caution' under the age of five years. Certainly, optic neuritis is a complication of both TBM and ethambutol therapy, however we note that, while it is well recognised, the retinopathy of ethambutol is dose dependent and uncommon, and reversible on withdrawal of the drug.

We acknowledge that hydrocephalus is a recognised complication of TBM and, as always, requires prompt diagnosis and surgical intervention as necessary.

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ANNE TUNBRIDGE
*Clinical Lecturer in Infectious Diseases*
ROBERT READ
*Professor in Infectious Diseases*
*Division of Genomic Medicine*
*Sheffield University Medical School*


## The Assisted Dying for the Terminally Ill Bill 2004

Editor – In the debate on end-of-life issues, Saunders (*Clin Med* November/December 2004 pp 534–40) reiterates some of the traditional arguments against the present Bill. In the context of care for those terminally ill patients who are suffering unbearably, it does not help to talk of Nazi fantasies and to see this Bill as a threat to other vulnerable groups. Depression and existential suffering can be relevant in any decision about treatment, not just at the end of life. As doctors we are involved in decisions in many ethically grey areas – including when to withhold or withdraw treatment, genetic testing etc. Saunders' last paragraph suggests a life-at-all-costs approach. This is not the best place for answering philosophical points – there is strong support for the Bill from some of our best-known philosophers and 'thinkers'. Of those who chair the ethics committees of the British Medical Association, Royal College of Nursing (RCN) and Royal College of Physicians, one is on the Board of Directors of the Voluntary Euthanasia Society, whilst another sees changes along the lines of the Bill as perhaps inevitable. The viewpoint of the RCN leaders may not be that of the rank and file, as suggested in the article. For patients, the moral difference between doctors who end life in trying to control symptoms and those who end life when it is the only way of controlling those symptoms, may seem academic. What is important is that there should be greater patient involvement in the choice. The present system has served us reasonably well but doctors are feeling increasingly under threat regarding pain relief post Shipman (Medix Survey, 2004). Even leaving a limited supply of morphine with the patient could be construed as 'assisting suicide'. This Bill could help to consolidate present good practice with clearer protection for patient and doctor. We must learn to discuss problems of prognosis with greater honesty but also to listen to the views of the patient. The medical debate should move on to looking at how the Bill should be implemented. After all, when I was first a student a book on medical ethics gave clear, practical advice about 'accelerating death' if all else failed to control symptoms.[1]

Declared interest: on the Board of Directors of the Voluntary Euthanasia Society.

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SIMON KENWRIGHT
*Consultant Gastroenterologist*
*East Kent Hospitals*


Editor – I am grateful for the publication of the debate on the Assisted Dying Bill and the request to engage the College Fellowship on this issue. The current neutral stance of the College has not been taken on the basis of wide consultation and in many quarters has been interpreted as tacit support for the Bill, which I submit is likely to be contrary to the views of the Fellowship. The views of medical professionals seem to be related to their involvement in the care of the dying, with those most closely involved being most set against the legalisation of assisted dying or euthanasia. Professor Tallis is in a minority of geriatricians on this issue, as a survey of UK geriatricians showed 81% considered active voluntary euthanasia never to be justified ethically.[1] Of palliative care specialists in the UK, 92% said 'no' in response to the question: 'Do you believe that the interests of patients with advanced incurable progressive diseases would be better served were legislation to be enacted to permit euthanasia or assisted suicide?'[2] In the Netherlands, 80% of patients receiving euthanasia are cancer patients, but we do not know the views of UK oncologists on this issue.

The core ethical argument in favour of the Bill is the 'request for the autonomy of the patient'. So, if a competent person persistently requests assistance to die, doctors should assist. If this is accepted, there is no philosophical reason why this should be limited to those diagnosed as 'terminally ill'.

In practice, the vast majority of requests for assisted suicide or euthanasia evaporate in the presence of high quality palliative care. As a profession, surely that is what we must argue for. If a small number of patients, despite high quality specialist palliative care, continue to request assistance to die, I do not think it is within the role of the medical profession to be the agents of the execution of that decision.

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TS MAUGHAN
*Professor of Cancer Studies*
*Velindre Hospital, Cardiff*


Editor – I do not criticise the College for taking a neutral standpoint on the Assisted Dying Bill as doctors themselves are divided on this issue. The letters condemning the College for being neutral are revealing in their own light. Each person is entitled to his or her own view, but the majority should not overrule those rare individuals who wish to be given the right

to assist their own death. The law needs to reflect this.

