rather than interpreting “placebo” responses as mysterious unexplainable responses to nothing, we should, as the editorial hints,³ get excited about what else might have led the patient’s brain to conclude that the need for symptoms had just reduced. To suggest we should use the placebo response in clinical practice seems a bit daft to me because it is the other things (we are yet to identify, accept, or understand), which change the brain’s evaluation of the need for symptoms, that we should utilise. I agree that the alternative therapies are way in front of us here—they know they are using some of these things, it just doesn’t make them conclude that what they do is useless.

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Competing interests: None declared.

- 1 Kaptchuk TJ, Kelley JM, Conboy LA, Davis RB, Kerr CE, Jacobson EE, et al. Components of placebo effect: randomised controlled trial in patients with irritable bowel syndrome. *BMJ* 2008;336:999-1003. (3 May.)
- 2 Waber RL, Shiv B, Carmon Z, Arieli D. Commercial features of placebo and therapeutic efficacy. *JAMA* 2008;299:1016-7.
- 3 Spiegel D, Harrington A. What is the placebo worth? *BMJ* 2008;336:967-8. (3 May.)

Helping patients feel better

On the basis of their study on the placebo response in irritable bowel syndrome, Kaptchuk et al conclude that the patient-practitioner relationship is the most robust component of

the placebo effect.¹ Despite some important limitations, including extremely brief follow-up and potential bias in patient recruitment, their findings fit with previous observations that the therapeutic relationship is correlated to beneficial outcomes.² However, the inclusion of another comparison group would have shed light on an important issue they do not discuss—how would patients respond to the augmented patient-practitioner relationship in the absence of sham acupuncture (or any other intervention)?

It is possible that the “doctor as drug” effect alone may be stronger than the study indicates.³ Doctors often feel under pressure to “do something,” when much of the time our patients may benefit most when we are free to just “be someone”—the one who helps them feel better.

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- 1 Kaptchuk TJ, Kelley JM, Conboy LA, Davis RB, Kerr CE, Jacobson EE, et al. Components of placebo effect: randomised controlled trial in patients with irritable bowel syndrome. *BMJ* 2008;336:999-1003. (3 May.)
- 2 Martin DJ, Garske JR, Davis MK. Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *J Consult Clin Psychol* 2000;68:438-50.
- 3 Balint M. *The doctor, his patient and the illness*. 2nd ed. Oxford: Churchill Livingstone, 2000.

Dangers of placebo

The ins and outs of placebo use in medicine are unfortunately forgotten by doctors, especially when controlled clinical trials are concerned.¹ So I would emphasise several dangers of placebo use: it spoils the doctor-patient relationship, enhances the asymmetric relationship—paternalism—between physicians who know and patients who suffer, can be medically dangerous—especially when the doctor’s aim is to determine whether patients have an organic disease—and strengthens medical arrogance, infantilising patients even more.

To quote Howard M Shapiro: “Finally we have to consider what may be the greatest danger of all for the physician, that giving a placebo will give him an even higher opinion of his own abilities to help.”²

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Competing interests: None declared.

- 1 Spiegel D, Harrington A. What is the placebo worth? *BMJ* 2008;336:967-8. (3 May.)
- 2 Shapiro HM. *Doctors, patients, and placebos*. Yale: Yale University Press, 1986.

Human effect is important

The dismissal of non-specific effects of care as placebo effects (which are rated as sham, pretend, dishonest, or false) does a huge disservice to patients and to doctors. The take home message in the article by Spiegel and



Harrington is spot on: “We treat patients in a social and psychophysiological context that can either improve or, alas, worsen outcome. The meanings and expectations created by the interactions of doctors and patients matter physically, not just subjectively.”¹

It’s time for doctors to reclaim the human aspects of their work. Caring for patients with due time and attention is not a luxury nor superfluous. It has a direct impact on outcomes. We cannot reduce medical practice to the physical components of our interventions because human beings are more than their physical components. We are thinking, feeling, meaning-seeking creatures. Unless we are treated as such we cannot expect the best outcomes from our medical experiences.

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- 1 Spiegel D, Harrington A. What is the placebo worth? *BMJ* 2008;336:967-8. (3 May.)

