

three main concerns we have with the paper's estimates are as follows:

■ The total number of patients on monotherapy in Box 3 of the article adds to 1.1 million, whereas elsewhere the authors state that 60% of all 1.2 million Australian patients treated for hypertension are on monotherapy, giving an estimate of 0.72 million. (These estimates of 60% and 1.2 million are not referenced in the article.) One reason for this discrepancy is that the authors have treated the sum of column 4 in Box 2 as patients, not patient-years of treatment (some patients are on dual or triple therapy), leading to a 40% overestimate of numbers of patients on monotherapy reported in Box 3.

■ Utilisation of prescription drugs is recorded by PBS/RPBS only if the cost to patient is subsidised. Therefore, PBS/RPBS expenditure divided by total patient numbers (Box 2) underestimates consumer cost for diuretics and β -blockers, both of which cost less than the non-concessional copayment. Of total PBS/RPBS scripts, 16% are for non-cardholders,² and the cost per script to these patients is about three to four times the prevailing 1998 cardholder copayment. As a rough estimate, total consumer cost for these agents may need to be doubled, and their omission is therefore material. Although non-concessional patients still have a saving, it is less than that estimated in the article.

■ Sensitivity analysis should have been performed on the following critical assumptions: (1) proportion of use for hypertension for each class of drugs, (2) the number of unsubsidised users of diuretics and β -blockers, and (3) the proportion of patients on each agent who are on monotherapy.

It is vital that the current scrutiny by all stakeholders of PBS/RPBS expenditure be informed by reasonable estimates of inappropriate utilisation. The contribution made by the authors in developing a technique to estimate appropriate use for this group of drugs is valuable. However, use of unreferenced estimates of key variables, insufficient application of sensitivity analyses, algebraic errors and inappropriately combining PBS with non-PBS data may cloud rather than shed light on this issue.

1. Nelson MR, McNeil JJ, Peeters A, et al. PBS/RPBS cost implications of trends and guideline recommendations in the pharmacological management of hypertension in Australia, 1994–1998. *Med J Aust* 2001; 174: 565–568.

2. PBS expenditure and prescriptions. January 2000 to December 2000. Canberra: Commonwealth Department of Health and Aged Care, 2001. Available at <http://www.health.gov.au/pbs/pubs/pbbexp/pbdec00/index.htm>. □

**Mark R Nelson,* John J McNeil,†
Anna Peeters,‡ Christopher M Reid,§
Henry Krum¶**

* Research Fellow; † Professor and Head; ‡ Research Fellow, Department of Epidemiology and Preventive Medicine, Monash Medical School, Alfred Hospital, Prahran, VIC 3181; § Senior Research Fellow, Baker Medical Research Institute, Melbourne, VIC; ¶ Associate Professor, Department of Medicine, Monash Medical School, Melbourne, VIC.

IN REPLY: We thank Pekarsky and Ewald for their comments.

It is difficult to estimate the percentage of patients on monotherapy from any source. We used data from IMS Health (<http://www.ims-global.com/>) to determine the number of person-years of exposure to drugs prescribed with a principal indication of hypertension. Some of these drugs were prescribed as a sole agent if the script was for this single drug alone. Exposure for such agents was expressed as a percentage of the total exposure of this drug. For example, angiotensin-converting enzyme (ACE) inhibitors were sole agents in 63.9%. In the other 36.1%, the co-prescribed drugs may have been another antihypertensive drug or another type of drug altogether. Corresponding figures for calcium-channel blockers were 61.3%, for diuretics 53.6%, and for β -blockers 60.0%. As an approximation, we used the estimation that 60% of patients were likely to have been on monotherapy for hypertension. Adding the number on monotherapy for each drug gives an estimate of 1.2 million for the total population on monotherapy for hypertension. Therefore, the total number on drugs is likely to be greater than the 1.2 million as estimated in our article. However, the essential figure is that of 1.2 million for monotherapy, which we stand by.

It is true that a minority of prescriptions (16%) are written for people without a concession card and that these are more likely to pay the full cost of a cheaper drug. Our economic perspective was that of the PBS/RPBS. Hence, consumer costs were only included where the government made a copayment. It is acknowledged in the Methods section that “with some drugs, the patient copayment covers the total cost; in

these instances the Commonwealth makes no contribution to the cost and these prescriptions are not recorded in the PBS/RPBS data” (page 566). It is also stated in the Discussion that the PBS/RPBS captures “much more of the cost of the newer, more expensive agents than thiazide diuretics or β -blockers” (page 567).

We chose to limit our sensitivity analysis to the key issue of redistribution of agents after initiation of monotherapy. The data we presented allow interested parties to conduct their own further sensitivity analyses, such as those suggested by Pekarsky and Ewald. □

MEDicine or MADness

David C Currow

Professor of Palliative and Supportive Services, Flinders University, Bedford Park, SA
david.currow@rgh.sa.gov.au

TO THE EDITOR: In his recent Commentary on hastening death in terminally ill patients,¹ Hunt may not have fully appreciated a very cogent point made in the research by Douglas and colleagues.² The surgeons surveyed clearly reported the intent of their prescribing. This is contrary to Hunt's assertion that “Intention is inherently subjective...complex [and] ambiguous”. Some surgeons gave a dose appropriate to the symptoms, others deliberately increased the dose beyond direct symptomatic control, and a few deliberately ended life, at times with no explicit request. As Douglas points out, the dose of a medication given will be an important clue in this. Good clinical practice is about minimum effective dose (MED), not maximum administrable dose (MAD). This is the case for all patients, whether they are near the end of life or not.