Such individuals have already demonstrated their willingness to travel and go through with assisted suicide in spite of the law, and it seems absurd that these people should be breaking the law, be fined or end up in prison. We should not be debating whether euthanasia should be legal as there will always be people for and against this question. This is no different from arguing that capital punishment should remain illegal despite the majority of the current public being in favour of it. Similarly, medical abortion is still a controversial area where people are strongly divided, but whether one accepts the moral arguments in either direction, legalisation of medical abortion allowed a marked reduction in deaths in women. Instead of debating whether assisted dying should be made legal or not (a matter of opinion), the real question is whether it can be strictly regulated. The easiest way to regulate it would be to dictate that a court order is mandatory. That way the difficult task of ensuring that assisted death is never misused can be left up to judges who take full responsibility for the decision.

The palliative care doctors are understandably concerned that they may be forced, or at least pressured, into performing the procedure of assisted dying if it becomes law. The law must state clearly that doctors can always refuse to perform assisted death, in order to reassure doctors that they will never be forced to perform this procedure (some gynaecologists refuse to perform terminations of pregnancy). If an individual patient wishes it, if judges are prepared to accept responsibility for the decision that a particular assisted death should be legal, and if there exist doctors and healthcare staff prepared to perform it, then I think assisted dying should be made legal. Those who do not wish to carry out such procedures must not stand in the way of lawmakers simply because of personal choice, as it should not affect them. To do this, the law must ensure that doctors are never discriminated against on the basis of their views on this matter. However, the choices of the very few who want to be assisted in dying must also be respected. For our part, we should not poll who is in favour or against euthanasia, but find out how many doctors are actually prepared to perform it.

The question of resources is a poor excuse in an important ethical debate. I would argue that resources simply should be made available – this is a drop in the ocean in terms of quality of life/death compared to numerous much more expensive interventions already widely in use.

MYLES LEWIS
*Specialist Registrar in Rheumatology*
*St Thomas' Hospital*
*London*

## Hippocratic oaths: medicine and its discontents

Editor – Professor Gordon points out (*Clin Med* January/February 2005 pp 83–4) that the pessimistic expectation that applications for medical school would fall has not turned out to be the case. In *Hippocratic oaths: medicine and its discontents*, I was quoting Chris McManus' paper, 'Medical school application – critical situation'.[1] However, I added a note of caution as follows: 'It is perhaps important not to read too much into short-term trends. In 2004, there was an overall increase in application to medical school of about 20%'.[2]

Whether or not medicine will remain attractive and whether those who have been attracted to medicine will stay is another matter altogether.

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RAYMOND C TALLIS
*Professor of Geriatric Medicine*
*Hope Hospital, Manchester*

## Chasing ideas: clinical research in the NHS

Editor – We read with great interest the editorial in the most recent issue of Clinical Medicine that bemoaned the lack of clinical research within today's NHS and asked, 'Is there any hope?' (*Clin Med* January/February 2005 pp 5–6). Whilst we agree that escalating demands on consultant time are made from an increasing variety of directions, we would argue that this does not preclude interested physicians from developing an active programme of clinical research, even within a busy district general hospital. Practising both as a physician and as a specialist allows exposure to a wider variety of conditions than might otherwise be encountered within a single discipline such as rheumatology (our area of special interest).

New observations on the natural history of chronic diseases continue to be made during the course of routine clinical practice. Over the last 10 years we have developed a range of clinical research projects leading to the development of a unit, which attract collaborative research from a range of other medical and paramedical specialties, academic departments and hospitals.[1,2,3] The move towards a consultant-led service and expanded roles of allied health professionals provide the opportunity to investigate and teach these findings to both junior doctors and other professional groups. These offer tremendous opportunities for generic training of junior doctors which fits well with the requirements of the Foundation Program and the Hospital at Night initiative, as well as the recent recognition that opportunities for training in general internal medicine are waning in the face of increasing specialisation.

Our programme has attracted enough funding to permit the expansion of the unit to include a research fellow and to allow consultant sessions to be dedicated to research and teaching. We feel that far from inhibiting clinical research, the rapid evolutionary changes we are witnessing within the NHS may offer new opportunities for exploring disease processes, which are still often incompletely understood. But we agree that it is vital that some consultant time is protected to allow clinical research initiatives to continue to be pursued.

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