

management of long-term conditions, increased focus on health and preventing illness and access to urgent care. If this is so, why does the report neglect so many of the proposals of its Staying Healthy Working Group such as the redesign of services for childhood immunisation and the prevention and treatment of sexually transmitted infections, the co-location of new centres with social and leisure services and, above all, to increase the investment in prevention. It is particularly disappointing that the tackling of health inequalities, seems to have disappeared, in spite of possible available measures.

It is of interest that my editorial has not been challenged about its comments on the lack of methodological rigour in the development of models, the lack of concern with social services coordination, or mental health services, lack of concern with training or the prediction that unnecessary use will be made of technological equipment and specialist expertise and thus the costs of care will increase.

There is no doubt that secondary, hospital care in London needs to be reorganised and rationalised. The need for better general practice facilities in some parts of London is accepted by all. But the justification of radical changes in the organisation of primary, general practitioner care, made largely by hospital practitioners, has not been made. It is dispiriting that with our experience of repeated changes in health services over the past 20 years that solutions are still being made on the basis of opinions rather than actual practical, evaluated trials – and that instead of rectifying known deficiencies, unproven organisational solutions are advanced.

WALTER W HOLLAND
Visiting Professor

London School of Economics and Political Science

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Never say die?

We are encouraged to see Alex Paton, a retired physician, using his long experience in medicine to consider such an important issue as euthanasia (*Clin Med* February

2008 pp 106–7). There are aspects to Paton's article that all doctors would agree with, such as the need for even better and more widely available palliative and supportive care. We recognise too how carefully powerful tools in the care of patients such as attempted resuscitation must be used and are heartened by the British Medical Association's recent review of this.¹ However there are errors of fact and interpretation in Paton's article. To deal with them all would be wearisome but there are some which it would be wrong to leave unchallenged.

The suggestion that reluctance to kill patients is evidence of 'physicians being loath to show compassion' is at best puzzling: compassion is manifestly not exclusive to either side of this debate. The palliative care services in Oregon (we assume Paton does not mean Orlando) are fundamentally different to the UK and so much of the Oregon experience is not directly transferable.² The practice of so-called 'involuntary euthanasia' in Holland suggests fears of a slippery slope may not be quite as misplaced as Paton suggests.³

Any doctor assuming the doctrine of double effect to be hypocrisy is labouring under a misapprehension. Of the four clear criteria that must be met to invoke double effect, a cardinal one is that the intention is to relieve a symptom and not to cause the death of the patient. Recent work has shown double effect to be largely irrelevant in palliative care.^{4,5}

Advance death planning is important and this is enshrined in the new lasting powers of attorney (LPA) which have replaced the enduring powers of attorney mentioned by Paton.⁶ The great value of these lies in the discussions they provoke between patients, those close to them and their medical staff. The views expressed in LPA can change, as can individual views on euthanasia, and it is this continuing communication while the patient is still able which is so valuable.

The whole tenor of Paton's article implies an irresistible tide of natural justice in favour of euthanasia being obstructed by a small and unrepresentative minority of doctors. The vast majority of doctors working in palliative care – not 'the slimmest of margins' – are against euthanasia.⁷ There is clear evidence of the danger of taking requests for

euthanasia at face value.⁸ There is also increasing recognition, even legally, of the importance of giving patients autonomy to refuse life-prolonging treatments.⁶ We too believe passionately in a 'gentle and easy death' but know that assisted dying is increasingly peripheral to achieving this.

TIM HARLOW

Consultant Physician in Palliative Medicine
Hospiscare, Exeter
On behalf of the Association for Palliative
Medicine Ethics Committee

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Practice-based commissioning

Charlton's article (*Clin Med* February 2008 pp 61–4) throws up major challenges for UK secondary care physicians. New imperatives may change specialist care in a fundamental way; 'shifting care into the community' may destabilise existing secondary care services.

Specialist care reconfiguration cannot be moulded into a nationwide template. Some plans, for example the Independent Clinical Assessment and Treatment Service (ICATS) network proposed for Lancashire and Cumbria designed to make care more convenient to patients actually made things worse. We must weigh up local advantages