

# 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](mailto:Clinicalmedicine@rcplondon.ac.uk)

*We normally only include letters in response to published articles in the next available issue. However, articles on ethical decision-making and assisted dying, which featured in the January/February issue, have generated such a response that we have made an exception to our general rule.*

### **Ethical decision-making in professional bodies**

Editor – I enjoyed reading John Saunders's characteristically erudite editorial (*Clin Med* January/February 2006 pp 13–5) about the stance of 'studied neutrality' that the College has taken towards Lord Joffe's Assisted Dying for the Terminally Ill Bill. Unfortunately, I could not agree with his arguments against that stance, some of which seem to remove the point of the current consultation exercise with Fellows and Members as to their views on assisted dying.

When I was Dr Saunders's predecessor as Chair of the Committee on Ethical Issues in Medicine I had two successive views of the Assisted Dying Bill. First time round, I was opposed to the Bill. In part this was due to the way the Bill was drafted. (It was subsequently modified.) In part, however (I am deeply ashamed to report), my initial opposition was justified by beliefs that I had not taken the trouble to expose to a reality check. I believed, for example, that first-rate palliative care would obviate the need for assisted dying; that assisted dying legislation would stunt the development of our current woefully underdeveloped palliative care services; that there would be a slippery slope in which assisted dying would be extended to people who did not

want it or could not give informed consent, particularly those vulnerable older people who have been my main professional concern; that it would break down trust between doctors and patients; and so on. Every single one of those assumptions has proved to be false in those countries where assisted dying is available. Indeed, as I pointed out in an article in this journal, the impact of liberalising legislation has been the reverse of what I had assumed.<sup>1</sup> I therefore changed my view and asked the Committee to look at the Joffe Bill in its revised form, with the consequence that – after much thought, consultation and extensive discussion – the Committee, too, changed its stance.

My own initial ignorance of some key empirical facts would seem to support Dr Saunders's resistance to ethical decisions regarding the Assisted Dying Bill being left to society as a whole. At the very least, Joe Public might turn out to be as ignorant as myself, his immediate predecessor in the office he now holds. Acknowledging that there is consistent and overwhelming public support for euthanasia (in a form much more liberal than is envisaged in Lord Joffe's Bill), he argues that 'democratic legitimation is ethically unreliable', pointing to the fact that 'public opinion has apparently been strongly supportive of capital punishment'. Where, then, shall we find ethically sound opinion? This is where Dr Saunders runs into trouble.

The consultation exercise the College is currently undertaking looks a little like a gesture towards the 'democratic legitimation' that he has dismissed as 'ethically unreliable'. It is not very clear how this very

badly designed epidemiological study of more or less informed opinion will be used. Dr Saunders informs us that Council's 'collective wisdom will reflect on opinion but not necessarily be mandated by it'. Presumably, it depends on whether the outcome coincides with the views of the majority on Council. This suggests that it is intended merely to make the Fellows and Members feel as if they have had a say. The consultees are asked to say whether their beliefs coincide with a statement that is riddled with ambiguities:

*We believe that with improvements in palliative care, good clinical care can be provided within existing legislation, and that patients can die with dignity. A change in legislation is not needed.*

What improvements in palliative care? Making current best practice universally available? Or some as yet unknown breakthrough? If the former, the factual answer (which may or may not correspond to respondents' belief) is no. All patients or nearly all patients? Again, if the former, the answer is no. Until the opening statement is clarified, it is not possible to respond intelligently to the question about the need for a change in legislation.

Dr Saunders speaks of Council as having 'a representative role' and the key function of a professional body being to express views 'on moral issues'. Did we vote for members of Council on the understanding that they would make ethical decisions for us? Will they do so in future? In that case, their positions, religious affiliations, etc will need to be set before the Fellowship. (I looked in vain for reference to ethical issues in the statements of the candidates in the recent presidential election.) What is more, councillors are not voted for by the general public whose support for assisted dying, informed by well-founded fears of a ghastly death with protracted unbearable suffering, could therefore be ignored by the College. What happened to the patient as partner? Will the views of the Patient and Carers Network be influential?

