Euthanasia

Precise definitions are needed

EDITOR,—The paper by B J Ward and P A Tate underlines some of the difficult issues that accompany many of the decisions concerning medical treatment at the end of life.¹ The paper addresses only doctors' difficulties, so is out of step with the modern management of the terminal phase of life: increasingly, this form of care is a team approach and such decisions are the result of discussions among the team. This approach clearly provides benefits and safeguards to both patients and the team.

Discussions about euthanasia, withholding or withdrawing treatments, advance directives, and patients' wishes and autonomy are complex. Precise definitions are therefore required if we are not to confuse important points and issues. The imprecise definitions in Ward and Tate's study tend to blur the issues.

The report of the House of Lords Select Committee on Medical Ethics, in paragraph 21 under the heading "Terminology," states: "The term passive euthanasia is often used to describe the withdrawal or withholding of some treatment necessary for the continuance of the patient's life. We consider this term to be misleading."² A BMA working party makes the point: "The qualifiers 'active' and 'passive' are often applied to 'euthanasia' but do not lead to precision in argument."³ The true definition of euthanasia, again taken from the House of Lords report, is "a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering."³ This should not be confused with the use of appropriate drugs, the intention of which is to obtain adequate control of symptoms, even if these are needed in increasing amounts.

The paper raises many points, such as the need for better training in communication skills, the implications for medical education, and the need for more open discussion. It is regrettable that the paper was not published earlier so that it could have been fed into the broad public debate initiated by the House of Lords select committee over the past year.

ANNE RODWAY
Vice chairperson

BMA Medical Ethics Committee,
London WC1H 9JP

1 Ward BJ, Tate PA. Attitudes amongst NHS doctors to requests for euthanasia. *BMJ* 1994;308:1332-4. (21 May.)

2 House of Lords Select Committee on Medical Ethics. *Report*. London: HMSO, 1994.

3 BMA. *Medical ethics today: its practice and philosophy*. London: BMJ Publishing Group, 1993.

Attitudes are influenced by age and religion

EDITOR,—B J Ward and P A Tate note five clinical implications of their survey on doctors' attitudes to euthanasia,¹ which received wide press coverage. Our survey of general practitioners in Glasgow does not support these generalisations.

Few data exist on the incidence of euthanasia and doctors' attitudes—There are indeed few published studies. Our unpublished study surveyed all 615 general practitioners in Greater Glasgow Health Board; the response rate was 56.3% (n=346). We asked 16 questions covering a range of issues related to euthanasia, including how many

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requests for active euthanasia had been received in the past three years. Some of the respondents did not answer all the questions.

Half had been asked to take active steps to hasten death—In our study 206 respondents had not had a single patient ask about euthanasia in the previous three years.

A third who had been asked to take active steps had complied—Although we did not ask doctors how often they had complied with requests for active euthanasia, 235 reported they would not comply with such a request, 72 were unsure, and only 13 indicated that they would assist in active euthanasia or assisted suicide.

Half would consider taking active steps to hasten death if this was legalised—Only 63 of our respondents agreed that they would be prepared to practise legalised euthanasia; 163 disagreed and 82 were unsure.

British law is unsatisfactory and euthanasia should be discussed openly—Like Ward and Tate, we found that age and religious affiliation influenced attitudes. It is more correct, therefore, to say that the law is unsatisfactory for different reasons for different groups. Some doctors might not be happy about the law because they cannot legally practise active euthanasia, while others, perhaps because of religion, believe that law in the United Kingdom is too permissive. That so few patients in Glasgow had asked about euthanasia indicates that Scots law is not unsatisfactory.

What can be concluded from the differences in the findings between the two studies? Firstly, real differences may exist between general practitioners in Scotland and those in England. Secondly, sample characteristics make a big difference to the findings of surveys on controversial topics. Thus all doctors must be cautious in drawing conclusions and generalising to the rest of the medical profession. This is especially so when the findings of a study are likely to be taken up by the media.

KENNETH COLLINS
General practitioner

Midlock Medical Centre,
Glasgow G51 1SL

MARY L M GILHOOLY
Codirector

Institute of Law and Ethics in Medicine,
University of Glasgow,
Glasgow G12 8QQ

KEITH MURRAY
Computing manager

Department of Public Health,
University of Glasgow,
Glasgow G12 8QQ

1 Ward BJ, Tate PA. Attitudes amongst NHS doctors to requests for euthanasia. *BMJ* 1994;308:1332-4. (21 May.)

Don't follow the Dutch

EDITOR,—By accepting B J Ward and P A Tate's paper (on doctors' attitudes to requests for euthanasia)¹ before, but not publishing it until after, the publication of the report on euthanasia by the House of Lords Select Committee on Medical Ethics² the *BMJ* has done both the authors and readers a disservice. Possibly the authors might not have concluded that "the current law on euthanasia is not satisfactory for patients" if they had been able to study the select committee's report. In contrast to Ward and Tate, the committee concluded that there is "not sufficient reason to weaken society's prohibition of intentional killing which is the cornerstone of law and of social relationships. Individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions."³

