

There should be no ethical dilemma or any conflict of roles in our ostensibly democratic society. Teaching patients is a fundamental task in general practice, and recent history is too full of situations where not to protest is taken as tacit approval.

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Advance directives

Sir,

The discussion paper 'Advance directives: partnership and practicalities' (April *Journal*, p.169) was helpful in drawing attention to some of the serious practical limitations and dangers of the increasingly popular practice of encouraging patients to make advance directives or living wills. These would indicate that should the patient 'become so mentally or physically ill that there is no prospect of recovery, any procedures designed to prolong life should be withheld.'¹ It is noteworthy that the paper commences with a favourable reference to an earlier paper arguing that doctors may be morally justified in assisting death.² David Short has observed that the strong support given to the advanced directive by the Voluntary Euthanasia Society shows clearly that it is designed to lead to the legalization of euthanasia.³

Among the objections to the advance directive hinted at in the paper is that the individual who draws up the advance directive has no basis for making an informed decision since the precise situation which he/she will face cannot be foreseen. This is why a considerable proportion of patients do not necessarily want their advance directives followed strictly.⁴ Also, an individual cannot foresee the changes taking place in his/her attitude over the years. There are many examples of people who have changed their minds when illness has struck. The healthy do not choose in the same way as the sick.⁵

Perhaps the most serious objection to the advance directive, which escapes mention in the paper, is that it puts the onus on the public to demand medical care, including compassionate and intelligent treatment, of a quality a doctor would wish to receive, which they are entitled to expect as a right. David Short suggests that it is doctors rather than patients who should sign a declaration — a declaration that they will never knowingly administer futile treatment or prolong suffering without real hope of recovery.³

A determination by doctors to pursue the highest standards of care, following

the Royal College of General Practitioners' motto *Cum scientia caritas* and adhering to the declaration of Geneva and the international code of medical ethics,⁶ should make advance directives unnecessary.

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References

1. The Law Commission. *Mentally incapacitated adults and decision-making: an overview. Consultation paper 119*. London: HMSO, 1991.
2. Institute of Medical Ethics working party. Assisted death. *Lancet* 1990; **336**: 610-613.
3. Short D. A physician's misgivings regarding the advanced directive. *Ethics Med* 1993; **9**: 1.
4. Sehgal A, Galbraith A, Chesney M, *et al*. How strictly do dialysis patients want their advance directives followed? *JAMA* 1992; **267**: 59-63.
5. Gardner BP, Theodeous F, Watt JWH, Krishnan KR. Ventilation or dignified death for patients with high tetraplegia? *BMJ* 1985; **291**: 1620-1622.
6. British Medical Association. *Philosophy and practice of medical ethics*. London: BMA, 1988: 96-98.

Accidents among children

Sir,

Carter and Jones' study of childhood accidental injury (April *Journal*, p.159) failed to demonstrate statistically significant differences in risk factors for accidental injury and in the possession of safety equipment between cases and controls as a result of their choice of outcome. Stewart-Brown and colleagues demonstrated the importance of definition of accidents in studies of risk factors.¹ In their analysis of the data from the third British national cohort study, they found that using admissions to hospital as the outcome resulted in more risk factors being associated with the outcome, than if a single medically attended accidental injury or repeated medically attended accident injuries were chosen as outcome measures.¹ The small numbers involved in Carter and Jones' study may also have resulted in insufficient power to demonstrate a significant difference in the frequency of risk factors between cases and controls even if such differences did exist. Stewart-Brown and colleagues failed to demonstrate association for some risk factors using a data set of more than 12 000 children.

Carter and Jones' conclusion that their study casts doubt on the value of safety equipment and knowledge in preventing childhood accidents cannot be substantiated from their results for the reason outlined above. Furthermore, they have not made it clear whether the equipment was possessed prior to the accident or not; it is possible that the accidental injury acted as a trigger to the family to obtain safety equipment.

Evidence from the published literature shows that environmental change is the most effective method of preventing childhood accidents.² Evidence exists that safety equipment such as smoke detectors,³ window guards,⁴ cycle helmets⁵ and infant and child car seats⁶⁻⁸ do reduce mortality and morbidity from accidents in childhood. The primary health care team should make efforts to educate parents about environmental changes and facilitate them to make such changes, as well as lobbying on a local and national level for a safer environment.

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References

1. Stewart-Brown S, Peters T, Golding J, Bijur P. Case definition in childhood accident studies: a vital factor in determining results. *Int J Epidemiol* 1986; **15**: 352-359.
2. Pless B. *The scientific basis of childhood injury prevention. A review of the medical literature*. London: Child Accident Prevention Trust, 1993.
3. Reisinger KS. Smoke detectors: reducing deaths and injuries due to fire. *Pediatrics* 1980; **65**: 718-724.
4. Spiegel CN, Lindaman FC. Children can't fly: a program to prevent childhood morbidity and mortality from window falls. *Am J Public Health* 1977; **67**: 1143-1147.
5. Thompson RS, Rivara FP, Thompson DC. A case-control study of the effectiveness of bicycle safety helmets. *N Engl J Med* 1989; **320**: 1361-1367.
6. Christian MS, Bullimore DW. Reduction in accident severity in rear seat passengers using restraints. *Injury* 1989; **20**: 262-264.
7. Agran PF, Dunkle DE, Winn DG. Motor vehicle accident trauma and restraint usage patterns in children less than 4 years of age. *Pediatrics* 1985; **76**: 382-386.
8. Margolis LH, Wagenaar AC, Liu W. The effects of a mandatory child restraint law on injuries requiring hospitalisation. *Am J Dis Child* 1988; **142**: 1099-1103.

Personal medical attendant reports

Sir,

William Hamilton's interesting letter on personal medical attendant reports (April *Journal*, p.172) concluded that 'Completing insurance forms appears to be more a problem of data retrieval than an ethical problem.' This view is short-sighted. The existence of these reports means that some patients avoid consulting their general practitioner for particularly sensitive problems, such as concern about human immunodeficiency virus (HIV) status. There are also many reports of insurance agents advising patients not to ask to see the doctor's report as this may delay the acceptance of the proposal.

Hamilton also quoted a study that showed that 57% of patients would have