

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'?

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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 Bill¹ 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.