Listening, or just hearing what they say?

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'Listening Doctors' is to be the theme of the new society president's tenure, which is entirely appropriate as proper communication skills are now more important than ever: patients clearly advise us of the great benefits that they derive from properly conducted listening and information exchange sessions. Information exchange must, however, always be two way—it should not be just a tick box exercise, and doctors should act upon (rather than ignore) what they have learnt through the listening process. They should also understand what is not said. We must not just turn a deaf ear and ignore something we are told just because it's inconvenient to know.

Voluntary euthanasia has long had major support among the public, who are also concerned about inappropriate intervention and resuscitation together with overt medicalization of the dying process—which itself is, after all, inevitable at the end of the road we all travel. 'Cardiac arrest' features everywhere too, including even continuing care settings; we can no longer be allowed to simply pass on. Drawing a distinction between 'right to die', 'right to be killed' and 'assisted dying' is academic; such semantic arguments are used by those who want to create artificial divisions. Most people simply want to have a dignified death, ideally through natural means, but not ruling out artificial causes. French medics were reported some years ago as wanting to see the legalization of euthanasia,¹ as did the public.² Many in the medical profession in this country also want to work to this end.

I believe the defeat of Lord Joffe's bill (Assisted Dying of the Terminally Ill) to have been misguided, as were subsequent attempts to draw attention away from this important subject. Doctors should work to improve the care of people who are dying, rather than requiring them to suffer and be a party to wasteful resource utilization because alternate approaches to care are excluded from consideration. It is right, however, that any requests for such intervention need to be addressed by open communication and a trusting relationship that puts the patient back in control and serves to properly distinguish a *right* to die from a *duty* to die. In these circumstances, good communication skills help us not to just hear what is said.

Having the option to die available does not *replace* palliative care. Good palliative care and the assisted dying option should both be available. So why the apparent belief that the two are mutually exclusive? Nothing should be further from the truth and, in agreement with Baroness Jay of Paddington (speaking to Lord Joffe's bill), I see no dichotomy at all between supporting both good palliative care and appropriate assisted dying: it needn't be either/or for optimum end-of-life care. Doctors must know how to look after a dying patient in a humane manner, and palliative medicine is not to be ignored. Of course palliative medicine specialists do not want a change in the law to allow assisted dying, but they need not be fearful for their jobs. We are, in any event, likely to need more of their skills in the future, given our ageing population and increasing numbers of patients with chronic disease.

Doctors, of course, do need to be involved, but not necessarily all, and unless specifically requested by the patient, any intervention could be by a caring, compassionate and independent outsider. Whatever the process, all connected health professionals obviously must feel comfortable with any provision for assisted dying.

As a profession we should exhibit compassion, ensuring as far as possible the avoidance of pain and suffering, involving the patient and not unnecessarily extending the natural dying process. Patients should be able to exercise informed choice above all in respect of this, their most important decision: it is the humane thing to do. Opponents misrepresent assisted dying by suggesting that if you're in despair (for whatever reason) then the only option is death, when it simply needs to be *an* option. If we listen we will know this to be true. A new approach is required, to include what I have (a little tongue in cheek) described as the Third Way: extending appropriate care to the patient between the 'do nothing (and allow suffering)' and 'do everything (and treat inappropriately)' options, with, naturally, built-in safeguards. The certainty of outcome at the particular time is a distinct benefit; death with dignity *after* appropriate palliative care.

Our living and our dying have an effect on those around us, and a good death is what many seek to ensure. The dignity of life itself is reduced when the final chapter of the book of life—death—is not treated with proper respect.³

I would urge all those sceptical of the need for assisted dying to properly address issue this issue now, as we need

to decide before forced to do so by some economic necessity. Avoid acting in haste (later) and then repenting at leisure (forever) by supporting the introduction of necessary and appropriate proposals. Ask yourself what you want to die from, and how. I suspect most readers want to be in control—so why should we offer less to our patients?

REFERENCES

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