Letters

What is a good death?

A good death follows a good life

EDITOR—A good death is like the final chapter of a good book: it wraps up the story of "life" with panache; is physically, emotionally, and spiritually satisfying to the author (the deceased) and the readers (kith and kin); and leaves no loose ends to be explained in a sequel.[1]

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Competing interests: None declared.

1 What is a good death? Join in our online discussions. *BMJ* 2003;327:66. (12 July.)

We must learn to live in the light of our mortality

EDITOR—At a recent training day on cultural awareness our facilitator commented that Western culture assumes immortality, and then strives to achieve it. The trouble is that we then come up against the reality of death, often finding it unpalatable, unfair, and something to be fought against.[1]

As Syed has already written (previous letter),[2] a good death follows a good life. His thoughtful metaphor is very much to the point here: not only does the final chapter complete the story of the life that it concludes, but every other chapter is in its way working towards that denouement.

So a good death follows a good life, yes. But also a good life looks forward to a death that, hopefully, will be good. We need to live in the light of our mortality.

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Competing interests: None declared.

1 What is a good death? Join in our online discussions. *BMJ* 2003;327:66. (12 July.)
2 Syed A. A good death follows a good life. Electronic response to: What is a good death? bmj.com 2003. bmj.com/cgi/eletters/327/7406/66#34541 (accessed 23 Oct 2003).

Death cannot be tamed

EDITOR—Tomorrow is not promised to anyone young or old.[1]

As Heraclitus said: "Death cannot be tamed. Death is unknown. Death is other. Death is death. When men die there awaits them what they neither expect nor even imagine."[2]

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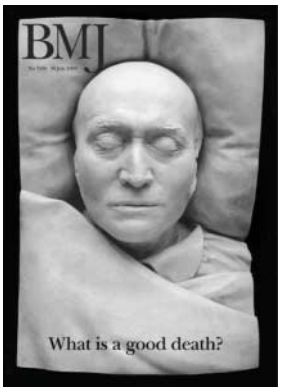

1 What is a good death? Join in our online discussions. *BMJ* 2003;327:66. (12 July.)
2 Hillman J. *The dream and the underworld*. Perennial, 1979.

Good death will happen if life was good

EDITOR—Smith's Editor's Choice should be included in the medical literature that students around the world need to understand.[1] A good doctor cares for a patient's body and soul. Doctors must take into consideration not only contingent questions related to a patient's health condition but also the fundamental questions about the sense and significance of the destiny of human beings.

We have to remember that death is the last of our habits: a good death can be achieved only if a patient, as well as his or her doctor, has spent life in a "good" manner. Where might human beings seek the answer to dramatic questions such as pain, the suffering of the innocent, and death, if not in the light streaming from the mystery of Christ's passion, death, and resurrection?[2]

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1 Smith R. Editor's Choice. Death, come closer. *BMJ* 2003;327. (26 July.)
2 Pope John Paul II. Encyclical letter fides et ratio to the bishops of the Catholic church on the relationship between faith and reason. 14 September 1998.

A painless exit is an index of how well you lived your life

EDITOR—Smith's Editor's Choice about the rarity of a privileged death[1] reminded me of my father's observation: "A painless exit is an index of how moral and helpful your earthly life has been."

I have not had occasion to test its veracity yet, but I think that his admonition has kept me straight more than once.

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Competing interests: None declared.

1 Smith R. Editor's choice. Death, come closer. *BMJ* 2003;327. (26 July.)

The best death would be while making love

EDITOR—In opera, theatre, or literature the best deaths generally are those of brave fighters who kill themselves to avoid capture and degradation; the suicide of lovers because they have, or believe they have, lost their beloved ones; the suicide ordered by rulers; and self sacrifice for a just cause.[1]

But I would rather die in my bed, making love, quite simply.

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Competing interests: None declared.

