Reference

1 Ernst E. Acupuncture – a critical analysis. *J Int Med* 2006;259:125–37.

Assisted dying

Editor – Though I do not for a moment question his *bona fides*, I believe that Stephenson (*Clin Med* July/August 2006 pp 374–7) is profoundly mistaken and, indeed, that he condemns his position with his own arguments. He says that 'in *most* cases [my emphasis] the physical symptoms of terminal illness can be relieved' and that even where patients have complex symptoms 'they can *usually* [my emphasis again] be alleviated.' These statements are obviously correct but are, frankly, irrelevant: as Stephenson himself agrees, those who advocate the availability of assisted dying do so in relation to an 'extremely small proportion [of terminally ill people]'; however small that proportion may be, the fact is that such people exist, as is eloquently demonstrated by another author in the same issue.[1] There are people who are resistant to opiates or who find their side effects intolerable and the same goes for the most commonly used antiemetic drugs. What are we going to provide for these people?

No one would suggest that assisted dying is an easy matter on which to legislate, but with sufficient determination it is possible to set aside absolutist arguments and to provide for the needs of vulnerable people even in contentious areas, as the 1967 Abortion Act showed. I would remind Stephenson, incidentally, that the Hippocratic oath also forbids abortion, yet many doctors are content to terminate pregnancies under appropriate circumstances.

Stephenson's attempt to raise a series of moral absolutes in opposition to assisted dying is honourable but ultimately illogical: for example, to say that some doctors will 'kill or facilitate the killing' of their patients is an emotive statement which bears no relation to the reality of what is being discussed. In the days of surgery before asepsis and proper anaesthesia, operative and postoperative mortality was high, yet it would have been wrong to have described surgeons as 'wounding or facilitating the wounding' of their patients.

Whilst it may well be the case that the general public's understanding of this area is inadequate, I firmly believe that they have got hold of a truth which many professionals are trying to deny, namely that the choice of the time of one's death is a fundamental human right and that it is not the place of legislators or health professionals to deny that right.

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Reference

1 Anonymous. A personal view of assisted dying. *Clin Med* 2006;6:412–7.

In response to Fisken

My statements about what can be achieved by palliative care are hardly irrelevant as it is important to establish the benchmark for what is possible. The appalling care highlighted by the author in the same issue, to whom Fisken refers, although tragically all too common is nonetheless suboptimal.[1] Palliative care is certainly not a panacea for all end-of-life ills, but whatever the limitations there is always something that can be done to bring a measure of relief.

There will always remain some people who would like the option of assisted dying. However, at what cost to others do we elevate their autonomy above other concerns? Fisken's faith in our legislators is admirable, but I'm afraid that I have rather less faith in human nature. He does his cause little favour by making the comparison with the 1967 Abortion Act. I doubt those who framed that legislation would have had any idea that the result would be abortion on demand, with only a tiny fraction of these being for foetal abnormality. Furthermore, while some may argue that there is scope for debate over viability of life or personhood of an embryo, there is absolutely no doubt that assisted dying involves ending a life.

While 'kill' and 'facilitating the killing' may be emotive terms, I'm afraid they do accurately represent the reality of what is being discussed. Euphemisms cannot hide the fact that the intention in assisted dying is to unnaturally end a life, and there is a world of difference between this and death resulting as a complication from surgery in which the intention is to save life.

On his final point, we will simply have to disagree. We hear much about supposed human rights, and very little about responsibilities. I do not accept that the choice of the time of one's death is a fundamental human right, and I would be interested to know the premise on which this assertion is made. If Fisken really believes this, and if this 'right' is not to be denied to people by legislators and health professionals, then presumably he would advocate that assisted dying be available to anyone who asks, of whatever age and whatever condition of health? A slippery slope indeed.

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Reference

1 Anonymous. A personal view of assisted dying. *Clin Med* 2006;6:412–7.

Assisted dying

Editor – While I share some of Dr Jeffrey Stephenson's concerns regarding assisted dying, I feel that several of the points raised need further attention. Firstly, I think it is presumptive to state that most of us working with the terminally ill are strongly against a change in the current law. Those physicians working in palliative medicine who have spoken out on this subject tend to be strongly against assisted dying. I'm sure that there must be other workers in palliative medicine, however, who have been examining the moral issues involved and feel that they cannot dismiss the idea without further discussion and thought.

