

“Right to die”

Legal view of right to life and death could threaten philosophy of palliative care

EDITOR—Grayling claims that the “right to life” means quite a rich life; withholding treatment with death as the result and giving treatment that causes death are indistinguishable; and death is the ultimate analgesic.¹ Grayling also implies that the double effect is widely abused.

The EC Convention for the Protection of Human Rights and Fundamental Freedoms protects against intentional deprivation of life.² Quality of life is not mentioned, and terminating a life at a person’s request is clearly not permitted. “Right to life” is perhaps a “right not to be killed,” in medicine, generally relating to survival and not assisted death. However, some interpret it as giving patients a right to cardiopulmonary resuscitation regardless of the clinical circumstances³; extrapolation to all potential interventions at the life-death interface could have disastrous consequences for the medical profession.

Patients obviously can wish for their life to be terminated without needing to explain why, and they arguably have a right to attempt suicide. However, a right to assisted dying equates to a right that somebody else will kill or help to kill them on request—very different from withholding treatment or the double effect.

Withholding treatment relates to interventions unable to produce the desired benefit.⁴ In palliative care withholding treatment does not directly cause death that arises from an irreversible and unsustainable pathological burden. And death without adequate analgesia is possibly the ultimate pain for everyone. Judicious use of analgesia is an essential part of good terminal care, and, in 15 years as a doctor, I have yet to see a death attributable to deliberate analgesic overdose by a doctor.

Palliative care affirms life until the moment of death, regarding death from advanced incurable disease as a natural process.⁵ It aims to relieve pain and other

distressing symptoms, enhance remaining quality of life, and neither hasten nor postpone death. These human “death rights” should perhaps be protected by legislation. Ill-conceived legislative changes that take the right to life or the right to death beyond sensible limits or give certain doctors the right to kill on request could jeopardise palliative care.

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- 1 Grayling AG. “Right to die.” *BMJ* 2005;330:799. (9 April.)
- 2 Council of Europe Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocol No 11. <http://www.echr.coe.int/Convention/webConvenENG.pdf> (accessed 8 Apr 2005).
- 3 Higginson IJ. Doctors should not discuss resuscitation with terminally ill patients: against. *BMJ* 2003;327:615-6.
- 4 British Medical Association. *Withholding and withdrawing life-prolonging treatment: guidance for decision making*. London: BMJ Books, 1999.
- 5 World Health Organization. Definition of palliative care. <http://www.who.int/cancer/palliative/en/> (accessed 8 Apr 2005).

Sensitivity and humility are needed when dealing with dying people

EDITOR—My many years’ experience of caring for dying people—I was medical officer to a small hospice in the early days of the hospice movement, and for 12 years a consultant geriatrician with a special interest in palliative care—have led me to believe that sometimes it is wrong to encourage or help people to hang on to life until the last moment—there are worse things than death. I agree with Grayling’s assertion that people have the right to decide when and how they die.¹

Their lives and their bodies belong to them, not to the medical staff or even to their relatives. Too often medical and nursing staff have tended to take over patients’ bodies, as though they owned them and knew what was right for them. We must learn to be less arrogant and less controlling as a profession and allow patients more autonomy. This is happening in general hospitals more, as patients become better informed, but hospices still tend to be rather too proprietorial about their patients. We need the utmost sensitivity and humility when dealing with dying people. It is too easy to be patronising and assume we know what’s best. We are not in their shoes.

I agree too that there really is no difference at all between withholding treatment,

with death as the result, and giving treatment that causes death. We are kidding ourselves if we think that there is. I believe we must grasp this nettle, for our patients’ sakes, and offer a compassionate and peaceful death to those for whom palliation is no longer relieving their distress. We fail in our duty to them otherwise.

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Changing “right” to “duty” may focus debate

EDITOR—The predictable outcry over Grayling’s editorial on the “right to die” has added little to an emotive debate.¹ The concept of a right to die is clearly in accordance with the current obsession with autonomy in vogue in UK medical ethics.

Responses restating Christian objections to any perceived undermining of the right to life, and objections from doctors about the lack of moral difference between omission and commission being secondary to effects on the moral agenda, are not fundamental to the issue—though both are views I share.

I believe that a more rigorous ethical refutation is found in moral argument against our rights based culture. Replacement of the term “right” by the term “duty” focuses the debate. Once the initial reactionary problems are explored, as in Hardwig’s article,² we can, in accordance with our interdependent human society, enable everybody to prepare for the best death that we can achieve with the appropriate palliative care support.

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- 2 Hardwig J. Is there a duty to die? *Hastings Center Report* 2997;27(2):34-42. <http://web.utk.edu/~jhardwig/dutydie.htm> (accessed 1 June 2005).

