This month • euthanasia • post-viral fatigue syndrome • lifestyle • immunization • statistics • psoriasis • psychotherapeutics

Euthanasia in Holland

IT is estimated that Dutch physicians have now killed between 5000 and 8000 terminally ill patients. The Dutch Medical Association allows terminally ill children to die even if their parents oppose it and Dutch physicians and judges have now accepted other cases for mercy killing, covering paraplegia, multiple sclerosis and 'gross physical deterioration at advanced age'. Although, over the last decade, these unusual developments seem to have been supported by the majority of the lay as well as medical population of Holland, they are certainly at variance with the beliefs of other individuals, institutions and countries and bear examination.

In a disappointingly superficial article, Gregory Pence from the Department of Philosophy at Alabama has reviewed this extraordinary state of affairs and attempted to draw some comparisons with the situation in the USA, where withdrawal of therapy has led to a number of famous legal actions.

Apparently, a Dutch physician is likely to be faced twice in every three years with a patient requesting mercy killing and some 80% of Dutch general practitioners have already had experience of it, the preferred method apparently being injection of morphine followed, after deep unconsciousness, with curare.

The legal position in Holland continues to be unclear, and the parliamentary bill accepting a State Commission's recommendations for 'decriminalization' still awaits enactment. Physicians are simply told that they will probably not go to jail for something which is technically a crime. Not surprisingly, many of them find this situation extremely difficult to live with.

(R.J.)

Source: Pence GE. Do not go slowly into that dark night: mercy killing in Holland. *Am J Med* 1988; **84:** 138-141.

Post-viral fatigue syndrome

CALDER and Warnock first noted an association between previous infection with Coxsackie B virus and myalgic encephalomyelitis (post-viral fatigue syndrome) in this *Journal* (*J R Coll Gen Pract* 1984; **34:** 15-19). Other investigators have attributed the syndrome to the functional sequelae of the initial virus infection rather than the continued presence of the virus.

Research has now shown the presence of chronic viral infection in patients with the post-viral fatigue syndrome. Enteroviruses (mostly Coxsackie B5) were isolated directly from the faeces of 22% of 76 patients with the syndrome and 7% of 30 controls ($P<0.01$) and the virus was still present 12 months later in one third of the patients who were positive. A more sensitive test for enteroviral infection using monoclonal antibodies specific for the enterovirus group detected enteroviral antigen in 51% of 87 patients with the post-viral fatigue syndrome.

(A.B.)

Source: Yousef GE, Bell EJ, Mann GF, *et al.* Chronic enterovirus infection in patients with postviral fatigue syndrome. *Lancet* 1988; **1:** 146-147.

Doctor–patient communication on lifestyle

IN 1983 Boulton and Williams published work based on tape-recorded consultations in general practice (*Health Educ J* 1983; **42:** 57-63) which showed that a relatively large proportion of doctor–patient contacts provided opportunities for problem-related health education. This was particularly true of smoking where in over 25% of consultations the presenting problem could be related directly to the smoking habit. In 20% of consultations the patient's diet could be related to the presenting problem. However, less than one fifth of these opportunities were taken up by general practitioners. Furthermore, where there was no clear link between the presenting problem and the patient's lifestyle it was exceedingly rare for doctors to take the opportunity to enquire about smoking, diet or alcohol.

This new study from Sweden uses similar methods to those of Boulton and Williams. The authors find that smoking was mentioned in 75% of consultations and alcohol habits in 30%. However, the level of information exchange was shallow and gave a fragmentory picture of the patients' habits in their social context. The physicians documented the habits but there was little evidence of serious attempts to influence the patients' lifestyles. This disappointing result shows how the opportunities in an influential face-to-face encounter are often missed. Six levels of health promotion were well defined by Stott in 1983 in *Skills and practices of opportunistic anticipatory care in primary health care* (Berlin: Springer Verlag, 1983) and it seems that doctors have not yet moved much beyond level one (to state and document the nature of the problem in patients' records).

(N.S.)

Source: Larsson US, Saljo R, Aronsson K. Patient–doctor communication on smoking and drinking: lifestyle in medical consultations. *Soc Sci Med* 1987; **25:** 1129-1137.

