

Letters

The *BJGP* welcomes letters of no more than 400 words, particularly when responding to material we have published. Send them electronically to jhowlett@rcgp.org.uk, and include your postal address and job title, or if that's impossible, by post. We cannot publish all the letters we receive, and long ones are likely to be cut. Authors should declare competing interests.

Assisted suicide

Last time I wrote about dying at home, it was my personal view of my grandmothers' euthanasia in Holland.¹ I have now been involved in a similar situation, a death from cancer in Britain — and I was not impressed. This time it was not a relative but a friend — an 88-year-old gentleman who died of lung cancer. I am a general practitioner in another city. I watched things unfold; I wanted to be there for him and not get involved.

I visited him in hospital, walking assertively onto the ward outside visiting hours. He was discharged on a Friday and told the Macmillan nurses would contact him on Monday. He was short of breath at rest, but talking in sentences, mobile, and eating small meals. His pleural effusion had been drained and pleurodesis attempted. He had been a very active man, walking miles a day with the dog until 6 weeks before admission. At home he lived with his 84-year-old wife. The family managed to arrange oxygen and sleeping tablets on Friday afternoon from his GP surgery; he had been comfortable on these in hospital. They were not supplied with his discharge (there was a note about not supplying sleeping tablets long term). He deteriorated quickly, became more breathless, stopped eating, and became bed bound. His wife had difficulty getting him to the toilet and this was a problem at night when they were home alone. The Macmillan nurse arrived on Wednesday, by which time the family was angry and had verbally complained about this delay. He was put on oramorph as required, and the social worker came the same day and arranged a night sitter. These nice ladies were not nurses and could come for 5 nights only. They could not administer oral medication. They did, however, agree to give morphine if his wife had drawn it up in advance but did not seem that confident about knowing when to give it. By Thursday, my friend had called out his GP and asked him to end it

all with an injection. Like my grandmother, he was losing his dignity and didn't want to go on anymore. His GP asked him if he was afraid to die, but with this remark the doctor missed the point. My friend wanted to die at that time and not suffer anymore. He was prescribed oral diazepam. I told him he knew euthanasia was illegal, but I would do my utmost to decrease his suffering. One Saturday I turned up early to find him breathless, exhausted and in distress. I gave him oramorph and diazepam (he had not had any since 10 o'clock the previous night) and he fell into a peaceful sleep. His wife told me she wished he'd sleep like that until he died. I rang the district nurses, and suggested a syringe driver because he was becoming unable to take oral medication and needed 24 hour symptom relief. Due to a shortage of diamorphine, a low dose fentanyl patch was tried. This takes a long time to work and he was to be given oral morphine until it did work. By Sunday morning he could barely take anything orally and again I asked for a syringe driver. Now there was diamorphine. The only problem was that the hospice had suggested 10 mg diamorphine over 24 hours with the patch, and the on call doctor prescribed 20 mg. The district nurse would not give my friend this dose and it took her 3 more hours to get the right dose. She was worried about suppressing his respiration, something the relatives by that stage could not understand. By 2 p.m. the syringe driver was up and at last my friend was comfortable. He died peacefully that night.

What shocked me was how much I had to become involved. I wanted to watch him die peacefully at home with good palliative care. If you won't allow euthanasia, please give people a good alternative.

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Competing interests

None.

I am writing in support of the views expressed in the essay by Ilora Finlay in the September edition of the journal.¹ The arguments against euthanasia and physician-assisted suicide were well presented, and I have felt motivated to write to my MP about this issue, in time for the forthcoming Parliamentary debate.

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1. Finlay I. 'Assisted suicide': is this what we really want? *Br J Gen Pract* 2005; 55: 720–721.

Congratulations to the RCGP for having the courage and determination to call for the law on euthanasia to remain as it is.

I feel both proud and relieved that one of the professional bodies to which I belong has now stated so clearly its opposition to euthanasia; and embarrassed and ashamed that the other (the BMA) has not.

