ing a case against Dr G's behaviour. The Judge expressed frustration with the lack of reasoning for the Tribunal's decision against Dr G. The second case also relied upon the four principles and the majority of the Tribunal's decision was overruled in the District Court. In both cases it was decided by the Tribunal that the doctors had caused harm to the patient. It is not questioned that from the patient's perspective they were harmed in some way and that this could justify the decision that the doctor's behaviour is maleficent. One Judge suggested that the behaviour may be "shabby if not immoral conduct" but that is not enough to impose disciplinary proceedings against a doctor. Had the Tribunal in both cases given reasoned decisions with explanations as to why they were imposing moral standards rather than purely justifying the imposition of a disciplinary measure, their conclusions might have been safer. The moral behaviour of the doctors in these two cases emphasises the often difficult consideration of role-related obligations, e.g. to the patient versus third party or employer/employee. When two professional roles are operating, it is important to give clear reasons in the argument that imposes disciplinary action. The four principles may have a place in disciplinary procedures but no reasons are good for no-one.

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LETTERS TO THE EDITOR

The frail elderly and their bitter pills

I read with interest in your December issue the *Back to Back* on treating the elderly with statins. In the same journal I was also stimulated by Bruce Arroll's book review of *A Bitter Pill: How the Medical System is Failing the Elderly* by John Sloan and have purchased a copy. Bruce says this should be compulsory reading for all GPs and I can only agree. Dr Sloan is a Canadian family physician who specialises in care of the frail elderly and his observations resonate with all of us who see in our daily practice the dangers, risks and futility of much preventive treatment in this group. The book points out that there is NO scientific basis for the vast majority of prevention that is advocated for the frail elderly, and gives a persuasive and logical argument for offering withdrawal of much of it.

Can I suggest that Bruce shares this book with his colleagues who seem so eager to recommend yet more medications for the elderly. Although Sue Wells's advice on prevention seems reasonable in theory, the net effect is often frail elderly patients on 20–30 medications, sometimes losing weight because after taking their pills there is literally no room in their stomach for food! The standard fare for frail elderly unlucky enough to be hospitalised for any reason is to leave on two to three osteoporosis medications, statins, oral hypoglycaemics, aspirin, several antihypertensives and of course omeprazole. I am sure a good case can be made for each of these drugs in a younger person—the cumulative result in the elderly is usually a disaster.

Paul Corwin

Letters may respond to published papers, briefly report original research or case reports, or raise matters of interest relevant to primary health care. The best letters are succinct and stimulating. Letters of no more than 400 words may be emailed to: **editor@rnzcgp.org.nz**. All letters are subject to editing and may be shortened.