# BRITISH MEDICAL JOURNAL

SATURDAY 14 NOVEMBER 1987


## LEADING ARTICLES



## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED



## MEDICAL PRACTICE



## NEWS AND NOTES



## SUPPLEMENT




NO 6608 BRITISH MEDICAL JOURNAL 1987 VOLUME 295 1221-1292
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 295 (6608) 1221-1292 (1987)

# CORRESPONDENCE



- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

## Euthanasia

SIR,—The Voluntary Euthanasia Society was founded in 1935 by, among others, distinguished doctors, including the royal surgeon Lord Moynihan. The signatories to this letter are members of the society, and most of us have worked full time in medical practice. We all believe that despite advances in medical knowledge since 1935 the need for legalised voluntary euthanasia has not diminished. If anything, it has increased because more people now survive to suffer the sort of physical and psychological distress which cannot be adequately relieved even by the best medical and hospice care. Social changes since 1935 mean that death and dying are less likely to take place in a supportive family setting and that patients are less uncritical of the views of their medical attendants. The acquired immune deficiency syndrome has added a new and rapidly growing group of often well informed patients who may not want to risk the dementia which so often supervenes.

Voluntary euthanasia has been effectively legalised in The Netherlands for several years, and organisations similar to the Voluntary Euthanasia Society have been established in nearly 30 countries. Many of them have a prominent medical membership. The biennial meetings of the International Federation of Right to Die Societies have been held in Tokyo, Oxford, Melbourne, Nice, and Bombay since its foundation in 1976 and have met with overwhelmingly favourable media interest.

Public opinion surveys in several countries have nearly always found majority support for legalisation, the latest British figure, in 1986, being over 70%. A poll of general practitioners this year found that over 30% favoured legalisation and that nearly 40% would be prepared to administer voluntary euthanasia if it were legalised. The official BMA view that "the profession condemns legalised active voluntary euthanasia" is clearly no longer accurate, if it ever was, and the recent setting up of a working party to consider the issue is evidently a recognition of this fact.

We have now established a medical group within the Voluntary Euthanasia Society and invite doctors who want to support us or who want further information to write to the secretary of the society.

MARY BLISS
MURIEL BRAYSHAY
COLIN BREWER
M R A CHANCE
DAVID CLARK
A C DALZELL
M R DAVIES
W H B ELLIS
D GAIRDNER
T GLANVILL
MARJORIE HARE
S L HENDERSON SMITH
P L LEWIS
M L MILLARD
K NORCROSS
S N RAY
A ROBERTS
S C TRUELOVE
S T WILLIAMS

c/o Dr C Brewer,
London NW8 9XP

## Consensus on preventing osteoporosis

SIR,—You are to be congratulated on the speed with which you published the report of the consensus development conference (10 October, p 914), the organisers of which also deserve credit for the speed with which they issued their report.

Longer consideration, however, might have produced a document that would more properly justify the considerable weight that this one is likely to carry. Perhaps it should also have provided information about the origins, officers, and source of funding of the European Foundation for Osteoporosis and Bone Disease and the way the consensus was reached. It represents only the views of the panel members; the "experts" were not to our knowledge shown the document or consulted about its contents.

As it stands the document calls for comments. Firstly, the minimum effective dose of ethinyloestradiol to suppress bone resorption is not 25 but 15 μg daily[1]; this slip may cause a lot of overprescribing. Secondly, and more important, the authors overemphasise the use of oestrogens and fail to recognise that their protective action on bone is probably lost within a few years of discontinuing treatment.[2] This is because withdrawal of oestrogen is followed by the same rapid phase of bone loss as follows a natural or an artificial menopause.[3] Thus to be truly effective oestrogen therapy would have to continue to the end of life, ostensibly in every woman, which is surely unrealistic.

The calcium section of the report is ambiguous. The panel recommends a calcium requirement of 800 mg in European women without specifying whether it is referring to premenopausal or postmenopausal women and apparently without realising that a requirement is not the same as an allowance. The current Australian recommendations[4] are allowances of 800 mg for premenopausal women, based on a mean requirement of 550 mg, and of 1000 mg for postmenopausal women, based on a mean requirement of 700 mg. If the panel means what it says then it is recommending an allowance of about 1200 mg for all women, which is probably not what it had in mind. Since it also