No man (or woman) is an island

EDITOR—John Donne would have had no intention, had he been writing today, of establishing a male norm when he wrote: “No man is an island, entire of itself; every man is a piece of the continent, a part of the main.” Grayling points out with great clarity how the right to life implicitly includes

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within itself a right to a certain basic quality of life, and therefore a right to die if that quality is impossible.¹

My ethics teacher reminded me that where there is a right, there is also a duty. Where there is a right to die, there is also a duty to live, and die, not just as an individual, but as a part of a web of all humanity, of all life, one can even argue as a part of the web of all being in the universe. My life, and my death, are not absolutely my own to do with just as I choose. I have a responsibility to live my life, and to die my death, to the best that I can in the light of this web of all being which I personalise as God.

The ongoing discussion on euthanasia and doctor assisted suicide entails the danger that we regard ourselves and our family and friends and patients as no more than individuals. Our rights must be exercised in the light of our duties. As Donne says, "Any man's death diminishes me, because I am involved in all mankind."

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1 Grayling AG. "Right to die." *BMJ* 2005;330:799. (9 April)

Situation is different in developing countries ...

EDITOR—Grayling's editorial on the "right to die" and the various responses to it are interesting.¹ I also followed Terry Schiavo's case closely, and I agree with the decision taken by the court. But what happens in developing countries is different.

The laws are the same and are more rigid in these countries. The medical decision to end life is influenced more by financial considerations than by the sanctity of life. Terry Schiavo would not have lived for 15 years if she had been born in a developing country and had been in a vegetative state. Governments in developing countries do not have the means to take care of such patients, and neither do the husbands, parents, and relatives. They do not guarantee the right to life for people who do not have the minimum means for living, let alone a decent living. The argument about a right to die becomes meaningless, and ethical considerations take on a different relevance.

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... but context of limited resources can be encountered in developed countries too

EDITOR—Grayling writes that it is perhaps characteristic of humankind that it regards reasoned choices about when and how to die as morally problematic, whereas ignor-

ing the question and hoping for the best is seen as acceptable or even right.¹ Vijayashankara (previous letter) reminds us of the need to consider such decisions in the context of limited resources.

This is particularly salient for those who care for the small minority of babies who are receiving mechanical ventilation for inevitably lethal conditions in neonatal intensive care units. A prospective study in 54 such units in the United Kingdom showed that occupancy was linearly related to the odds of risk adjusted mortality.² In other words, the more babies already receiving intensive care in a neonatal intensive care unit, the more likely it was that a newly admitted baby would die. This is likely to reflect the effects of increased staff workload.

If we ignore the question of limiting intensive care when it cannot prevent but only prolong dying, one consequence is that preventable deaths may be more likely to occur.

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1 Grayling AG. "Right to die." *BMJ* 2005;330:799. (9 April)

2 Tucker J, for the UK Neonatal Staffing Study Group. Patient volume, staffing, and workload in relation to risk-adjusted outcomes in a random stratified sample of UK neonatal intensive care units: a prospective evaluation. *Lancet* 2002;359:99-107.

Summary of responses

Most respondents to Grayling's editorial agreed that there is no such thing as a right to die: the European Court of Human Rights had already ruled so and there is also the Hippocratic oath.¹

Unusual for the *BMJ*, many correspondents added an explicitly spiritual dimension, emphasising that the right to give and take life is God's and not that of human beings. Others remarked that a right to die was by no means the same as a right to be killed. Those in favour of a right to die advocated individual choice in the matter of a person's own death—a principle of autonomy that does not mean the choice is necessarily good.

The idea that a life had to have a certain quality was food for thought and discussion. Correspondents were anxious because the perception of quality is subjective, may change over time, and may be subject to sociocultural and individual norms or biases. It may also marginalise people who are already vulnerable (those who are old, frail, or sick, for example), and it may forever prevent people from regaining a sense of their life's value and improving their quality of life.

The finer distinctions between withholding treatment—not doing the patient any good—and administering a lethal agent—foreseeing and intending a death—were debated passionately and at great length. We were reminded that the clinical difference is also an ethical one: treatment can be withheld without intention of killing but a

lethal agent cannot be given without this intention. Potentially sinister political implications of "death on demand" were highlighted, and several correspondents questioned whether our overdeveloped standard of living skewed our perception of what constituted a life with "value."

This serious debate proved the richer and more interesting for its deeply moral convictions and personal and religious beliefs—especially as many people nowadays may mistakenly assume that doctors are merely technocrats obsessed with fulfilling quotas. Numerous palliative care specialists set the tone: doctors need training in dealing with death and dying, and they should cherish their patients and enable them to live the best life possible until their natural death.