Measles immunization

A STUDY of knowledge about measles immunization has shown considerable differences between health visitors, clinical medical officers and vocational trainees in general practice (*Community Med* 1986; **8:** 340-347). In particular, contraindications for measles immunization became confused with the contraindications for pertussis vaccine. The continued controversy about vaccinations for whooping cough may have something to do with the low uptake rate for measles vaccination which has risen to about 68%. Nevertheless in 1986 there were over 90 000 provisional notifications of measles in the United Kingdom which was over 60 times the incidence in the USA. Much higher vaccine update rates, probably at least 90%, are required to control measles.

(D.H.)

Source:Communicable Disease Surveillance Centre. Communicable disease report April to June 1987. *Community Med* 1987; **9:** 382-389.

Uptake of immunization

THERE is much talk, in numerous publications of the College and in the government's white paper, of the opportunities for prevention in general practice. Yet our immunization rates are low and are a poor reflection on our commitment to preventive medicine. It is helpful to read two articles trying to pinpoint some of the exact reasons for low uptake.

The first study examined the service in Maidstone health authority, looking at the effects of the information system, and both professional and parental attitudes on the uptake for measles immunization.

The second questioned groups of mothers in the Strathclyde area, using a market research approach to determine what role there could be for a mass media campaign.

The information system in the Maidstone area was responsible for some non-uptake; there was a lack of feedback to general practitioners both of overall rates and of apparent defaulters, delays in processing changes of address, and sending an appointment for measles immunization was suspended if the child had not had the last 'triple' immunization. On the whole, parental attitudes were positive. In both studies immunization was seen as desirable, but in the Maidstone study parents had concerns about possible side effects, erroneously supported in some cases by doctors, advising for instance, against immunization in cases of non-anaphylactic egg allergy. Similarly, some parents consciously decided against immunization because of a previous episode of measles. In the second study there was evidence of parents carefully weighing the advantages and disadvantages of immunization. For polio, tetanus and diphtheria the illness was perceived as serious and outweighed other considerations, whereas measles was perceived as less serious and the vaccine was not seen as damaging. In that case timing became important and because the immunization is scheduled for the second year of life there was some accidental rather than deliberate non-uptake.

Taking the various identified reasons for low uptake into account, 90% uptake was thought possible. What is required is better information for general practitioners, both about current recommendations on contraindications, and about the status of their own patients. The mass media may have a role, but should stress the seriousness of measles; a recent Health Education Council pamphlet, *Measles is misery,* tends to reinforce the view of the disease as unpleasant but not serious. Second, the material used must acknowledge that parents are taking decisions based on a balance of advantages and disadvantages and recommend immunization in those terms. The risk of reducing uptake rates by more open discussion of side effects is accepted, but Hastings concludes with the challenge that applies to all preventive activity: '...the health educator must decide whether his or her main concern is with improving immunization rates or with encouraging well informed decision-making about health.'

(D.J.)

Sources: Lakhani ADH, Morris RW, Morgan M, *et al.* Measles immunisation: feasibility of a 90% target uptake. *Arch Dis Child* 1987; **62:** 1209-1214. Hastings GB. Infant immunisation: do we need a media campaign? *J R Soc Health* 1987; **107:** 88-91.

Making statistics make sense

THE International Committee of Medical Journal Editors met last September in Helsinki and has now published a new edition of the 'Uniform requirements for manuscripts submitted to biomedical journals'. As well as new guidelines about repetitive publication in different languages and standards for authorship this edition has a new section on statistical reporting. Perhaps the most important new recommendation is that the form of a ± b, frequently used to report a mean and standard error or standard deviation, be abandoned and that variability be more accurately described by the use of the 95% confidence interval. These suggestions have already been taken up by a number of journals and a detailed consideration of guidelines for statistical reporting in articles for medical journals has been published by Bailar and Mosteller.

