

letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk.

Assisted Dying for the Terminally Ill Bill, 2004

Editor – It is both regrettable and reprehensible that the RCP Committee on Ethical Issues in Medicine presented a neutral stance on euthanasia to the House of Lords Select Committee on the Joffe Bill, and felt it right to leave any decision on the matter to 'society as a whole'.

'Reflective physicians ... have an obligation to be informed and to inform public debate. So do medical institutions...' – including the College (*Clin Med* November/December 2004, pp 534–40). Of course, 'society as a whole' will eventually make the decision, but it is not acceptable for us

simply to leave a matter of such fundamental importance – in effect – to the editors of tabloid newspapers. There is reason to think that the 'neutral stance' has been seen by many, including the Select Committee, as giving a 'green light' to the proposed Bill. A poll by Opinion Research Business in 2003 demonstrated that 60% of doctors opposed physician-assisted suicide and 61% opposed euthanasia.¹ The College should have supported the nurses and the BMA. The passage of such a Bill would gravely undermine the whole ethos of medical practice. The College's fundamental change of stance could only be justified by a poll of Fellows and Members.

Space does not permit detailed analysis

of the arguments, which are carefully considered and set out in the recent paper, but Professor Tallis seems to have a rosy view of the Dutch situation. It has been claimed that some in Holland are now sufficiently worried to go abroad in the event of serious illness, precisely to avoid any risk of euthanasia. Euthanasia was prompted there by a lack of palliative care facilities in the first place and their enhancement is an understandable reaction rather than a response.

I am surprised that religious faith and religious experience have barely received a mention, since they are important in this context, both to patients and to physicians.

Reference

- 1 Poll by Opinion Research Business, May 2003, conducted through doctors.net.uk, to which 986 doctors responded. www.opinion.co.uk/documents/EuthanasiaAssistedSuicidePresentation-FV.ppt

IAN JESSIMAN
Retired GP, Chislehurst

Editor – I am horrified to hear that the College's stance towards euthanasia in relation to the Assisted Dying Bill is one of 'neutrality', thus leaving this important moral decision to the general consensus of society. If the College is unable to take a moral stance on such a vital issue, then I wonder who is? Should we also therefore leave it to society to decide on all other medical ethics? If that is the case, then parents for example should be able to decide to have their loved ones resuscitated despite it being futile and contrary to medical opinion? Also, majority opinion does not make something morally right. The Communist revolution is a good example of this. Because society deems euthanasia acceptable it does not by default make it morally right.

The College, by its very inception, was founded to benefit the public by offering a high moral standard of safe ethical clinical practice, and was founded on absolute Judeo-Christian principles. Once we lose sight of this solid firm foundation then the whole meaning of right and wrong disappears. What is the point of even having ethics committees if they themselves are neglecting their responsibility to protect the

The position of the Royal College of Physicians on assisted dying

The College's stance of neutrality in relation to the proposed Bill on Assisted Dying for the Terminally Ill has been misinterpreted by many who believe that it represents either an attitude of indifference, or suggests its support for the Bill. Neither of these interpretations is correct. In correspondence both to the President of the Royal College of Physicians and to *Clinical Medicine*, Fellows have criticised the failure of the College to present a clear moral case against a Bill promoting euthanasia, and five of these letters are published here. Opposition to the Bill by many Fellows was evident from lengthy and informed discussions both in the College Council and in the College's Committee on Ethical Issues in Medicine, where strong views were expressed that the College should oppose the Bill. Yet it has become clear that physicians are not unanimous on this issue, and that there are many who support its intentions. It was as a result of this division of opinion that the College has presented views for and against the Bill both to the House of Lord's Select Committee and by publication in *Clinical Medicine*.¹ The College is not indifferent to this critical issue.

Reference

- 1 Tallis R, Saunders J. The Assisted Dying for the Terminally Ill Bill 2004. *Clin Med* 2004;4:534–40.

PETER WATKINS
Editor, *Clinical Medicine*

innocent, defend the sick and to stand for truth? The RCP must never be neutral because to do so would be to undermine the very ethos of the College's Royal Charter.

NICHOLAS HERODOTOU
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Editor – Thank you for finally bringing the Assisted Dying Bill for the Terminally Ill to the attention of members of the College (*Clin Med* November/December 2004, pp 534–40). It is disappointing that open discussion did not occur prior to the RCP's recent public statement to the House of Lords' Select Committee.

