FORUM

Never say die?

Alex Paton

Alex Paton
MD FRCP, Retired Consultant Physician, Oxfordshire

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Death would appear to be merciful and nothing to fear. It is the twin horrors of pain and imbecility that guard its gates which one should fear.

John Heath-Stubbs

The older I get the more obsessed I am about achieving a gentle and easy death. Don't we all want the same? So why the relentless argument about our right to have it? And why is the leadership of the Royal College of Physicians, whose Fellows and Members look after so many dying people, opposed on the slenderest of grounds to solving the impasse? The poor showing by euthanasiasts in a 2006 poll, in which only a quarter of the 5,111 physicians who responded agreed to help at the end of life, seems to have been accepted as a pretext for ending further debate. Yet surely no self-respecting statistician would be comfortable with such a small sample of the many thousands of potential voters in the College?

A conspiracy against dying

I first became aware of the discomfort of confronting dying in the 1960s with the introduction of resuscitation and intensive care.[1] Suddenly we were able to manipulate death, seemingly to postpone it at will, and perhaps, in time, to find a cure. Horror stories appeared in the medical press of patients who were not allowed to die until every kind of aggressive and even harmful treatment had been tried. 'You no longer die peacefully in hospital', said one ward sister, 'you have a cardiac arrest'. And in case this is dismissed as a thing of the past, we ought to be shocked to read an identical tale of thoughtless and brutal mismanagement in the College's own journal nearly 40 years on.[2]

I decided in those early years to do everything to ensure an easy death when the time came; my resolve has only been strengthened by the endless and inconclusive debate that has raged ever since. It is my belief that acceptance of euthanasia has been deliberately delayed by its opponents on spurious grounds: confusing definitions, inappropriate ethics, and more than a whiff of hypocrisy. Raymond Tallis, the former chairman of the College's ethics committee, describes the present situation as 'shrouded in clinical, ethical and legal sludge'.[3]

Why, for instance, do we continue to talk about 'assisted suicide', when suicide bears a stigma of desperation that should have nothing to do with euthanasia? And since physicians are loath to show compassion, let us stop using 'physician assisted' and allow individuals the means for ending their own lives. The late Dutch judge, Huibert Drion, for example, suggested that people over 75 might be provided with a prescription to use at their discretion.[4] As for worries about the 'slippery slope' – that once euthanasia is legalised it will become a free for all – many years' experience in Holland and Orlando shows that numbers requesting help remain small and come from people who know exactly what they are doing.[5] Those who believe that palliative care is the answer should be aware that there is still a desire for euthanasia even when facilities for the former are excellent, as in Orlando.

The doctrine of the 'double effect' – that giving large doses of morphine to relieve pain or sedatives to allay undue suffering is acceptable provided the intention is not to kill the patient – is a particularly hypocritical argument. And what is the moral difference between withdrawal of ventilation or food and water (passive euthanasia) with the object of ending life and the giving of a drug for the same purpose (active euthanasia)? Refusal of treatment knowing that death may result is lawful, but compassionately helping someone on the way is a criminal offence.

Plans for dying

Public support for euthanasia has always been strong, presumably because autonomy and choice are important. Means are available for advanced planning and individuals who are serious about their final days should take the necessary steps.[6] Unfortunately, possible actions are at present limited and hedged with safeguards. They do not include euthanasia but the time will surely come. Indications will then need to be broadened from incurable illness and unbearable pain and suffering to physical disintegration, and loss of dignity and independence. In time, progressive neurological conditions, irrecoverable stroke, irreversible coma, and dementia will be included and it is good to see that 'tired of life', a condition with which physicians will be familiar, is being debated in Europe as an option.

Anyone who is serious must prepare a 'living will' (advanced directive)[7] at the earliest possible moment and an enduring power of attorney in the event of

their becoming mentally incapacitated. It is extraordinary how relatively few people in Britain have taken up the idea even though the first living will was written in the US in the 1930s. This will ensure that the final decision is a personal one, taken without manipulation or coercion.[8] Clearly views for and against euthanasia are strongly held, and as with other emotive issues like abortion and animal experimentation, it is unlikely there will ever be a consensus. The wishes of those who find the idea of assisted dying morally repugnant should of course be respected, but why should they override individuals and helpers who believe in a gentle and easy death?

Acknowledgement

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References

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lesson of the month

Serotonin syndrome secondary to fluoxetine precipitated by radiation induced cerebral vasculopathy

Serotonin syndrome is a predictable consequence of excess serotonergic agonism of the central nervous system receptors as well as peripheral serotonergic receptors.[1] The clinical manifestations of the syndrome range from barely noticeable to fatal features. In serotonin synthesis, ingested tryptophan crosses the blood–brain barrier and enters neurones where it is hydrolysed and decarboxylated to serotonin. The serotonin is stored in vesicles and released into the synaptic cleft with resultant depolarisation of the presynaptic neurones.[2,3] Removal of serotonin from the cleft is via reuptake pumps and it is either repackaged or degraded by monoamine oxidase (MAO). Monoamine oxidase has two isoforms: MAO-A which metabolises serotonin, and MAO-B which metabolises catecholamines.[4] Theoretically, damage to vascular endothelium is associated with a decrease in MAO-A activity, hence a reduction in the capacity to metabolise serotonin with a resultant increase in levels of serotonin. This lesson reports the case of serotonin syndrome in a 71-year-old man secondary to fluoxetine believed to be precipitated by radiation-induced vasculopathy.

Lesson

A 71-year-old man was admitted in September 2006 with a one-week history of increased confusion, unsteadiness of gait, and stiffness and tremors involving all limbs. Five weeks before admission he developed jerking of hands followed a few days later by stammering, staggering gait and generalised shaking of the body while at rest. He progressed to confusion and agitation. He had no fever, headache, vomiting or weakness. Past medical history included: tonsillar carcinoma for which he had received radiotherapy to the left tonsil during February and March 2006; prostate cancer; depression; spinal stenosis (diagnosed in September 2003); and a monoclonal gammopathy of unspecified significance. For over a year his regular medications were: fluoxetine 20 mg once a day, amitriptylline 10 mg once a day, fentanyl 50 mcg/hour, simvastatin 20 mg and allopurinol 300 mg once a day. There had been no changes in his regular medications and he gave no history of taking over-the-counter cough syrups. Clinically he was afebrile, blood pressure 160/90 mmHg, heart rate 80 bpm and his Glasgow Coma Scale was 14/15 (confused speech). General examination was normal.

Isaac Chirwa
MB BS, Senior House Officer

Mark Savage
MB ChB MD FRCP, Consultant Physician and Endocrinologist

Aisha Sarwar
MB ChB, Senior House Officer

Andrea Norris
MD MRCP, Consultant Physician and Endocrinologist

Department of Endocrinology and Diabetes, North Manchester General Hospital

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