1 What is a good death? Join in our online discussions. *BMJ* 2003;327:66. (12 July.)

Humour may be important even at the end

EDITOR—I write to contribute to the discussion of what constitutes a good death.[1] Some years ago my colleague Peter was dying from secondaries from a bowel carcinoma. Looked after devotedly by his wife and his medical carers, Peter gradually deteriorated. However, even near the end he was able to spend a day on his beloved West Somerset Railway, organised by friends.

A northerner, Peter shared a blunt, affectionate, sense of humour with my wife, Joan. Saying farewell, after what was to be our last visit to him, Peter commented that he was worn out and now just wanted to go with dignity. With her usual speedy repartee Joan replied: "You've never done anything with dignity before, Peter. Why start now?" Peter's chuckles remain with us as a memory of a very brave man and as a reminder of the importance of laughter in our lives, even at the end.

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1 What is a good death? Join in our online discussions. *BMJ* 2003;327:66. (12 July.)

Grandmother's death was a good example

EDITOR—My grandmother was what you could call a "grand old dame," in terms of dignity, not wealth. One day she decided it was time to die. She lay down in her bed and did not get up any more until she was dead—three months later.[1]

In the years before this day, with a razor sharp mind in a fragile body, she had often asked if there was any way we could help her to die. She often had health problems and pain. However, she was happy and friendly and still enjoyed life's good moments, family events, parties, etc. She lived life to the full. When she went to a party, she exhausted herself so much; she often had to "pay" for days afterwards.

I visited her one month before her death. I had to leave the country for a medical attachment in the United States, and we both knew we would not see each other any more. We chatted a whole afternoon, calmly and with breaks—she was already weak. We crowned this by having a small glass of beer together, which she loved. She then gave me her blessing for the future and I left. After I had left the room I cried, but sadness and happiness had melted into one great feeling in my heart during this truly amazing event.

She died in her room in a nursing home at the age of 95 years, surrounded only by a few of her most cherished items and by my family. I am sure she at one time had feared the anticipation of this great last step in life, but she died in peace, happy and content, and grateful.

I hope I will one day be able to die up to her standards, in dignity. I hope my family will celebrate a good life (as so nicely put by Syed (first letter[2]) on my deathbed, just like their ancestors celebrated my birth and birthdays.

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1 What is a good death? Join in our online discussions. *BMJ* 2003;327:66. (12 July.)
2 Syed A. A good death follows a good life. Electronic response to: What is a good death? bmj.com 2003. bmj.com/cgi/eletters/327/7406/66#34541 (accessed 23 Oct 2003).

Life is all we have

EDITOR—Life is all that matters to me.[1] I would not like it shortened even by a second. As a medical student, I have seen people who said brave things about dignity, but when the moment has come, they changed their minds—they didn't want to die. Neither do I.

I am willing to suffer. I know what pain is. Please, dear doctors, do not take these painful moments of life from me. Do anything you can. Do prolong my life. It may be painful, but it is all I have.

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Competing interests: None declared.

1 What is a good death? Join in our online discussions. *BMJ* 2003;327:66. (12 July.)

Good death may be possible in emergency departments

EDITOR—The final hours of a dying patient may be spent in an emergency department.[1] In 2001, 444 patients died en route or in the emergency departments of Edmonton, Alberta. The number of family members immediately affected by the disclosure of this news while in the department is perhaps double this or more. Family members often experience grief when death occurs there because the patients are often younger and the deaths sudden and unexpected.[2]

Ensuring a good death while the patient is in an emergency department is a multidisciplinary endeavour that requires the help of nurses, social workers, pastoral care workers, and doctors. In a good death the patient's advance directive (if he or she has one) is respected, and the patient suffers minimally. Also, in a good death the patient's emotional concerns are addressed in a caring and compassionate manner. This may include informing the family of the patient's illness.

Communicating with family members of critically ill patients can be challenging and stressful for both family members and healthcare providers.[3] A caring and considerate approach to communication with family members about the patient's condition can perhaps help to minimise the development of potential pathological grief responses.