Secondly, I have worked with patients who had symptoms that could not be alleviated through palliative care. These have included patients with progressive neurological disease who were profoundly disabled, but who had no remedial symptoms such as pain or nausea, and cancer patients who have had symptoms such as fatigue and weakness, which we have been unable to reverse. There may be a very small proportion of our patients who, whatever we do, wish to end their lives, and this should be acknowledged.

With regards to violation of the Hippocratic oath, a longstanding tradition

should only be upheld if it is morally sound and relevant in today's society. As to the alleged abandonment of the prohibition on killing, exceptions such as killing in war, killing in self-defence and capital punishment have already been made. It may be possible that assisted dying in certain circumstances may be a valid consideration, particularly if we consider the autonomy argument. We place a good deal of importance on patient autonomy in many areas of modern medical practice. I acknowledge that protection of the doctor–patient relationship, and protection of vulnerable groups are both essential considerations in this debate, which will continue to attract interest from a wide-ranging audience.

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In response to Mullick

I'm not for a moment suggesting that the idea of assisted dying be dismissed without discussion or thought. I have shared my own views, arrived at after much of both! My presumption about the views of those working with the terminally ill is based on personal experience and survey evidence. In April of this year a survey of its members by the Association for Palliative Medicine (with a response rate of 68%) found that 94% were opposed to a change in the current legislation. I would call this an overwhelming majority.

Part of the ethos of palliative care is to acknowledge that dying is a natural process rather than a medical failure. Fatigue, weakness, increasing dependence and disability are an inevitable part of this process. To argue that because we have no remedy for them we could resort to the option of 'therapeutic killing' risks pandering to the very ethos that the hospice movement evolved to counter. We would do well to humbly ponder the old aphorism on the role of a physician: to cure sometimes; to relieve often; to comfort always.

I have indeed acknowledged that there are some patients who might wish to end their lives prematurely, but the question is whether their autonomy should be elevated above other concerns, for all the reasons described in my article.

As to the moral basis and relevance of the Hippocratic Oath, I don't think we have moved on as much as some would have us think. It seems to me that a prohibition on assisted dying is far more relevant to today's society than ever before. In centuries past, when very little could be done to alleviate the symptoms and distress of the dying, the argument that it was a necessary option might have carried more weight. I don't think that killing in war and in self-defence bear any comparison to what we are wrestling with here. Lastly, we abandoned capital punishment long ago, as it seemed incompatible with a humane society and because of the irrevocable consequences of getting it wrong. It seems ironic that many are now pushing for assisted dying, when the consequences of getting it wrong are equally disastrous and irrevocable.

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Assisted dying

Responding to various recent articles in *Clinical Medicine* I agree that in many instances end-of-life care is suboptimal and everything possible should be done to achieve good palliative care for everyone who needs it. Much of the attention has focused on people with pain or physical symptoms amenable to palliation. My worry is that this leaves a group of people with conditions such as neuromuscular wasting disorders or quadriplegia who are in a predicament not amenable to adequate palliation. Such people may typically retain their mental faculties but lose the ability to bring about their own death other than by refusing sustenance – and even this option may be denied those being tube fed. Examples include instances of people with such disorders seeking assisted suicide abroad and the fictional character portrayed in the play about a quadriplegic person, *Whose life is it anyway?* Offers to 'come alongside you' or 'go through this with you' might understandably provoke anger or frustration when the help they really want is being denied them.

I am concerned that as a profession we sometimes have difficulty accepting our limitations. If someone is not adequately palliated it must be because the service is substandard or because the doctors involved lack the correct expertise, rather than recognising we may not have the answer.

I share the huge concerns widely voiced about assisted dying. However, it seems to me that for a small group of people this may be the least bad option, with as many safeguards as possible being built in. I think we need to recognise that satisfactory palliation is not possible for everyone and that some sort of assisted dying should be made available in a very limited number of instances.

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