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 sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Sir Raymond Hoffenberg's paper on assisted dying (*Clin Med* January/February 2006 pp 72–4) drew a number of responses. The exchange between Michael Trimble and Sir Raymond is followed by further recent correspondence from Philip Berry and Stephen Hutchinson and a second response from Sir Raymond.

Assisted dying

Editor – I am writing in response to Sir Raymond Hoffenberg's article regarding the subject of physician assisted dying. He raises several points of concern:

1 As an argument in favour of the legalisation of physician assisted dying, Sir Raymond cites the concern that good quality palliative care is not freely available for all those who require it. If this is truly the case, then surely we should campaign for adequate palliative care services, rather than physician assisted suicide.
2 In attempting to rebut the argument that voluntary euthanasia might open the door for involuntary euthanasia of the vulnerable in society, Sir Raymond states that 'in a civilised society it is highly unlikely that a doctor other than a criminal would acquiesce to the involuntary killing of individuals'. Sir Raymond clearly has a positive view of human nature but there are many incidents that happen daily in our country that should not happen in a 'civilised society'.
3 Sir Raymond notes the objection to physician assisted suicide made on religious grounds. The belief that killing is morally unacceptable outside of a just war, self-defence, or possibly as a capital sentence, is held within the Judeo-Christian tradition and also by those with other religious beliefs (and by many with none). Including a conscience clause in the legislation cannot rebut this important principle.
4 Ethical decision-making is described as being of 'paramount importance … to the principle of autonomy'. Autonomy is not the sole principle in ethical decision-making and needs to be balanced by the principles of beneficence/non-maleficence and justice and also the context in which the decision is made. It is also stated 'that there is very little ethical distinction between allowing patients to die … and taking more active steps to end their lives.' This is simply not true. Legally, ethically and philosophically the intention is as important as the consequence. It is this historical distinction between intentional killing and the recognition that death may occur as an unintended consequence of palliative drugs or withdrawal of excessively burdensome treatment, that separates criminal acts from what may well be good medical treatment.
5 Sir Raymond makes a parallel with the legalisation of abortion in an attempt to show that it is good to make legal provision for what might happen covertly. Abortion legislation, originally intended to make exceptions in only extraordinary circumstances, has led to around 200,000 abortions a year largely on psychosocial grounds.
6 Sir Raymond feels that the College is out of step with the public with regard to public opinion in favour of assisted dying. Most people have little understanding of the complexities and dangers in changing the law in this way. It is significant that the Association for Palliative Medicine and the Royal College of General Practitioners, representing those doctors closest to the dying patient, remain overwhelmingly opposed to any change in the law. There is broad-based concern regarding any change in the legislation. Care Not Killing[1] is a new mainstream UK alliance which has been set up to oppose assisted dying and includes representatives from the Association for Palliative Medicine and the British Council of Disabled People among its 25 member organisations. Surely the role of the profession is to guide opinion not merely to follow.

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Reference

1 Care Not Killing. www.carenotkilling.org.uk

In response

In reply to Dr Trimble's letter (my numbering refers to his paragraphs):

1 I am all in favour of additional and better palliative care. Unless things have changed substantially in recent years, however, I believe my original statement remains true (despite his use of the conditional clause) – that adequate services are not available to all who need them. As I said in my article, there remains a cluster of symptoms (including intractable pain) that are less amenable to palliation.
2 Dr Trimble indulges in irrelevant generalisation. I said 'in a civilised society it is highly unlikely that a doctor…would acquiesce in involuntary killing'. What has this to do with the unconnected daily happenings outside of medicine?
3 In my article, I acknowledged the objections to assisted dying held by those with religious or other beliefs. Nowhere did I suggest that it should be made compulsory, that doctors or others should be obliged to act against their beliefs. I do, however, question the right of those who hold religious objections to oblige others

to conform to their beliefs. A substantial majority of people favour assisted dying; should their views be subordinated to the views of a minority?

4 I did not claim that autonomy was the sole ethical principle; I said it was of 'paramount importance', which means it ranks above other principles in importance, not that it displaces them. I do not know how old Dr Trimble is but those of us of mature age will remember with some embarrassment the days when patients had no say at all in what was done or not done to them. The ascendancy of autonomy is the most significant change in medical ethics of the last half-century. I believe most medical ethicists would agree with this.