Having family members present at the bedside of the patient as he or she undergoes resuscitation or medical care can facilitate in communication of death and critical illness. Family members never have to question whether everything was done.[3] The dying patient may gain emotional benefit from the comfort of family presence.

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1 What is a good death? Join in our online discussions. *BMJ* 2003;327:66. (12 July.)
2 Walters DT, Tupin JP. Family grief in the emergency department. *Emerg Med Clin North Am.* 1991;9:189-205.
3 Iserson KV. The gravest words: sudden-death notifications and emergency care. *Ann Emerg Med* 2000;36:75-7.

Pathologists could provide new spaces to say goodbye to the dead

EDITOR—A good death includes the way we say goodbye to the dead person.[1] However, an appropriate environment for such goodbyes is missing in most hospitals.[2 3] This important act has to happen in bathrooms, cold storage chambers, or necropsy rooms. Guidelines for establishing an appropriate environment and the necessary equipment are lacking.

We suggest that such a room must fit different cultures and religious persuasions. The challenge for artists, in collaboration with pathologists, is to create a room that is fitting for a religious ceremony as well as a silent atheistic ritual, without obstructing either.[4]

The room where relatives wait before encountering a familiar person as a dead body requires thought. We decided against gentle music, favouring visual diversions such as pictures and aphorisms on the wall to give relatives an opportunity to look, read, and become absorbed without embarrassment. Relatives should also be informed about the possibility of a death mask.

The room for the ceremony should seem warm, perhaps from light falling through a stained glass window. A crucifix, prayer rugs, the Bible, Koran, or Torah should be provided as required. An opportunity for ritual ablution should be given, and there should also be a hidden sign pointing to Mecca.

The corpse is laid out on an altar-like square stone in the centre of the room. Its orientation is psychologically important. It faces the light rather than the entrance signifying that there is no way back:

> "O pleasant light, my confidence and hope, conduct us thou," he cried, "on this new way."[5]

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Competing interests: None declared.

1 What is a good death? Join in our online discussions. *BMJ* 2003;327:66. (12 July.)
2 www.medizin.uni-koeln.de/projekte/dgss/Archiv/PC101.html
3 Drlicek M, Kraml P. Considerations on a morgue. *Pathologe* 2003 (in press).
4 Kraml P, ed. *Kunst: Ort.* Stadt Linz: Linz Kultur, 1998.
5 Dante A. *The divine comedy.* Purgatory, Canto XIII www.hn.psu.edu/faculty/jmanis/dante/comedy.pdf (accessed 28 Sep 2003).

Survival predictions may hasten death

EDITOR—I have always been concerned about predictions of death, a subject discussed by Glare et al.[1] While in some cases predictions may be a boon to seriously ill people and their families, in other instances they may hasten death unnecessarily—particularly when given months and years in advance.

Studies show that people can choose, to some degree, the timing of their death, as when there is a particular reason to go on living. For example, people die more often after a major holiday than before.[2] In the literature on psychological treatments for cancer, when people find a reason to live, their disease may even arrest or regress.[3]

On the opposite side, and here is my concern, there is the Musselman phenomenon (noted first in German concentration camps) of giving up and dying within hours.[4] By predicting a death, the doctor may, in effect, be "pointing the bone." The literature on hex deaths points to the possibility that negative expectations may contribute to an early demise.[5] Negative effects of spiritual healing may also be activated in this way. Shamanic literature has many case reports to this effect.[5]

So a caution to those who are in the position to be asked to predict people's deaths. Every prediction is based on a probability. A prediction can be stated as, "You have a 90% probability of dying in three months" or "You have a 10% probability of surviving in three months." In the complementary, alternative, healing community we add: "So why don't we see how we can help you be in the 10% group, if you'd like to work towards that goal."

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Competing interests: None declared.