Placebolotherapy

I am thinking of setting myself up as a placebolotherapist.¹ Placebolotherapy—the standard by which all other treatments are measured. At least as effective as all types of psychotherapy and all “alternative” healthcare treatments. Treats physical health conditions and mental health problems (especially mood disorders). Evidence based. No spurious claims or pseudoscientific explanations. No reliance on ill defined terms such as “energy,” “auras,” “crystal power,” or “spirituality.”

Placebolotherapy is not a replacement for any proved treatment, it is an enormously helpful adjunct.

Placebolotherapists spend an hour with the “patient” in a pleasant room, giving them their full and undivided attention. They explain that what they are doing is backed up by rigorous scientific evidence, is extremely effective, and that the patient will feel better afterwards.

That’s it. Cost £50 a session. Research into placebo shows that the more value the patient puts on it, the more effective it is (a placebo

injection is more effective than a placebo pill), so an expensive session will be more effective than a cheap one.

Or should I set myself up as a homoeopath?

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Competing interests: NJW often uses hot lemon cold cures.

- 1 Pittrof R, Rubenstein I. The thinking doctor’s guide to placebos. *BMJ* 2008;336:1020. (3 May.)

Implementing placebo

Pittrof and Rubenstein make the important point that the “placebo effect” is actually an effect—people often do get better on placebo.¹ However, most, if not all, of the evidence for placebo effects comes from studies where patients expected to have a reasonable chance (generally 0.5) of receiving the active treatment. There is therefore no evidence base for prescribing placebos in a standard clinical setting, which is what the authors seem to advocate.

We do not know whether placebos will have an effect if patients are aware of what they are receiving. The most likely explanation for the placebo effect, particularly in mental disorders, is that it works as a proto-psychotherapy, using the patients’ conviction that they are being helped and mobilising their own positive resources. We know very little about the brain mechanisms of the placebo response, but the available evidence suggests that, like psychotherapy, it partly operates through the same pathways as the relevant active drugs.² I would therefore expect the patient’s belief that some aspect of their brain chemistry is actually being changed to be a crucial part of the placebo effect.

There may still be ways in which patients can benefit from placebos, even if they cannot be prescribed like ordinary drugs. Firstly, in a setting that re-creates the original trial, including randomisation to placebo or active treatment, but then the physician would not have control over who receives the “reduced benefits for much reduced risks.”¹ Secondly, if physicians were to deceive patients, telling them that they are receiving an active treatment when they are not, this would face both ethical and practical challenges. Thirdly, by administering placebo-like substances in the context of a quasi-medical model such as homoeopathy, but this will work only if the patient (and probably the doctor as well) believes in this model.

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- 1 Pittrof R, Rubenstein I. The thinking doctor’s guide to placebos. *BMJ* 2008;336:1020. (3 May.)
- 2 Linden DE. How psychotherapy changes the brain—the contribution of functional neuroimaging. *Mol Psychiatry* 2006;11:528-38.



AHMAD MASOOD/REUTERS

OPIUM PRODUCTION IN AFGHANISTAN

Is the US or the Taliban responsible?

Working for a year in the Kabul children's hospital in the 1970s gave me a perspective on Afghanistan that conflicts with the Foreign Office's view that "the Taliban is promoting opium production to finance terrorism."¹

The simple facts are that opium production was high under the US influenced government of Afghanistan of the 1970s, decreased 10-fold by 2001 under the Taliban, and then increased 30-fold and more under the US to the same level as in the 1970s.²

History shows us how empires function; be they British or US. The East India Company organised the opium trade through "free traders"—men with fast ships and guns to fend off the pirates. One of the most famous free traders was Francis Light, founder of the British province of Penang. These are facts, whereas the idea that the CIA runs opium from Afghanistan would be a conspiracy theory—unless, you thought about the United Nations statistics or happened to have been to Afghanistan.

I wonder if "Clive of the East India Company," whose statue is outside the Foreign Office's front door, has influenced its interpretation of world events.

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Competing interests: None declared.