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Competing interests: None declared.

1 Electronic responses. "Right to die." *bmj.com* 2005. <http://bmj.bmjournals.com/cgi/eletters/330/7495/799> (accessed 2 Jun 2005).

Scottish model for surgical mortality used in Australasia

EDITOR—Two days before the *BMJ* published Baxter's editorial expressing doubts about whether the Scottish Audit of Surgical Mortality was applicable elsewhere,^{1,2} the Western Australian Audit of Surgical Mortality published its second annual report.³ The audit was based on the Scottish audit and started in 2001. It has already shown clear changes in local practice despite the different surgical environment. For example, unlike the NHS most surgical operations in Australia are performed in the private sector.

Current participation (96% of surgeons submitted 60% of all deaths) is not as complete as in Scotland because, unlike in Scotland, there is not an established culture of regional surgical audit. A particular problem at the outset was the highly aggressive medical legal environment in Australia. Qualified privilege was an essential prerequisite.

The principal area of public and media interest was the degree of surgeons' participation. The clear expectation is that surgeons participate in the audit process. Little attention was directed to the adverse events themselves.

The Royal Australasian College of Surgeons has announced its intention of establishing the Australian and New Zealand Audit of Surgical Mortality. This will be based on Western Australia's audit methods, which although now modified for local practice, retain the concepts of the Scottish audit at its core.

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- 2 Thompson AM, Stonebridge PA. Building a framework for trust: critical event analysis of deaths in surgical care. *BMJ* 2005;330:1139-42. (14 May.)
- 3 WAASM. Western Australian Audit of Surgical Mortality. www.surgeons.org/about/waasm.html (accessed 3 Jun 2005.)

Clarification: doctors did not accuse Indian authorities of massaging leprosy data

EDITOR—Members of the panel which held discussions at the Press Club of India on 6 May 2005 did not accuse the authorities of the Indian state of massaging leprosy figures, as reported by Mudur.¹

The title of the article does not reflect the proceedings of the press conference, where J P Muliyl and I participated, along with others. The thrust of the presentation was to bring to the attention of the community at large in India through the media that leprosy as a disease and its consequences—such as deformities—have been controlled to a notable extent, but the new cases seen along with complications such as visible deformity, as well as highly deficient socioeconomic rehabilitation, should continue to cause concern to the public and the authorities concerned.

I was quoted as saying that leprosy will remain a public health problem even after the prevalence drops to one per 10 000. This is not a correct version of what I said. What I said was that given the current definition of elimination of leprosy as a prevalence of less than one per 10 000, with India's current population of over 110 crores [1 crore = 10 million], the country will continue to have over 1 lakh [1 lakh = 100 000] patients a year. Will they not be an issue of public health concern?

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- 1 Mudur G. Doctors accuse India of massaging leprosy figures. *BMJ* 2005;330:1104-b. (14 May.)

Why clinicians are natural bayesians



Every part of clinical history and examination can be seen as a diagnostic test

Bayesian confusion

EDITOR—Gill et al say that the pretest odds multiplied by the likelihood ratio of a test provides the post test odds.¹ However, Bayes's work referred to probability rather than odds.

Bayes developed his famous theorem about conditional probability. He showed that the probability of some event A occurring given that event B has occurred is equal to the probability of event B occurring given that event A has occurred, multiplied by the probability of event A occurring and divided by the probability of event B occurring. Bayes theorem states: $P(A|B) = P(A) \times P(B|A) / P(B)$.

The fact that Bayes refers to probability and articles such as those by Gill et al refer to odds has led to confusion, with some people thinking that it does not make any difference whether odds or probability are used or even that it is "debatable" which is used in correct bayesian calculations.^{2 3}

As the authors say, the pretest odds should be multiplied by the likelihood ratio to reach the post-test odds. The likelihood ratio is a simple calculation from the sensitivity and specificity of a test, but the likelihood ratio as such is never used in Bayes's work. As we have shown, however, it is a simple calculation to show that multiplying the pretest odds by the likelihood ratio and deriving the post test odds is equivalent to the proposal of Bayes.⁴

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- 2 Hutchon DJR. Absence of nasal bone and detection of trisomy 21. *Lancet* 2002;359:1343.
- 3 Hutchon DJR. Trisomy 21:91% detection rate using second-trimester ultrasound markers. *Ultrasound Obstet Gynecol* 2001;18:83.
- 4 Hutchon DJR, Khattab A. How to use Bayes theorem to estimate sequential conditional risks. Odds ratio or risk: that is the question! www.obgyn.net/us/us.asp?page=/us/news_articles/hutchon_bayes (accessed 24 May 2005).