5 I used the analogy with abortion simply to emphasise that in the face of legal prohibition many covert abortions were carried out. I believe – and there is evidence to substantiate this – that the same thing is happening on quite a large scale within our profession with regard to assisted dying, usually under the guise of the double-effect principle. Dr Trimble's citation of the vast number of abortions now being carried out is another irrelevancy. I do not believe legalisation of the process of assisted dying will unleash an orgy of medical killing; it has not done so in countries that have legalised it.

6 It is Dr Trimble's final paragraph that persuaded me to reply. His dismissal of the public view in favour of assisted dying on the grounds of their inability to understand the complexities or dangers of assisted dying is an example of the sort of arrogant paternalistic medicine that I thought we had eradicated. Are we going back to 'leave it to doctor; he knows best?'

RAYMOND HOFFENBERG
Past President
Royal College of Physicians

Assisted dying

Editor – Raymond Hoffenberg's account of the arguments he gave to the Select Committee concerning the Assisted Dying for the Terminally Ill Bill coincided with a fascinating debate on the same subject, organised by the Christian Medical Foundation (CMF), that took place at Guy's Hospital on 16 February.

Dr Margaret Branthwaite, doctor and barrister, explained with forensic clarity why the Bill should be passed in terms of medical need and public demand, before pre-empting the factual and duty-based, or deontological, reasons that are often presented in opposition. Dr Jeff Stephenson, a palliative care consultant, countered passionately and offered differing interpretations of data available from the Netherlands, Oregon and oft-quoted public surveys in the UK. He won the debate, increasing the proportion of the 152-strong audience who would vote against the Bill from 32% to 44%, gaining the majority (given the number of 'don't knows').

Attendees found pamphlets printed by the CMF on their seats. These argued strongly against assisted dying and euthanasia from a heavily religious perspective.[1,2] In stark contrast, the debate itself contained very little reference to religion. Dr Stephenson, who has written about his own Christianity in relation to palliative care,[3] made no mention of it at all. Dr Branthwaite argued that religious beliefs should not be allowed to influence what is a secular issue.

This relegation of religious argument is paralleled in Sir Hoffenberg's article. In a very brief paragraph at the end of the section titled 'Doctors and patients', he finds that religious objections can be accommodated by the Bill because 'no doctor should be obliged to carry out any measure that is contrary to a firmly held belief or principle.' I wonder if sufficient attention is being paid to the concerns of those for whom the termination of life represents a spiritual and religious contravention.

As a doctor without strong religious beliefs, why should I be concerned about the scant mention of religion in these two contributions to the public debate? Surely an overwhelmingly factual approach is preferable, and least likely to irk atheists like myself. My concern is that in evading religious matters we are underestimating the importance of spiritual reflection as individuals struggle with the question 'Could I ever kill a fellow human?' When the conventional arguments – medical, emotional, statistical, deontological – have been heard and mulled over, it is to their perception of life and its relation to God (or their personal philosophical construct if atheist) that each doctor will have to look.

Religious belief is relevant to our society's approach to the subject of assisted dying. By concentrating solely on 'solid' arguments, and delicately skirting politically sensitive issues of faith, proponents and opponents of the Joffe Bill risk failing to engage with the fundamental concerns of many.

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References

1 Maugham T. Euthanasia. *CMF Files* 2003;**22**.
2 Myers K. Physician assisted suicide. *CMF Files* 2000;**9**.
3 Stephenson J. Being a Christian in palliative care. *Nucleus* July 2004:11–7. www.cmf.org.uk/literature/content.asp?context=article&id=726

Assisted dying

Editor – The paper by Sir Raymond Hoffenberg was certainly provocative and I could take serious issue with many of his arguments in what would be a much longer letter. Let me, however, make five brief but necessary points.

1 Sir Raymond states that the objective of legislation to permit assisted dying is to provide a lawful way to alleviate intolerable suffering in terminally ill patients despite appropriate medical treatment. He then goes on to say that the majority of patients do not have access to optimal terminal care. The point is that many of the patients in question do not receive 'appropriate treatment'. It is wholly inappropriate to legislate in favour of assisted dying on that basis when the responsible approach is to optimise treatment and increase the availability of the appropriate care he correctly espouses. In any case, the Joffe Bill[1] does not specify the need for failure of treatment.

2 I strongly refute the statement that palliative care specialists believe they can 'always relieve physical pain'. We are only too aware that we cannot relieve all suffering, but that must inspire further investment and research into symptom management rather than the legalisation of assisted dying.