In the same issue of *Annals of Internal Medicine,* Leonard Braitman has written an extremely lucid and useful editorial about confidence intervals, concentrating particularly on the way that clinically useful information can be more readily extracted from the use of confidence intervals than from more traditional statements of probability. Using a number of clear examples, he shows how confidence intervals convey information about magnitude and precision simultaneously, keeping these two aspects of measurement closely linked.

The way in which statistics are being applied to the analysis of experimental data is constantly changing and familiarity with the theory and practice of confidence intervals is becoming increasingly important.

(R.J.)

Sources: Bailar J, Mosteller F. Guidelines for statistical reporting in articles for medical journals: amplifications and explanations. *Ann Intern Med* 1988; **108:** 266-273. Braitman LE. Confidence intervals: extract clinically useful information from data. *Ann Intern Med* 1988; **108:** 296-298.

Treating psoriasis

EVIDENCE that psoriasis is caused by a disorder in arachidonic acid metabolism has prompted a trial of treatment with fish oil, which contains eicosapentaenoic acid, a fatty acid structurally very similar to arachidonic acid.

In a double blind, randomized, placebo controlled trial 28 patients with stable chronic psoriasis took 10 fish oil capsules (MaxEPA, Seven Seas Health Care) or 10 olive oil placebo capsules daily. After eight weeks the fish oil group had significantly less itching, erythema and scaling and less of the body surface was affected. No change was seen in the control group. The authors note that daily consumption of only 5 oz of oily fish such as mackerel would provide the same amount of eicosapentaenoic acid.

(A.B.)

Source: Bittiner SB, Cartwright I, Tucker WFG, Bleehen SS. A double-blind, randomised, placebo controlled trial of fish oil in psoriasis. *Lancet* 1988; **1:** 378-380.

Psychotherapeutics and the doctor

THE general practice literature has in the last few years contained several articles on the value of psychologists working in primary care teams. Here, for lovers of well-written invective, is a sort of counterblast: a strong argument that psychiatrists (and general practitioners) are the most suitable people to treat mental illness.

Colin Brewer begins by affirming the usefulness of medical treatments for both mental illnesses (lithium in manic depression, antidepressants in severe depression, and antipsychotic drugs in schizophrenia) and some non-medical problems (supervised disulfiram for alcoholism, surgery for severe obesity and beta-blockers for performance anxiety). He then castigates social workers, psychologists and psychiatric nurses for preferring attractive theories to therapies based on objective assessment.

There are few accounts of rigorous trials of psychosocial techniques. The three quoted here, of conventional alcoholism treatment services, of psychotherapy, and of intensive task-centred social work to reduce repeated overdoses in those who had already taken one deliberate overdose, all showed the treatment to be no better than minimal intervention. This serves to remind us that we are all 'walking placebos'; what distinguishes doctors is their ability to offer, when appropriate, something else in the form of an examination (possibly enhancing the placebo effect) and drug treatment. This is illustrated by imagining a therapeutic competition between psychiatrists and their competitors. All

will offer a single leisurely consultation, and broadly psychological treatment, involving their families if necessary. The doctors are in the happy position of being able to prescribe drugs if they are needed to facilitate the psychotherapeutic process, without diluting the therapeutic relationship.

What Colin Brewer fails to address, of course, is the vital argument about cost. If he is correct that few patients need drugs, then the competitors come cheaper for nearly as good a service. Using part of his own thesis, surely the cost-benefit analysis of different therapists is the crucial question, and one just as amenable to critical enquiry? Nevertheless the repeated plea for health workers to question their own cherished beliefs is important and applies as much in general practice as in psychiatry.

(D.J.)

Source: Brewer C. Doctors heal the parts ordinary health professionals cannot reach. *J R Soc Health* 1988; **108:** 15-19.

Contributers: R. Jones, A. Bichard, N. Stott, D. Hannay, D. Jewell.

INFECTIOUS DISEASES UPDATE: AIDS

The role of the general practitioner

As a testimony to how important we consider the role of the general practitioner in dealing with human immunodeficiency virus (HIV) infection the *British Medical Journal* recently devoted one leading article and three research papers to the subject.[1-4] The consensus was undoubtedly that our ability to control the spread of HIV infection depends much on the efforts of the primary care team.