Is there a bayesian doctor in the house?

EDITOR—According to Gill et al, clinicians are natural bayesians.¹ Their reasoning about patients is intuitive, probabilistic, and reiterative. Such subjective, context dependent reasoning is integral to clinical judgment and useful when diagnosing rare diseases.

In the same issue, the fictional Dr House is described.² He, too, must be bayesian. He solves rare cases intuitively through flashes of grim insight, this occurring against a backdrop of reiteration: obscure diagnoses are hurled back and forth. He is also likened to fictional detectives, which is interesting because the detective model of clinical judgment has already been described.³ At its core is the collection of evidence about the patient's condition by the clinician, who interprets and reinterprets this in a context dependent way, such evidence being given due weight and accepted or rejected according to the coherence it brings to the diagnostic picture.

It therefore seems that the detective and bayesian models of clinicians are closely similar, if not the same. Both consider information presented by the patient. The detective model expresses the probability of this being relevant in terms of non-numerical

"weight," whereas the bayesian model expresses this numerically.

Also, both models focus on the individual patient. The detective model is compared to the scientific model, which provides a well validated evidence-base for practice generally but does not allow for the unique circumstances of the individual patient. The bayesian model is compared to the limitations of decision making based on frequency statistics and associated algorithms.

The scientific approach, with its reductive abstractions and generalisations based on frequency statistics, causes the clinician to lose sight of the individual patient who is pushed to the margins of attention. Hurrah for bayesianism—its insistence on attention to the patient as context returns the patient to the centre of the clinician's considerations.

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- 1 Gill CJ, Sabin I, Schmid CH. Why clinicians are natural bayesians. *BMJ* 2005;330:1080-3. (7 May.)
- 2 Drife JO. House. *BMJ* 2005;330:1090. (7 May.)
- 3 Downie RS, MacNaughton J, Randall F. *Clinical judgement: evidence in practice*. Oxford: Oxford University Press, 2000.

Clinicians have to be bayesians

EDITOR—Clinicians are natural bayesians when it comes to diagnosis.¹ They have to be. The alternative approach might be to use the methods of classical hypothesis testing, but probably only once.

The Neyman-Pearson diagnosis of coeliac disease

(Assume that the sensitivity and specificity of transglutaminase IgA are both 95%.)

Parent: Well doctor, have you got the result of the test yet?

Doctor: Yes I have. When you brought little Johnny in with weight loss, short stature, and diarrhoea I thought it was worth checking for coeliac disease, and the test has come back positive.

Parent: Does that mean he has coeliac disease?

Doctor: I can't be certain, but it is likely.

Parent: Well, how likely?

Doctor: I can't actually tell you that, but given that he does not have coeliac disease, there was a 95% probability that the test would have been negative, and it in fact was positive.

Parent: Well, does that mean he has a 95% chance of having coeliac disease?

Doctor: No. I can't say that.

Parent: Well what can you say?

Doctor: Given that he does not have coeliac disease, there was a 95% probability that the test would have been negative, and only a 5% chance of obtaining this result.

Parent: We're going around in circles. What about the fact that he has the diarrhoea and weight loss?

Doctor: Well, that's why I did the test.

Parent: Well, does it make coeliac disease more likely?

Doctor: I can't say that.

Parent: Well, what do we do?

Doctor: We could do the test a few more times, and if it keeps coming up positive, it makes the diagnosis more likely.

Parent: How much more likely?

Doctor: I can't say, but more likely. In fact if I did this test on many patients with the same signs, in the long run I wouldn't go far wrong.

Parent: That won't help Johnny. Are you a complete idiot or what?

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Authors' reply

EDITOR—Hutchon is correct that Bayes's original theorem concerned probabilities rather than odds. We should have stated more clearly that expressing this is an application of Bayes's theorem expressed as odds. Odds and probabilities are interchangeable quantities [$P = 1/(1 - \text{odds})$; and $\text{Odds} = (1 - P)/P$]. This can be expressed more precisely by using Bayes's original equations as follows, although these are cumbersome and not as intuitively useful as the version that we presented in the paper.

Posterior odds are $P(D|\text{data})/P(\text{not } D|\text{data})$ (where $P = \text{probability}$ and $D = \text{having the disease}$). By Bayes's rule, the numerator is $P(D)P(\text{data}|D)/P(\text{data})$ and the denominator is $P(\text{not } D)P(\text{data}|\text{not } D)/P(\text{data})$. Dividing these out gives $P(D)/P(\text{not } D)$ times $P(\text{data}|D)/P(\text{data}|\text{not } D)$ which is prior odds times the likelihood ratio. So by using Bayes's rule for probabilities the odds relation can be shown.