1 Glare P, Virik K, Jones M, Hudson M, Eychmuller S, Simes J, et al. A systematic review of physicians' survival predictions in terminally ill cancer patients. *BMJ* 2003;327:195. (26 July.)
2 Phillips DP, King Elliot W. Death takes a holiday: mortality surrounding major social occasions. *Lancet* 1988;2:728-32.
3 LeShan L. *Cancer as a turning point: a handbook for people with cancer; their families, and health professionals*. Bath: Gateway, 1989.
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5 Krippner S, Welch P. *Spiritual dimensions of healing: from native shamanism to contemporary health care*. New York: Irvington, 1992.

Responding to unexpected events

Maybe skills for this case were missing

Editor—Saunders et al describe a difficult and sad case, something of which they were very aware.[1] As a non-medical healthcare professional I was acutely aware of the absence of certain aspects of care in the case history.

No description is provided of the technically difficult task of sitting with this man at midnight to help him decide what he wanted in this situation, to help him in making a choice about the course of action that would be consistent with his values and wishes. In the United States clinically trained chaplains and social workers provide this kind of technical care. It entails skills that are not taught in every medical school curriculum.

If patients are to "retain control of their environment and destiny" they need the skills of others who have been trained to help people do that. It is not always doctors who have best been prepared to do this. Benefits are to be gained by having a non-doctor function in that role.

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Competing interests: None declared.

1 Saunders Y, Ross JR, Riley J. Planning for a good death: responding to unexpected events. *BMJ* 2003;327:204-6. (26 July.)

Patients have to be treated as individuals

Editor—Saunders et al discussed responding to unexpected events in planning for a good death.[1] I was recently in a very similar, difficult, and sad situation.

My husband for 14 years had been treated for prostate cancer for three years, in an outpatient clinic, where he received chemotherapy, radiotherapy, and intravenous isotopes, focusing on bone metastases. He had no pain and was full of plans and ideas for the future. Iliac artery thrombosis developed; he was taken to hospital and was given heparin as an antithrombosis regimen. A few days after returning home he began to have intense bleeding from the bladder. His condition deteriorated, but he was full of hope, knowing that new treatments had prolonged his life on many occasions.

A urology specialist from another hospital decided to try to detect the cause of the bleeds and, seeing his expectation, we transferred my husband by ambulance to a hospital 30 km away. The bleeding came from a ligated artery, but the mucosa of the bladder was swollen and brittle. He was very weak but still full of hope. Three days later he started to have massive bleeding from the bladder and stomach, and he died—very still, in the presence of family, almost to the end conscious.

I think that with every patient we have to look at the individual person, taking into consideration the patient's physical, mental, and psychological state. We cannot deprive a patient of hope, even knowing that his or her chances are minimal.

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Competing interests: None declared.

1 Saunders Y, Ross JR, Riley J. Planning for a good death: responding to unexpected events. *BMJ* 2003;327:204-6. (26 July.)

Issues related to humanities are close to core of science

Editor—Lewis discussed medical humanities.[1] Bringing humanities closer to medicine is long overdue. Humanities introduce the elements of reflection and qualitative approach to increasingly commodified, quantitative medical science. However, far from being "soft," issues related to humanities are close to the very core of science.

An understanding of the philosophy of science is needed to deal with issues such as logarithmic growth of publications, peer review,[2] and the role of judgment in science. Humanities are about communication, and recent problems with the public image of medicine (evident in debates on necropsy or on pathology specimens) may have stemmed, at least in part, from communication being inadequate. Communication in preventive medicine translates into adherence to treatment and acceptance of lifestyle changes. Within science, good writing is fundamental for creating consensus.[3 4]

The discipline of medical humanities is a natural place for linking the medical, arts, and literature communities. This medical humanities unit, formed in an NHS institution, has since its inception acted as a networking hub. For example, the teaching staff on the module we offer to students at the University of Glasgow include medical practitioners, a philosopher, artists, historians of art and medicine, and a medical illustrator.

