

consultation, but supporters of change can hardly complain that their view has not been represented.

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References

- 1 Hoffenberg R. Assisted dying. *Clin Med* 2006;6:72–74
- 2 Saunders J. Assisted dying: considerations in the continuing debate. *Clin Med* 2005;5:543–7. See reference 21.
- 3 Tallis R, Saunders J. The Assisted Dying for the Terminally Ill Bill, 2004. *Clin Med* 2004;4:534–40.

Assisted dying

Editor – We represent the Association for Palliative Medicine, an organisation of over 800 palliative medicine doctors working in hospices, hospitals and the community.

We agree with Hoffenberg (*Clin Med* January/February 2006 pp 72–4) that as practising doctors and because of our experiences the views we express should have added weight when discussing assisted dying.¹ Every day we see patients with advancing illness and the positive effects that good symptom management can achieve. We strive to encourage all health professionals to improve their palliative care skills so that this care can be extended to a greater number of dying patients.

Palliative care does not claim to relieve all suffering, particularly as a service which is under-resourced and unevenly distributed across the country. We would argue that addressing these inequalities and diverting research funds to improve the care we can provide, rather than assisting dying, appears a better way forward.

Most requests for assisted dying are expressions of distress and fear. Such requests need to be addressed by open communication and a trusting relationship which puts the patient back in control rather than a law that could damage this. Polls of healthy individuals cannot be used to judge what is right for this vulnerable group.

Saunders makes a valid point: ‘neutrality in practice is not neutrality at all’.² A poll of our membership demonstrated 96% were opposed to any change in the law. We welcome the decision by the Royal College of Physicians to be clear on its position and its Members’ views.

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On behalf of the Ethics Committee of the Association of Palliative Medicine:

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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.

Editor – In response to Hoffenberg’s recent article (*Clin Med* January/February 2006 pp 72–4) we felt compelled to offer an alternative viewpoint. As palliative care physicians we realise the limitations of what the specialty can offer patients – we certainly would never claim that we can relieve all symptoms and all distress but we believe physician assisted dying is not the answer.

There is no doubt that as doctors we witness death and dying on a daily basis yet to state that we have seen ‘more than we might have wished’ carries with it the implication that death is a profoundly negative event. As doctors, we are frequently indoctrinated to cure illness – to accept death as a natural process could undermine our abilities as physicians and could also cause us to question our own mortality. Yet death is one of the few certainties in life. Death provides an opportunity to prepare for and face the end, to heal mind and allow spiritual growth, to act as a forum for reconciliation and to experience the joy of love and family. If we view our role as one of alleviating suffering then there is much to be done at the end of life, and to organise a physician assisted rapid

death runs the risk of losing this opportunity and switches the focus away from what patients can achieve.

References are made throughout the paper to ‘intolerable suffering’ – surely this is something that is impossible to define and must encompass physical, emotional, social and spiritual pain. The solution to suffering is not the ‘quick fix’ provided by euthanasia, instead it is the careful exploration of fears and anxieties, of determining and alleviating symptoms. What one patient defines as an unbearable symptom may to another be relatively minor – is there not the possibility that this might extend to the treating doctor? It is widely acknowledged that a patient’s will to live fluctuates widely throughout the course of their illness. Also, the ability to prognosticate at the end of life is widely acknowledged to be difficult and this has huge implications for the Assisted Dying for the Terminally Ill Bill. Euthanasia is irreversible and even with reference to the response of the Royal College of Physicians and detailed provisions in the Bill, keeping error ‘to a minimum’ cannot be viewed as acceptable. The wider implications that an incorrect decision would have on both the patient’s family and the healthcare professionals involved have not been addressed.

How can the deliberate taking of life ever be construed as an extension of the physician’s responsibility? In the wake of Shipman, society increasingly mistrusts the medical profession – how can we ever expect to regain its confidence when one of our agendas may be to take life? Louis Lasagna’s modern version of the Hippocratic oath states:

*If it is given to me to save a life, all thanks.
 But it may also be within my power to take
 a life; this awesome responsibility must be
 faced with great humbleness and awareness
 of my own frailty. Above all, I must not play
 God.¹*

Is physician assisted dying not the ultimate example of playing God?