In response to the astute remarks of Chitty regarding the similarity between infectious disease diagnosis and detective work, we couldn't agree more. In fact, one reason why Gill loves his clinical work so much is the sense that we're on the hunt for a "villain"—who can often be captured and tamed, once identified.

We enjoyed McCrossin's hilarious encounter between doctor and patient. We cannot resist the temptation to extend his hypothetical dialogue.

Doctor: In fact, if I did this test on many patients with the same signs, in the long run I wouldn't go far wrong.

Johnny (a precocious, although short, 6 year old): But, Doc, what about my height? I'm so much shorter than all my friends.

Doctor: Yes, this is clearly true. But on the basis of standardised growth curves distributed by the Centers for Disease Control and Prevention in Atlanta, 5% of children will be at or below the 5th centile for growth. So I would have anticipated this.

Johnny: Doc, what illnesses might make me so short?

Doctor: It could be the case, in fact, it probably is the case, that you're not eating enough. Lack of adequate food intake is a

major cause of malnutrition, and hence short stature.

Johnny: That's funny. I seem to be eating all the time. In fact, I eat six meals a day, and snack constantly, but somehow, I always feel hungry.

Doctor: That's clearly excessive eating. I want to refer you to our dietitian to educate you and your mother on the risks of overfeeding young children.

Johnny: But, Doc, if that's not the cause, what else might it be?

Doctor: Well, statistically speaking, the most likely cause of short stature is a condition called "congenital short stature." This means you are short now because you were born to be short.

Johnny: But my dad isn't short. Actually, he's pretty tall. Mum, how tall is Dad?

Parent (mother): He's 6 feet 6 inches—and is a goalkeeper for Manchester United.

Doctor: But has he ever been tested for abnormal growth hormones? Perhaps he should come in for a test...

Stay tuned for the next episode of "Statistics and your health."

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Online music model could work for journals

EDITOR—The main issue I see about professional journals is their greed.¹ I once wanted to download an article from one of the major US journals because I was too lazy to walk down a flight of stairs to go to the department library, and the paper seemed interesting in a train of thought I didn't want to interrupt. The charge asked was \$40 (£22; €33). Considering the cost of a yearly subscription and the number of research papers per year, the cost per printed research paper was about \$0.40 (online cost without paper, ink, or postage could be much lower).

I did not pay the \$40: I walked down to the library, and photocopied the article, which cost me less than a dollar, at no profit to the journal. I could also have asked a colleague with a subscription to download it for me and email it.

Had the online paper been for instance at \$0.99 (as the songs on iTunes or other similar services) I would have paid that amount without any qualms and without noticing it, probably spending overall much more on the journal at the end of the year than the \$40.

By charging too much per paper, the major journals are shooting themselves in

the foot. It would be interesting to see whether a business model charging a small sum (\$0.99 or €0.99 or £0.69) would lead to increased downloads of papers. And for that sum, most people would not try to find an illegal copy.

Free is better of course, but not always realistic. Exorbitant is bad. It works for music, why shouldn't it work for science? The models are out there.

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Competing interests: NDM does not feel the need to subscribe to journals for just a few papers per year and doesn't want to pay 100 times the actual cost of the papers online. Application of this model could benefit consumers, including himself.

1 Lenzer J. Medical societies react against public access to findings. *BMJ* 2005;330:1104-d. (14 May.)

English surgeons may at last be about to become doctors

What about nurses with PhDs?

EDITOR—Surgeons calling themselves or who prefer being called Mr/Ms/Mrs are becoming less common nowadays and may become a thing of the past.¹ Members of the public could easily think that they are not being cared for by a "doctor," so I hope the anachronistic surgeon will finally agree to retain the title "Dr" even after passing the professional examination.

As more and more nurses are getting PhDs, I would like to know how the medical profession feels about nurses being called Dr. The irony is greatest if the doctor is a "Mr" and the nurse a "Dr."

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1 Dobson R. English surgeons may at last be about to become doctors. *BMJ* 2005;330:1103. (14 May.)

Anyone for bolting on the German system?

EDITOR—With reference to Dobson's article,¹ I quite like the German system [where "Dr" is an academic title, awarded for writing a thesis and sitting vivas. And you can gain more than one Dr by doing the required work]. Then we could call someone with an MD (a British one, that is, not an American one) and a PhD "Dr Dr Dr So-and-so."

What fun. As some of the respondents on bmj.com imply, titles and status are so very important.

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