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It is encouraging to find a stand being taken against assisted suicide, something clearly repugnant to the majority of GPs and elegantly discussed in the article by Ilora Finlay.¹

Over a long life in general practice I have never found it impossible to find pain relief for patients either administered by myself or the practice nurse, or in one of our excellent hospices. Moreover, it always seemed to me that we did our best and if sometimes death was hastened by our drugs, that is surely a common feature of

medical practice, possibly more common these days with so many potent and interacting drugs with some unfortunate side effects.

The urge for euthanasia is surely utilitarian. It saves time for doctors and relatives, and avoids the experience of failure when we can't cure. It may be that GP training needs to concentrate more on the value of life, and even the mysterious value of suffering. I well remember a patient with severe pain from gastric cancer, who refused all pain relief, as he wanted to 'be brave'. He was an agnostic and I doubt if he understood the value a Christian attaches to suffering, But he was an example to all who cared for him.

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Low carbohydrate diets for diabetes control

Fleming, Cross and Barley¹ are right to be concerned about the growing prevalence of type 2 diabetes in General Practice.

Despite the growing incidence of type 1 and 2 diabetes and the accelerating cost of the resources needed to monitor and treat these patients, we are obviously not succeeding in reducing either the number of people affected or the severity of the complications of these conditions.

Yet there is a simple, effective, low-cost strategy that is proven to work with diabetes: reduce the amount of sugar and starch in the diet.

This is backed up by rigorous scientific research and I have included a few of the more recent reviews concerning this subject below.^{2–4}

On a more personal note, my son became diabetic 18 months ago. His HbA1C is 5.1 and his insulin requirements have not increased since stabilisation after diagnosis. His blood sugars are rarely out of the 4–7.8 range even after meals on a

restricted carbohydrate diet. He rarely experiences hypoglycaemia and has had no severe events.

I have also encouraged my diabetic patients to try this way of eating for themselves. It is usual for patients with type 2 diabetes to experience a 2–3% drop in HbA1C after 3 months on a low carb diet. The impact on reducing complications and associated drug costs can be imagined.

The lower the carbohydrate consumed the less insulin is needed for type 1 diabetics and the less hard the pancreas has to work for type 2 diabetics. For example, insulin dependent diabetics can expect to half or third their insulin requirements. Less insulin injected results in more predictable blood sugars and less hypoglycaemia.

The medical establishment has been less than enthusiastic about adopting low carb diets. All of the usual gripes have been thoroughly debunked or can be dealt with by modifications to the diet. It is time to stop feeding patients a diet of junk science and start feeding them food that makes them well instead of sick.

You would think that Diabetes UK would be interested in promoting a diet that does all of these:

- prolongs honeymoon phase in type 1 diabetics;
- prolongs pancreatic function in type two diabetics;
- promotes a healthy weight;
- reduces need for insulin;
- reduces need for oral hypoglycaemic drugs;
- promotes high HDL and low triglycerides;
- Reduces hypoglycaemia;
- Reduces development of glucose intolerance to type two diabetes;
- optimises glycaemic control including post prandial blood sugars.

Sadly, Diabetes UK does not.

If health professionals or patients want to learn more about this I can recommend Dr Bernstein's *Diabetes solution*.⁵ Dr Richard Bernstein became an insulin-dependent diabetic when he was 12 years old and continues to practice as a physician dedicated to diabetes management at the age of 67. He was the

first patient to use a portable blood sugar monitor, and through careful self experimentation he managed to reverse most of his diabetic complications. He has developed a comprehensive educational course that turns normal patients into highly competent self carers with truly normal blood sugars round the clock.

How long can we as a profession afford to keep our heads in the sand regarding the benefits of low carb diets for diabetics?

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Breakdown in communication

While I feel that Mike Fitzpatrick does set out to be deliberately provocative I cannot let his September offering on communication skills go without comment. I cannot claim to write for all the communication skills educators throughout the world but the negative tenor of this article certainly dismisses part of what I do for a living.

Certainly we know that there are still problems with the way that doctors communicate with patients. The fact that communication training is being extended into the postgraduate years is a good thing and does not provide evidence that undergraduate communication skills experience is failing to meet its objectives. However Dr Fitzpatrick cannot have it both ways: that doctors' communication is not