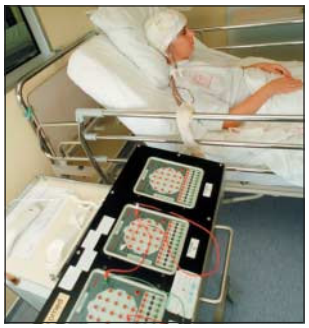
three moral outlooks and concludes that permitting euthanasia in limited circumstances seems the most beneficial approach. And a Dutch group reflects on a deade of monitoring euthanasia in the Netherlands (p 691).



AUX/PHANIE/REX

Treat status epilepticus with benzodiazepine followed by phenytoin

An evidence based clinical review of status epilepticus (p 673) finds few randomised trials and little evidence to support one treatment regimen over another. Walker advises that all patients with status epilepticus who have not responded to benzodiazepine and phenytoin should be referred to a neurologist for further management, as should all patients with suspected non-convulsive status epilepticus. Health professionals who care for patients with epilepsy should warn patients not to stop taking their drugs suddenly as this is one cause of status epilepticus.

POEM*

Endovascular repair is worse than open repair of abdominal aortic aneurysms

Question Is open repair better than endovascular repair for patients with abdominal aortic aneurysms?

Synopsis In this multicentre study, patients 60 years and older with abdominal aortic aneurysms at least 5.5 cm in diameter were randomly assigned (masked central allocation) to endovascular aneurysm repair (EVAR; n = 543) or traditional open repair (n = 539). These patients had been cleared, medically, for surgery. After repair of the aneurysm, the researchers evaluated the patients at one, three, and 12 months, and yearly thereafter. Although the study was unblinded, it's pretty hard to fudge the main outcome, all cause mortality, which was assessed via intention to treat. The study was designed to be able to detect a 5% difference in all cause mortality. The median duration of follow-up was 2.9 years, and only five patients were lost to follow-up (two in the EVAR group and three in the open repair group). The all cause mortality rate was approximately 28% in each group. There was a small reduction in death in the first 30 days after EVAR (0.2% *v* 0.5%) and a 3% absolute reduction in aneurysm related mortality, but EVAR costs more, didn't improve health related quality of life, increased postoperative complications, and increased the need for repeat procedures.

Bottom line Endovascular aneurysm repair (EVAR) offers no real advantage over traditional open repair in medically fit patients with abdominal aortic aneurysms.

Level of evidence 1b – (see www.infopoems.com/levels.html). Individual randomised controlled trials (with wide confidence interval).

EVAR Trial Participants. Endovascular aneurysm repair versus open repair in patients with abdominal aortic aneurysm (EVAR trial 1): randomised controlled trial. *Lancet* 2005;365:2179-86.

* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

Editor's choice

A time to die

Ask friends about the deaths of their loved ones, and the "bad death" stories crowd out the "good death" ones. Reflections along the lines of "They wouldn't let a dog die like my old Dad died," recur uncomfortably often. This is presumably one of the reasons why public support for legislation to permit assisted dying exceeds 80% (p 681). While doctors' attitudes are harder to summarise, there are signs that a majority of UK doctors now favour legalisation of physician assisted suicide with stringent safeguards (p 686).

In this issue we've assembled five articles that discuss assisted dying from a range or perspectives. We've also included a review of a film about EXIT, the Swiss organisation that provides "suicide assistance" (p 702). Our intention is not to tell you what to think but to arm you with information to help you make up your mind. Are you for, against, or—like the BMA and the royal colleges of general practitioners and physicians—neutral? Since doctors are likely to have a key role in assisted dying we think they should decide where they stand, and why.

The immediate context for this current concern is next month's debate in the House of Lords on the issues raised by Lord Joffe's bill on assisted dying for the terminally ill, which ran out of time before the general election last May. The most significant development since then has been the decision of this year's annual representative meeting of the BMA to drop its opposition to the legalisation of assisted dying (p686). The legislators might now begin to move—if the public wants the law changed and doctors have dropped their opposition to it.

It's hard to tell from where we sit whether a majority of doctors have dropped their opposition to assisted dying. Any mention of euthanasia in the *BMJ* seems to precipitate a barrage of criticism from opponents of a change in the law that drowns out the messages of support. Do the opponents have more, or better, arguments than the supporters of a change in the law? Are they more numerous, better organised, or just noisier? We'll be watching carefully the feedback to these articles. So, one suspects, will the government.

Elsewhere we publish feedback to an earlier idea floated in the journal: scenario planning for academic medicine. Respondents to an online poll rated the "Global academic partnership" (main concern: to improve global health) the most creative and desirable scenario but also the least likely. "Academic Inc" (the triumph of the market) was rated the most distasteful but the most likely scenario (p 672). Among a cluster of letters on the topic, one reports on an intriguing method to improve collaboration between academic departments—a modified form of speed dating. Members of one department were rotated at three minute intervals between stations "manned" by members of another department, with the chance for interested pairs to follow up their introductions over coffee (p 695).

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