- 1 Malloch-Brown M. Opium production in Afghanistan. *BMJ* 2008;336:972. (3 May.)
- 2 United Nations Office on Drugs and Crime (Vienna Office). *Afghanistan: opium survey 2004*. www.unodc.org/pdf/afg/afghanistan_opium_survey_2004.pdf

Editorial gives misleading impression

Malloch-Brown surely gives a misleading impression when he writes that global demand for opiates for medical purposes is fully satisfied.¹ The International Narcotics Control Board has reported that there is little or no reported medical use of any opioid (not just heroin/diamorphine) in some two thirds of the world's countries.

People there have the same need for the relief of pain and suffering, especially in palliative care and because of the ravages of AIDS epidemics, but they have no access to doctors or other prescribers or nobody is willing to prescribe or is not allowed to do so. This often results from the indiscriminate demonisation/prohibition in anti-drugs campaigns.

As it happens, we in the United Kingdom are now in the fourth year of a major diamorphine injection shortage such that street heroin—said to be increasingly pure because of abundant supply—is much cheaper than diamorphine ampoules, the only form licensed for non-oral administration. But at least in the UK this is owing not to a lack of wholesale diamorphine (we are the world's largest producer) but to a sudden lack of freeze drying capacity at the end of 2004 which has never been satisfactorily explained and remains unresolved.

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Competing interests: None declared.

- 1 Malloch-Brown M. Opium production in Afghanistan. *BMJ* 2008;336:972. (3 May.)

NHS COMMISSIONING

Current system has lost touch with reality of patient care

Ham's dissection of the problems of NHS commissioning is welcome to me as it shows I am not the lone voice crying in the wilderness that I feared I was.^{1 2}

The current system of commissioning has lost touch with the reality of patient care. Commissioners have become obsessed with saving money and have started playing games to achieve this. Secondary care services are (largely) paid for through the payment by results (PbR) tariff, but increasingly we are seeing attempts to commission cheaper services by finding ways around paying tariff rates. In my own area, a consultant service in rheumatology has been established in a general practice, so not subject to PbR. It costs less than half the PbR tariff rate, which I, as an acute trust employee, cannot match.

Can my own service go off tariff? Actually it seems that it can—by establishing clinics that call themselves something else (for example, a medical musculoskeletal service). Using such a title I can tender my services at a newly competitive rate and win back some lost business (about 50% of my non-inflammatory joint disease caseload). My trust will make less of a profit, but it gets some money instead of none. It is, of course, unfair for a service to be forbidden to set its own price. At least that's what I think, but I can't get anyone to test this;

the Competition Commission, the Office of Fair Trading, and the trust lawyers refuse to act, and I cannot afford to mount a judicial review myself.

In Hillingdon the primary care trust put out a tender for the entire musculoskeletal service which, I understand, was awarded to a private company. The trust set charges that were between two thirds and three quarters of the PbR tariff. I have been told that the acute trust's lawyers advised that it could not tender below tariff and was thus excluded from applying to do its own work. The knock-on effects of removing an entire service from a hospital are worrying. So how has Hillingdon got away with this? Did it consult the patients? Would they have agreed? From my own experience I doubt it.

If we are to avoid such absurd perversities and the need to play games it is essential for all barriers to fair competition to be removed. However, the risks to existing systems from such competition must be factored into any financial analysis.

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Competing interests: None declared.

- 1 Timmins N. Move to split role of healthcare purchaser and provider may have to be abandoned, expert says. *BMJ* 2008;336:979. (3 May.)
- 2 Ham C. Competition and integration in the English National Health Service. *BMJ* 2008;336:805-7. (12 April.)

NHS DENTISTRY

General practitioners are doing dentists' work

For some time patients have been finding it ever harder to register with an NHS dentist and especially to see a dentist outside of core working hours. I have noted an increasing stream of patients needing to see a doctor for what is essentially a dental problem.

I therefore audited the work of our practice, which has 10 000 registered patients. I analysed all dental related consultations during the two years 1996-8 and 2006-8, discovering a 1600% rise in their number over this 10 year period.

There is no provision in the NHS contract for general practitioners to be remunerated for dental work, despite health minister Ben Bradshaw's advising patients who could not get dental treatment to visit their general practitioner.

My audit results may be a symptom of declining dental availability. They also show, once again, how general practitioners are left to pick up work that should be performed by other professionals without adequate remuneration.

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