Thus humanities in the medical context benefit patients, students, and medical science. However, I believe the true watershed for medical humanities will come when leading researchers, those who wield power in the medical faculties, decide to support the humanities dimension in their science oriented institutions.

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Competing interests: None declared.

1 Lewis W. Medical humanities. *BMJ* 2003;327(suppl):s65-6. (30 August.)
2 Dominiczak MH. Funding should recognize the value of peer review. *Nature* 2003:421:111.
3 Knight J. Clear as mud. *Nature* 2003;423:376-8.
4 Dominiczak MH, McFall K. Science writing: visuals are another story. *Nature* 2003;424:128.

Everyone has own spirituality

Editor—Gatrad et al encourage the growth of understanding of the needs of minorities.[1] We are all, of course, minorities in our own way. As they point out, each of us has a culture, and possibly a religious tradition, to come from and to fall back on, but as they also observe, each of us as an individual observes and follows these in our own way.

Fundamental change in institutional arrangements, education, and the willingness of service providers (not just in health care) to embrace complexity and diversity is certainly required.

The move towards teaching or training in "spirituality," so far advanced in an avowedly secular United States, is slowly being taken in the United Kingdom. Our centre was commissioned to review the research literature and evidence on spirituality in health by the Leicester health action zone, and much of the resultant material is recorded on our website (http://users.wbs.ac.uk/group/ceehd/home/end_of_life).

The journey of a thousand miles begins with the first step, and that means the personal realisation by all healthcare professionals that their clients will have their own spirituality—however we, and they, may define that.

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Competing interests: MRDJ is director of a research centre dedicated to promoting evidence based "cultural competence" and a contributor to a proposed national resource of the training of healthcare professionals in transcultural healthcare practice.

1 Gatrad AR, Brown E, Notta H, Sheikh A. Palliative care needs of minorities: Understanding their needs is the key. *BMJ* 2003;327:176-7. (24 July.)

ATAC trial did not report interim results

EDITOR—We agree with Goodare et al that it is inappropriate to publish interim analyses.[1] However, the results of the ATAC (arimidex, tamoxifen, alone or in combination) trial published in the *Lancet* were the first major analysis as fully defined in the protocol, not an interim analysis.[2]

The statistical power of the trial, defined in the protocol, determined that this analysis would be triggered at 1056 events. Using first event as the primary end point in breast cancer trials is widespread since it is highly likely to predict later survival.

Data from the first analysis of the ATAC trial indicated the potential superiority in efficacy and overall tolerability of anastrozole over tamoxifen as adjuvant treatment for postmenopausal women with early breast cancer. However, it also showed the disappointing performance of the arm receiving combined treatment, which the independent data monitoring committee advised us to close, to limit exposure of trial participants to two drugs when one would do. Informing patients of the early results has not had an adverse effect, as drop out rate has been very low.

The reporting of the positive or negative results of a pre-planned analysis is not only good science, but also informs breast cancer patients about potential new therapies. The results of the ATAC trial provide, for the first time, an alternative to tamoxifen for women with early breast cancer—a breakthrough for both science and patients. This study will continue to define the therapeutic index of anastrozole versus tamoxifen with additional follow up.

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1 Goodare H, Dimmer C, Page K. ATAC trial: reporting interim results is not helpful. *BMJ* 2003;326:1329. (12 June.)
2 The ATAC Trialists' Group. Anastrozole alone or in combination with tamoxifen versus tamoxifen alone for adjuvant treatment of postmenopausal women with early breast cancer: first results of the ATAC randomised trial. *Lancet* 2002;359:2131-9.

Respiratory hazards of "nail sculpture"

EDITOR—We report our concern about the respiratory hazards of "nail sculpture."

From October 2001 to August 2002 we identified in the Yorkshire and north Lincolnshire area three cases of respiratory ill health (work related wheezing, tight chest) related to nail sculpture, a work activity which we think is growing in popularity; it entails using resins to improve the cosmetic appearance of fingernails.

