Euthanasia

EDITOR,—We were surprised to read that we are now living in a post-religious society in which theological notions such as the sanctity of life should not be overvalued.¹ Though recognising that a rational defence of theologically based ethics would be out of place in the *BMJ*, we must ask by what new scale of values we are to re-evaluate traditional moral principles. The tenor of Richard Smith's editorial seems to be that surveys of popular sentiment might form a more reliable basis for the moral law. We countersuggest that on both rational and historical grounds both popular sentiment and academic opinion are apt to be unreliable. In addition, ethical and political advances made in the past few centuries have not been exclusively the preserve of atheistic societies or of anti-traditional thinkers.

Hospice medicine and terminal care have advanced considerably in recent times, and doctors with a religious background have made an appreciable contribution in both. Perhaps an expert in terminal care would have resolved Dr Nigel Cox's dilemma² more satisfactorily; the narrow compartmentalisation of medical specialties does not always operate in patients' best interests.

What has been shown by recent medicolegal developments is that "liberalisation" of ethics (for example, in abortion) has not always had a liberal effect on medical practitioners. It is well known that doctors who are opposed to abortion, perhaps because of their adherence to Christian principles, are no longer able to obtain posts in gynaecology. Given that doctors in many medical specialties occasionally care for dying patients, we wonder what the effect on public confidence in the medical profession would be if those doctors opposed to euthanasia were similarly squeezed out. Perhaps this is what is meant by a post-religious society.

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1 Smith R. Euthanasia: time for a royal commission. *BMJ* 1992;305:728-9. (26 September.)
2 Dyer C. Rheumatologist convicted of attempted murder. *BMJ* 1992;305:731. (26 September.)

EDITOR,—We have great sympathy both for Lillian Boyes, who died in such pain, and for Dr Nigel Cox, who found himself helpless in the face of such suffering.¹ There can be few of us who have looked after dying patients who have not, on occasion, been tempted to act as he did.

We wish to suggest a technique that we have used successfully when faced with unrelievable pain in patients dying at home. As members of a primary health care team, with the support and advice of pain control specialists and local hospices, we find that we can control pain adequately by using conventional techniques in most patients dying at home. Occasionally, however—perhaps once a year for a list of 8700 patients—we have been faced with a patient who suffers agonising pain or distress whenever he or she is awake. These have been patients with bone pain, for whom any movement has caused pain; in our most extreme case—a patient with multiple cutaneous chemo-dectomas—the slightest pressure on any of the lesions resulted in agonising pain. For these patients the only effective option has been to give

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high dose analgesia (for example, 1000-2000 mg of diamorphine subcutaneously/24 h) and then induce sleep, for which we use continuous intravenous midazolam, titrated to keep the patient asleep and with a peaceful appearance.

We are not aware of other people who adopt this approach for patients dying at home; as with all terminal care, it is demanding, of both staff time and emotions, but the reassurance felt by carers who know that any signs of distress can be relieved in a few minutes by simply increasing the infusion rate is of enormous benefit. All the feedback we have received from carers has been extremely positive.

As a last resort, we recommend this type of technique as a way of coping with the extreme demands faced by Dr Cox; in this grey area, we believe that it stays within the law.

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1 Dyer C. Rheumatologist convicted of attempted murder. *BMJ* 1992;305:731. (26 September.)

EDITOR,—An editorial in the *Times* commented on "mercy killing" and "active euthanasia."¹ The case that prompted it—reported by Clare Dyer² and discussed by Richard Smith³—is not really an example of these. In my experience it is extremely rare for patients to have pain that cannot be controlled by analgesic drugs if these are given in sufficient dosage, especially intravenously. If such pain did occur it would still be unnecessary to give a drug such as potassium chloride, which relieves pain only by causing death. I would consider recommending an intravenous anaesthetic, continuously administered, with the agreement of the patient, the family, and the attendants, so as to render the patient unconscious and therefore pain free until death occurred naturally. There would be risk in the anaesthetic process, which would be acceptable in this rare circumstance. In such a "wholly exceptional if not unique" case (Mr Justice Ognall's words⁴) the drug would be used with the primary action of producing general anaesthesia—that is, to relieve pain (as normally done for surgery). This method would not be applicable as an excuse for euthanasia in other circumstances.

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1 Mercy for mercy. *Times* 1992 Sept 21:15 (col 1).
2 Dyer C. Rheumatologist convicted of attempted murder. *BMJ* 1992;305:731. (26 September.)
3 Smith R. Euthanasia: time for a royal commission. *BMJ* 1992;305:728-9. (26 September.)
4 *Smith v. Grady* [1982] 1 All ER 131.

EDITOR,—Euthanasia may well be ripe for review,¹ but nothing has changed save that Nigel Cox's

actions have drawn more general attention to difficulties we already knew about.² The hospice view—that euthanasia should remain illegal—could be interpreted as reflecting complacency rather than providing a realistic assessment. It is all the more important, therefore, to draw attention to the data on euthanasia reported from some 60 general practitioner headquarters in the Netherlands, which care for 1% of the Dutch population of 14 million.³ Discussion about euthanasia is dominated by strong opinions and only rarely supported by facts.

Most of the patients in the Netherlands who requested euthanasia were old and lived at home. Nearly three quarters were suffering from disseminated cancer; heart and lung disease each accounted for less than 10% of applications. Rheumatoid disease was mentioned rarely.

The reasons given for the request for euthanasia were pain or the fear of pain, anxiety, and the pointlessness of living. Most physicians working in hospices would say that these challenges can often be tackled with some success. Support for their view comes from the age of the patients with cancer. For all diseases except one, requests were more common with increasing age. The exception was breast cancer, when more young than old patients sought euthanasia. This hints, surely, that the complex reasons of fear, pain, humiliation, self disgust, and loneliness would be better palliated by the wider dissemination of hospice skills than by any legislative changes.

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1 Smith R. Euthanasia: time for a royal commission. *BMJ* 1992;305:728-9. (26 September.)
2 Dyer C. Rheumatologist convicted of attempted murder. *BMJ* 1992;305:731. (26 September.)
3 Netherlands Institute of Primary Health Care. *Continuous morbidity registration 1988/1989*. The Hague: Ministry of Welfare, Public Health and Culture, 1991.

EDITOR,—The publicity attendant on Dr Nigel Cox's conviction for attempted murder¹ will no doubt bring cries for a change in the law to favour euthanasia.

I must counsel against such general legislation: we have only to look back to the debates on abortion in 1966 to recognise the slippery slope that we would set out on. At that time abortion was said to be necessary because young girls were being raped; older women were having babies with Down's syndrome; mothers with mitral stenosis were dying in mid-trimester; and Catholic mothers, denied contraception, were having to bear large numbers of children into penury because of the brute-like demands of their unemployed and drunkard husbands. As we know, a tiny minority of the millions of abortions since performed in Britain fall into these categories; most are performed for trivial reasons that could never justify taking a life.

Another lesson from the past should warn us against putting in the hands of doctors the means to shorten the lives of old women in nursing homes who have altered their wills in favour of the practitioner. Nor is it easy to frame legislation that would allow mercy killing and prevent mercenary killing. A whole profession (accountancy) has grown up to worm its way around difficult and complicated legislation. Far better to leave these