One paper revealed a strong commitment of general practitioners to solving the practical problems of infection with HIV.[2] Indeed 90% of practitioners responding to a questionnaire revealed they were giving advice on risk reduction. If this were to be reflected nationwide, the practitioners' present role in prevention would justify full recognition. However, another survey of a group of practitioners[3] revealed that only half of those who responded to a questionnaire showed interest in health education being part of a training programme for managing the acquired immune deficiency syndrome (AIDS), and only just over one quarter had even raised the question of AIDS with a patient unprompted. These findings are worrying as they suggest regional differences in the practice of AIDS prevention.

Another finding likely to cause concern was an uncertainty about methods of transmission for HIV. Forty-five per cent of one group of practitioners[3] considered oral sex to be a high risk activity (the evidence for transmission via this route is minimal) and 48% considered deep kissing to be a low risk activity (no significant evidence exists at present for this being a mode of transmission). In addition, there was an apparent underestimate of the risks of heterosexuals as opposed to homosexuals. It is therefore clear that practitioners who are not fully aware of the facts regarding transmission will need to address this problem quickly if uniform and accurate messages are to be delivered to the general public. The general practitioner's role in curbing the AIDS epidemic cannot be underestimated.

Risk of heterosexual HIV transmission

A recent study by Peterman and colleagues of the risk of HIV transmission for the heterosexual contacts of individuals infected via blood transfusion[5] showed two (8%) of 25 husbands and 10 (18%) of 55 wives testing positive for the virus. Although one of the seropositive women had had only a single sexual contact with her infected husband and another had had only eight, 11 wives remained uninfected after more than 200 sexual contacts. Thus heterosexual transmission of HIV does occur in both directions, can occur with only one sexual contact and may not occur with hundreds of contacts. Other studies reviewed by Peterman revealed transmission to wives of infected haemophiliacs (10/48 in one study and 2/21 in each of three others), to female sexual partners of bisexual males (8/43), and to female sexual partners of intravenous drug misusers (32/76).

In a recent Edinburgh study[6] of heterosexual transmission, out of 123 subjects with no apparent risk factor for infection other than heterosexual intercourse with a subject either infected or at high risk of being infected with HIV, seven were found to be seropositive.

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3. Milne RIG, Keen SM. Are general practitioners ready to prevent the spread of HIV? *Br Med J* 1988; **296:** 533-535.
4. Boyton R, Scambler G. Survey of general practitioners' attitudes to AIDS in the North West Thames and East Anglia Regions. *Br Med J* 1988; **296:** 538-540.
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Contributed by Dr D. Goldberg, Research Associate, AIDS Surveillance Programme Scotland, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB.

AIDS and suicide

A number of reports have shown that certain medical conditions, such as chronic renal failure and Huntingdon's disease are associated with very high rates of suicide, although suicide rates among cancer patients are only modestly elevated compared with the general population. A study from New York has reviewed all cases of suicide in New York City during 1985, to establish how many of the victims had been diagnosed as having AIDS.

The total number of suicides in 1985 in New York City was 668, with a rate for men between 20–59 years of 18.75 deaths per 100 000 person years of life. In the same year there were 3828 New York city residents with a diagnosis of AIDS; the suicide rate for men with AIDS in the 20–59 year age group was 680.56 deaths per 100 000 person years of life. This represents a relative risk of suicide over 36 times that of men in this age group in the general population. When women with AIDS are included in the analysis, the relative risk rises to over 66 times that of the general population.

These are important and alarming figures; there is tendency for these suicides to occur early in the course of the illness so that evaluation of suicide risk soon after diagnosis must be considered carefully. Although the illness is terminal, the authors argue that attempts at suicide prevention are appropriate. These results are particularly important in view of the recent advocacy of mass population screening for HIV antibody. They also suggest urgent prospective research into the associations between AIDS-related neurological and psychiatric syndromes and suicide risk.

(R.J.)

Source: Marzuk PM, Tierney H, Tardiff K, *et al.* Increased risk of suicide in persons with AIDS. *JAMA* 1988; **259:** 1333-1337.