Acrylic resins were the predominant (though not exclusive) resin type used. Although all three women had received training, none had been warned of the potential for adverse respiratory effects. Two of the three abandoned the work with improvement of symptoms; the other was able to continue after changing to another resin.

The respiratory hazards of using acrylic resins and applying artificial nails are well documented.[1 2] Nail dust has also been associated with respiratory problems.[3] We hope that this letter will alert family doctors, respiratory physicians, and others to this occupational hazard. Advice on applying artifical nails, from which useful comparison with nail sculpture can be drawn, is obtainable on the US government website http://www.cdc.gov/niosh/hc28.html

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Competing interests: None declared.

1 Piirila P, Hodgson U, Estlander T, Keskinen H, Saalo A, Voutilainen R, Kanerva L. Occupational respiratory hypersensitivity in dental personnel. *Int Arch Occup Environ Health* 2002;75:209-16.
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Tamoxifen is unproved for gynaecomastia

EDITOR—We were amazed at Khan and Blamey's recommendation of tamoxifen as first line treatment of gynaecomastia.[1] This drug does not have a product licence for such treatment.The evidence base for their conclusion is small (135 patients) and is certainly not derived from randomised controlled clinical trials.

Gynaecomastia is most common in pubertal boys, in whom the condition is usually self-limiting,[2] and data are insufficient to show that tamoxifen is safe in this group of patients. Many questions remain unanswered.

What effect does it have on bone growth? Does the gynaecomastia come back after stopping treatment? What is the optimum duration of treatment?

This editorial is misleading, and until more evidence shows that tamoxifen is safe in this condition it should not be recommended as first line treatment, especially in pubertal boys.

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Competing interests: None declared

1 Khan HN, Blamey RW. Endocrine treatment of physiological gynaecomastia. *BMJ* 2003;327:301-2. (9 August.)
2 Nydick M, Bustos J, Dale J H, Rawson RW. Gynaecomastia in adolescent boys. *JAMA* 1961;178:449-557.

Small risk ratios may have strong public health impact

EDITOR—Traversa et al studied the hepatotoxicity of nimesulide and other non-steroidal anti-inflammatory drugs (NSAIDs).[1] Nimesulide may arguably have a small risk of the more severe hepatic injuries with an odds ratio of 1.9 (95% confidence interval 1.1 to 3.81). Since the drug is widely used in Italy the population attributable risk could account for a number of avoidable cases.[2]

The characteristics of users of the different NSAIDs were assumed to be similar on the basis of the numbers of packets per prescription. If, rather than the number of packets, the number of defined daily doses per person had been used—a more reliable approach—the conclusion would have been different since the mean number of defined daily doses per user of nimesulide and NSAIDs were 50.9 and 73.2, respectively.

A substantial proportion of nimesulide induced hepatotoxicity occurred after a comparatively long time of exposure. In Spain five of the 11 most severe cases of hepatotoxicity related to nimesulide occurred after more than one month of treatment[3]; the average duration until occurrence in a series of 13 published cases of severe hepatotoxicity was 62 days.[4]

Nimesulide does not seem to have any demonstrated advantage over the most widely used NSAIDs in efficacy or safety. This

was shown for upper gastrointestinal complications by García-Rodríguez et al in a case-control study performed in Italy (nimesulide: odds ratio 4.4, 2.5 to 7.7; ibuprofen: odds ratio 2.1, 0.6 to 7.1; diclofenac: odds ratio 2.7, 1.5 to 4.8).[5]

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Dolores Montero, clinical pharmacologist, and Fernando de Andrés-Trelles, professor of pharmacology, both at the Spanish Medicines Agency, are co-authors of this letter.

Competing interests: None declared.