Hunt also states that “The duty of doctors is to strive to satisfy the wishes and interests of their patients and their patients' loved ones”.¹ This is a disturbing comment if left unqualified. There is a broader accountability for doctors to the community through the registration process, quality assurance and continuing education, and the criminal code. If the article by Douglas et al highlights nothing else, it should be clear that there are certain members of the medical profession who believe that they are above the law and have control over the life and death of their patients, with no external review.² It is frightening that such paternalism still exists. Unfortunately, the Dutch experience of tolerating euthanasia does not appear to

Correction

*Re: “Impairment bible” [book review of *Guides to the evaluation of permanent impairment*], by Ganora A, in the 21 January issue of the *Journal (Med J Aust 2002; 176: 82)*. By editorial error, the reviewer's name was misspelled Gandora.*

We apologise to Dr Ganora for the error.

have decreased unilateral decision-making on the part of some doctors.^{3,4}

If the premise that the interests of the patients' loved ones is a consideration in the duty of care,¹ then we are risking the loss of patient autonomy in an unprecedented way. As a practising clinician, the majority of requests that I receive to hasten death are from relatives, not patients. These relatives ask that they be put out of their own misery by ending the patient's life prematurely. To do something to a patient for a third party, however concerned or distressed, is an unacceptable action for clinicians.

For the profession to credibly engage in the debate about end-of-life care, we must accept that we are part of the community and hence governed by its laws. There are reference points external to the profession by which we will be judged.

1. Hunt RW. Intention, the law, and clinical decision-making in terminal care [commentary]. *Med J Aust* 2001; 175: 516.
2. Douglas CD, Kerridge IH, Rainbird KJ, et al. The intention to hasten death: a survey of attitudes and practices of surgeons in Australia. *Med J Aust* 2001; 175: 511-515.
3. van der Wal G, Dillmann RJ. Euthanasia in the Netherlands. *BMJ* 1994; 308: 1346-1349.
4. van Thiel GJ, van Delden JJ, de Haan K, Huibers AK. Retrospective study of doctors' "end of life decisions" in caring for mentally handicapped people in institutions in The Netherlands. *BMJ* 1997; 315: 88-91. □

Roger W Hunt

Clinical Lecturer in Palliative Care, Flinders University, Bedford Park, SA.
Roger.Hunt@rgh.sa.gov.au

IN REPLY: The survey by Douglas et al¹ indicated that, under the current criminal code, about one in three Australian general surgeons are at risk of prosecution for murder because of the way they treat their dying patients. It is likely that many other Australian doctors are similarly at risk of prosecution. This is a serious problem that raises important questions: Why are so many doctors breaking the law? Should these practices be kept covert or brought out into the open for audit and discussion? Is the law serving the needs and interests of dying patients, those who care for them, and the wider community?

Rather than argue that doctors are above the law, I have argued that the practice of medicine should be congruent with the law.² Laws have been established and refined over time so doctors can help their patients (eg, with procedures and the administration of drugs) in ways that are illegal for others. An integral part of the medical role involves the negotiation of life-death decisions. I believe murder laws should be refined to reflect the reality that some terminally ill patients want death as a release from suffering and seek the help of their doctor to provide this. Just as there are

differences between rape and making love, I see obvious differences between common murder and the hastening of death that doctors provide for terminally ill patients out of compassion, mercy, and respect for their wishes. Unfortunately, the ethics of current practices are difficult to elucidate because the existing law makes investigations problematic.

The current crude law does not reflect community values — Morgan Gallup polls indicate about 80% of Australians are in favour of allowing voluntary euthanasia in certain circumstances.³ As Currow observes, these widely held values are sometimes expressed by the relatives of dying patients. In my experience, however, these relatives are usually advocating for the patient's wishes and interests, rather than undermining patient autonomy. I support the established hospice tenet that "the family is the unit of care" and there is a duty to address the concerns not only of patients but also of their loved ones.

I think it is only a matter of time before politicians introduce the reforms that render the legal framework for terminal care more congruent with community values, the wishes of patients and their families, and current medical practices. These reforms should enable research, audit and the better regulation of end-of-life care.

1. Douglas CD, Kerridge IH, Rainbird KJ, et al. The intention to hasten death: a survey of attitudes and practices of surgeons in Australia. *Med J Aust* 2001; 175: 511-515.
2. Hunt RW. Intention, the law, and clinical decision-making in terminal care [commentary]. *Med J Aust* 2001; 175: 516.
3. Morgan poll. Finding No. 2933. *The Bulletin* 1996 Sep 17. □

HIV among injecting drug users of Indo-Chinese ethnicity in Victoria

Jane S Hocking,* Peter G Higgs,†
Cathy M Keenan,‡ Nick Crofts§

*†‡Senior Research Officer, § Deputy Director,
Macfarlane Burnet Centre for Medical Research,
PO Box 254, Fairfield, VIC 3078.
hocking@burnet.edu.au

TO THE EDITOR: Australia has been successful so far in maintaining a low prevalence of HIV infection among injecting drug users (IDUs). This has been achieved by adopting a harm-reduction approach to the prevention of bloodborne virus transmission, including needle and syringe programs, methadone maintenance and peer-education. Sharing of needles and syringes has declined markedly: cross-sectional surveys among users of needle and syringe programs across Australia have