I was shocked and saddened to learn of my College's new position on euthanasia by reading press reports in October 2004.¹ To declare, on behalf of thousands of physicians, that we are neutral on this extremely important issue is a disgrace. If the RCP Committee on Ethical Issues in Medicine cannot come to a uniform opinion, it is also unlikely that the College membership would agree. To adopt a new position of neutrality surely requires a survey of all members to result in a 50:50 split?

It is not acceptable for the RCP to side-step the importance of the doctor–patient relationship by declaring the Bill 'a matter for society as a whole'. It is not. If the Bill becomes law, doctors would be involved with the practical outworking of assisted dying. Society would not. The law must be a means of protecting vulnerable members of society, not destroying them.

As doctors, we are advocates for our patients. We must not allow this relationship of trust to be undermined by the suspicion that we may be angels of death. We must also stand up for the rights of the profession to maintain its integrity and hold to the Hippocratic tradition.

The GMC states that our role as doctors is 'to show respect for human life'.² We should care for and protect our patients as best we can. We can enable them to live valued lives within the constraints of illness. In terminal disease, this is achieved through high quality palliative care and interventions to address physical, psychological, social and spiritual concerns.

Our role as doctors is not to judge our patients lives as worthless and then to kill

them at their request. I believe assisted suicide should remain illegal. Instead, resources should be directed to making good palliative care readily available to everyone who needs it.

References

- 1 <http://news.bbc.co.uk/go/pr/fr//1/hi/health/3745714.stm>
- 2 General Medical Council. *The duties of a doctor registered with the General Medical Council*. www.gmc-uk.org/standards/doad.htm

SE WENHAM
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Editor - I am writing to express my opposition to the views of Professor Tallis in his article supporting the Assisted Dying for the Terminally Ill Bill (*Clin Med* November/December 2004, pp 534–40). He asserts that there is a 'clinical need' for assisted dying. Killing (except for usual exceptions, eg just war) is morally wrong. Surveys into the wishes of the general public or doctors cannot make right something that is morally wrong; no such clinical need can therefore exist. I agree that autonomy is an important tenet of medical ethics but it does not stand supreme or in isolation. To be members of a society we have to limit our autonomy not only for our own benefit but for that of others; not legalising patient-assisted suicide (PAS)/euthanasia is another example of this. Legalisation of PAS/euthanasia would, I believe, be to the detriment of our society as a whole, damaging further the doctor–patient relationship and leading us as a society to continue to avoid, rather than confront, issues of dependence and suffering around death.

I believe that my role as a doctor in palliative care is not to judge my patients' lives as worthless and then to kill them, even at their request, but rather to cherish them and enable them to live their lives to the full as much as is possible. Even in the face of irremediable suffering, our role is to share their journey with them and not to terminate it. Practice in the Netherlands demonstrates that non-voluntary euthanasia and non-registered euthanasia both occur. No amount of regulation could prevent these or other abuses from occurring in the UK. In addition, legalisation of PAS/euthanasia could lead to fragmenta-

tion of palliative care services. Hospices are small places requiring unity of vision and purpose within the multidisciplinary team so that they can provide their unique atmosphere for care of the dying. Legalisation of PAS/euthanasia may lead to fracturing of these relationships as each hospice will have to decide whether or not to undertake assessment or provision of PAS/euthanasia. If the Bill is passed, it will also require allocation of already scarce resources and staffing in palliative care to implement a policy that will only be used by a minority of patients.

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The management of rare diseases

Editor – A meeting to discuss the management of rare diseases was held at the College on 5 October organised by the RCP and the National Institute for Clinical Excellence and sponsored by the drug firm, Genzyme. As an interested observer with 45 years experience in this field I must confess I was disappointed, not in what was said but in what was not said. I was left with the impression that the allocation of resources was more important than the care of the individual patient and that advances in therapy should be left to industry. The role of the individual researcher was not mentioned.

The development of drugs for orphan diseases can never be a commercially attractive proposition for a pharmaceutical company. Dr Shami suggested that the cost of development could be as much as £500 million. In a recent article in the *Lancet*, Trevor M Jones put the figure as high as \$800 million.¹ Profits on this sort of expenditure can hardly be recouped on an orphan drug. Individual initiative is still required in this field.

Let me now turn to those aspects of the problem which were omitted from the meeting:

- 1 *The structure of rare disease clinics and their funding, and the relationship of the individual doctor to his patients.* This is a lifelong commitment for both doctor and patient; it is not satisfactory for the patient to be seen