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Non-pharmacological options may have role in postmenopausal osteoporosis

Editor—Cranney's editorial thoroughly covered the pharmacological options available for treating postmenopausal osteoporosis.[1] Non-pharmacological treatments may also have a role, given the uncertainties in managing osteoporosis.

Exercise is a simple intervention that can be advised for postmenopausal women with osteoporosis and is beneficial for other health issues as well. Several systematic reviews have shown an increase in bone mineral density.[2]

Another key issue is the need to decrease the risk of falling. Systematic reviews show the effectiveness of measures to prevent falls, and evidence shows that some available interventions are likely to be effective.[3]

In the last update of a review about hip protectors the initial beneficial effect observed was not confirmed from studies using individual randomisation.[4] Another issue is that most trials targeted people at particularly high risk of fracture.

Head to head comparisons are required, however, and not just among pharmacological options. Results from the women's health initiative trial have made clear that we need to be cautious about the long term effects as sometimes harms might surprisingly outweigh benefits.[5]

How long are we going to keep treating patients with these drugs? Will we have to tell them to stop because of new unexpected adverse effects? Women who are taking a treatment might change their mind if they knew how little we know about the actual benefit they might be obtaining.

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Competing interests: None declared.

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Costs and effectiveness of prehospital thrombolysis need to be clear

Editor—Pedley et al provide further evidence that paramedical staff providing prehospital thrombolysis for acute myocardial infarction is feasible and reduces the treatment delay.[1] However, no cost data were presented.

The authors say that two extra lives might be expected to be saved per 100 patients treated. It is unclear how this estimate was derived. We suspect that this is from the meta-analysis by Boersma et al.[2] Importantly, this health benefit of a one hour reduction in the treatment delay must be within three hours from symptom onset. Pedley et al describe collecting times of onset of symptoms but do not present their results. This is an important omission as the mortality benefit of thrombolysis is directly related to treatment delay from the time of the onset of symptoms. The health benefit of a one hour decrease in treatment delay will be considerably reduced if the total delay is longer than three hours.[2]

Evidence from audit that the care pathway for acute myocardial infarction is achieving the maximum possible health benefit is needed before considering introducing a prehospital thrombolysis service.

We believe that the emphasis of research should now move to establishing and evaluating cost effective models of care for prehospital thrombolysis rather than feasibility studies. Proposals for a prehospital thrombolysis service will be competing against other healthcare interventions in the prioritisation process of primary care trusts. Therefore the costs and effectiveness of such a service will need to be clear and robust to achieve long term funding.

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Competing interests: None declared.

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Equality for people with disabilities in medicine

Editor—The view of the General Medical Council in respect of students with disabilities going to medical school is crystal clear and very positive.

We believe that students with a wide range of disabilities can—and we know that they do—successfully complete the medical curriculum. We would become concerned only in the rare instances where public safety might be at risk. This is spelt out in *Tomorrow's Doctors*.[1] Being in a wheelchair, for example, should not of itself be a bar to studying medicine, and I am personally aware of one such student who recently began their medical studies.

I set this position out in the Career Focus of 18 October.[2] I was therefore surprised and disappointed by the editorial in the same issue of the *BMJ*[3] because it gave the erroneous impression that the GMC gets in the way of students with disabilities going to medical school—we don't. Since the editorial was not cross referenced to my article, despite my article having been commissioned by one of the authors of the editorial, quite the wrong message was conveyed.

The editorial is also misleading in its references to the Heidi Cox case by stating that she "won her initial complaint" against a "ruling" by the GMC that she should not study medicine.[3] This is incorrect. Ms Cox has never won any complaint against the GMC and her case had no basis in law.

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Competing interests: None declared.

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⁂We apologise for unintentionally missing out the link from the editorial by Mercer et al to Professor Rubin's article. We published it in a rapid response to the editorial (bmj.bmjjournals.com/cgi/eletters/327/7420/882#38388). The link is bmj.bmjjournals.com/cgi/content/full/327/7420/s123