Patients’ autonomy forms one of the cornerstones of palliative care and of course all patients have the right to refuse food and water. However, it is widely acknowledged that appetite declines as disease progresses and that there is no evidence to suggest that withholding fluids

in the final days of life is either distressing or hastens death.²

Some of the assertions in the paper are contradictory. Hoffenberg suggests, for example, that many 'good and caring' doctors practice the principle of 'double-effect medicine' but the recent survey of BMA members – the largest organisation of doctors in the UK – quoted in the paper actually revealed no evidence of covert euthanasia.

Even if this Bill were to become practise in the UK, the training involved to ensure physicians are as well equipped as possible to make these decisions and the identification of appropriate facilities where euthanasia can take place undoubtedly have costly implications – surely this money would be better spent on educating those who care 'for the majority who die in acute hospitals or nursing homes' where the 'experience is bad'? Also, if specialist palliative care centres became involved in physician assisted dying is it not possible that this would undermine their public support and ultimately their funding? If, as stated by Richard Smith, 'for the minority who die under the care of palliative care teams [the experience] is probably good' then the solution is to provide greater palliative care services and promote palliative care education in medical schools.

Although today's society demands quick fixes to problems, the wider implications of physician assisted dying are enormous. Palliative care is a young specialty with much to offer patients. The common goal of palliative care professionals is to provide symptom relief, to encourage patients to live to the full and to be there for them at the end of life. We sincerely hope that given time, greater financial resources and increased public education it may be that this Bill is not necessary.

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- 1 Lasagna L. Hippocratic oath – modern version. 1964.

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Writing to patients

Editor – O'Reilly, Cahill and Perry have analysed some effects of sending letters to patients following an outpatient consultation and have highlighted the benefits (*Clin Med* March/April 2006 pp 178–82).

I found over many years an added bonus from dictating and discussing the letter with the patient (and relatives) sitting with me. This improved my attitude to them and it was very rare indeed for me to have to send a separate message to the GP. Sometimes I felt that the harder it was to dictate, the more worthwhile it was!

I surveyed 118 GPs in North Bristol and 117 found the letter copied to them helpful. Recently, in Gloucester, 30 patients with diabetes were surveyed, 21 out of 23 patients responding and 24 out of 26 GPs surveyed very much liked the system.

It is important to ask the typist to use large print for patients with poor sight and, incidentally, it made the life of the secretary much more interesting even if the letters may have been a little longer than usual.

However can we think we are putting patients in the centre of our practice without writing to them?

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Editor – We much enjoyed reading the recently published results of the randomised controlled trial of the effects of post-consultation letters to patients (*Clin Med* March/April 2006 pp 178–82). The authors showed that following a consultation in a haematology clinic in Ireland, patients were very satisfied with a personal letter sent to them which summarised their outpatient consultation. The majority of referring doctors also apparently found the letter to be 'very useful' or 'useful' in lieu of the standard outpatient correspondence and were satisfied with the information provided.

As the authors stress, these studies need to be widened to include a variety of spe-

cialties. We have recently published a similar study in cardiorespiratory clinics comparing patients' and general practitioners' (GP) views regarding a specific letter written to patients and a letter sent to the GP.¹ Whilst we showed a number of other interesting points regarding the comprehensibility of the two types of letter, we cannot confirm from our study that a letter written specifically to a patient would be a substitute for a traditional consultant–GP letter. Fifty-eight per cent of our patients wanted to receive both the letter written to them and a copy of the letter written to their GP, whilst 21.6% would prefer the GP letter alone and 20% only their letter. The majority of GPs who received both letters during the period of this study (42 out of 45) wanted either the GP letter alone or the GP and the patient letter, not just the letter to patients. In our study, letters to GPs were significantly longer than letters to patients but significantly less comprehensible to patients. The GPs generally found the structure and lack of specific clinical detail in the letters to patients unacceptable.

What we now need to do is to combine results from all of these reports and if only one letter is going to be written, determine the optimal format in terms of structure, content and comprehensibility to serve the needs of both referring doctors and patients.

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Reference

- 1 Roberts NJ, Partridge MR. How useful are post-consultation letters to patients? *BMC Medicine* 2006;4:2.

'Heaven's gate, built in Jerusalem's wall?'

Editor – All doctors admire the efforts of colleagues such as Sylvia Watkins who devote their talents to improving the standards of medical schools struggling in adverse conditions of the kind she encountered at the Al-Quds University in East Jerusalem. However, it is axiomatic that reports on such experiences in medical or