It will be obvious why I was glad that the Ethics Committee opted for a stance of 'studied neutrality' in 2004. It is important not to misunderstand what this means. *Pace* Dr Saunders, it does *not* imply indifference to the issue. It means what it says:

the College as a whole is neither for nor against assisted dying, though individuals (such as Dr Saunders and myself) have strongly held, but opposed, views. (Our Committee was pretty evenly divided.) Nor did our focussing on the clinical issues surrounding assisted dying in our written and verbal submissions to the House of Lords Select Committee amount to implicit support for the Bill. We were emphatic on this point: we were looking at the clinical implications of the Bill *if* it were enacted. The College, we felt, had unique expertise in this area. Indeed, this was recognised, as the evolution of the Bill was greatly influenced by the clinical concerns we expressed. We did not discuss whether assisted dying should be carried out by people other than doctors because this was not the exam question posed to us, though I personally feel that doctors should be at the centre of it, for clinical and ethical reasons. One should see this kind of help – which those opposed to the Bill always describe as ‘killing’ thus blurring the profound ethical distinction between murder and helping a dying patient to die with dignity and in comparative peace – as the final phase in the therapeutic alliance between the physician and those few patients whose unbearable suffering cannot be alleviated and who warrant assistance in death.

I hope the College will stick to its stance of ‘studied neutrality’, thereby reflecting both the profound differences of opinion among its Fellows and Members and its appropriate contribution to the debate within society as a whole – a debate to which doctors may contribute as independent individuals, as I have myself.

RAYMOND TALLIS  
*Professor of Geriatric Medicine*  
*University of Manchester*

#### Reference

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

#### In response

Public policy requires ethical choice. That is true for going to war in Iraq or determining pensioners’ heating allowances; in the context of the Royal College of Physicians (RCP), it is true for, shall we say, tobacco control or ‘assisted dying’. No one resists ‘society as a whole’ having the final say, as Ray Tallis suggests: that is what parliament represents. But the public looks to professional institutions with relevant expertise and experience for their overall judgement. That is what a prominent euthanasia supporter, Sir Raymond Hoffenberg (in ‘The College’s View’), and I were saying in January’s *Clinical Medicine*.<sup>1,2</sup> Informing that judgement means actively seeking opinion, precisely because representatives in institutions like ours are not elected on a slate of policies. Without such opinion, assertions of deep division are not evidence but prejudice. Moreover, failure to advocate neutrality as a desirable stance until conversion to support the Joffe proposals demonstrates inconsistency. As the shared position of Hoffenberg and me demonstrates, there is no logical connection between ‘neutrality’ and one’s opinion on legalising euthanasia. Neutrality is an unprincipled stance if only adopted to appease a vocal minority against a substantial majority.

Ray Tallis’s personal testimony to his conversion will doubtless fortify the true believer, but it is entirely irrelevant to the editorial he criticises. And the ‘reality check’ has taken many in the opposite direction. There is at least some evidence that doctors are becoming less likely to support such proposals, including the RCP’s Ethical Issues in Medicine Committee (no less informed than in Ray’s time).

Philosophers are famously incapable of defining a chair, yet most of us can count the number in our living room on request without declaring the concept ‘riddled with inconsistencies’. Similarly, it is pretty implausible to suggest that most College Fellows cannot answer a straightforward question asking if they support a change in the law. I suspect that the chief concern is that they will give the ‘wrong’ answer.

For there is a simple answer to Ray Tallis’s question as to where ethically sound opinion is to be found. It is, however imperfect, in the structures of representative

democracy – of any public institution. The weakness of Ray Tallis’s position is that he is unclear how either to define an ethical/moral issue or how it should be decided. In his Royal College of Patients, Carers and Physicians nothing will ever be decided by anyone.

JOHN SAUNDERS  
*Chairman,*  
*Committee on Ethical Issues in Medicine*  
*Royal College of Physicians;*  
*Honorary Professor, Centre for Philosophy,*  
*Humanities and Law in Healthcare*  
*University of Wales Swansea*

#### References

- 1 Hoffenberg R. Assisted dying. *Clin Med* 2006;6:72–4.
- 2 Saunders J. Ethical decision-making in professional bodies. *Clin Med* 2006;6:13–5.

#### Ethical decision-making in professional bodies

Editor – Although John Saunders’ recent editorial was interesting I would like to comment as I feel it was biased.<sup>1</sup>

When the Royal College of Physicians (RCP) gave evidence to the House of Lords on the Assisted Dying for the Terminally Ill Bill, the College confirmed that ‘extensive debate both within the committee ... and within council did not bring agreement closer.’ Thus it is clear that the RCP is in a position where there is no agreement among its Fellows and Members to adopt any position other than ‘studied neutrality’.

Many RCP Fellows and Members are in favour of changing the law to give patients of sound mind the option of requesting a prescription for medication which will end their life with careful safeguards. Several independent surveys of British doctors, including Medix-UK 2004 and a survey published in *General Practitioner* 2005, indicate that at least 50% support a change of legislation.

The argument that adequate palliate care will obviate the need to legalise assisted dying for the terminally ill is a misrepresentation of the facts. A recent report from Oregon examined patients’ reasons for choosing assisted suicide. Almost all patients had multiple concerns but inadequate pain control, or concern about it, was one of the least important reasons given, mentioned by only 24% of patients.