It is disturbing, therefore, that nearly half the doctors surveyed by Ward and Tate would welcome the liberties extended to the medical profession in the Netherlands in relation to voluntary euthanasia. Again reference to the select committee's report is apposite: "We do not think it is possible to set secure limits on voluntary euthanasia... We took account of the present situation in the Netherlands; indeed some of us visited that country... We returned feeling uncomfortable, especially in the light of evidence indicating that non-voluntary euthanasia... was commonly performed in Holland. We learned of one... case in which voluntary euthanasia was accepted by both doctors and lawyers in a physically fit 50 year old woman alleged to be suffering from intolerable mental stress."³

So what do we make of the assurances in Gerrit van der Wal and Robert J M Dillmann's paper that all is well in the Netherlands and that there is no evidence of a slippery slope from voluntary to non-voluntary or involuntary euthanasia?⁴ As pointed out above, the slippery slope already exists. Incredibly, it is acknowledged but brushed aside by van der Wal and Dillmann.

The extension of euthanasia to patients who are not physically ill is another example of the slippery slope. The women referred to above was divorced, and one of her sons had died of cancer and the other by suicide. Euthanasia for morbid grief or depression? This is where the experience in the Netherlands has taken the Dutch. In the light of such evidence I prefer the select committee's caution to the conclusions of Ward and Tate and the hollow reassurance of van der Wal and Dillmann.

ROBERT TWYXCROSS
Macmillan clinical reader in palliative medicine
University of Oxford,
Sir Michael Sobell House,
Churchill Hospital,
Oxford OX3 7LJ

1 Ward BJ, Tate PA. Attitudes amongst NHS doctors to requests for euthanasia. *BMJ* 1994;308:1332-4. (21 May.)

2 House of Lords Select Committee on Medical Ethics. *Report*. London: HMSO, 1994. (HL paper 21-1.)

3 Medical ethics: select committee report. *House of Lords official report (Hansard)* 1994 May 9;554:cols 1344-9. (No 83.)

4 Van der Wal G, Dillmann RJM. Euthanasia in the Netherlands. *BMJ* 1994;308:1346-9. (21 May.)

Opinion polls are helpful

EDITOR,—Andrew Fergusson of Healthcare Opposed to Euthanasia is plainly wrong to believe

the House of Lords Select Committee's statement that opinion polls on euthanasia are "far from decisive."

The most telling of these polls, as it was commissioned by the World Federation of Doctors Who Respect Human Life (an organisation explicitly opposed to euthanasia), was conducted by Market and Opinion Research International (MORI) in 1987. They had approached 1808 respondents with the following question:

"Now I would like to ask you some questions about euthanasia. By euthanasia I mean when a doctor is allowed by law to terminate the life of a patient. In Holland, some doctors carry out euthanasia when patients request it, by giving sedatives and injecting muscle relaxants so as to paralyse breathing. Some people have said the law in Britain should be changed so as to allow euthanasia in some circumstances as is done in Holland. Others believe the law should not be changed. Looking at this card, which of these options comes closest to your view?"

Options on the card were:

(a) Euthanasia should be made legal in all cases when a patient requests it.

(b) Euthanasia should be made legal only when a patient who requests it is suffering from a severe illness and is in a lot of pain.

(c) The law should not be changed so as to allow euthanasia.

(d) Don't know.

The results were 23% for option (a), 49% for (b), 19% for (c), and 9% for (d).

Their Lordships were perfectly entitled to side with the 19% of the population who are opposed to changing the law. However, their statement that the polls are "far from decisive" cannot be regarded as being an objective assessment of the evidence.

The difficulty with the euthanasia debate is that it tends to polarise between the quarter (approximately) of the population who advocate a "prochoice" euthanasia on demand stance and another quarter who support a "prolife" position to proscribe it completely, while ignoring the remaining half of the population who would allow euthanasia in selected circumstances only. A procedure of formal notification before any act of euthanasia, backed up by a system of tribunals in some cases,² would improve on current practices in the Netherlands, which are rightly criticised as unsafe in Fergusson's letter.

TIM HELME

Senior registrar in the psychiatry of old age

St Martin's Hospital,
Littlebourne Road,
Canterbury, CT1 1TD

1 Fergusson A. Ethics and euthanasia. *BMJ* 1994;308:1570. (11 June.)

2 Helme T. "A Special Defence": a psychiatric approach to formalising euthanasia. *Br J Psychiatry* 1993;163:456-66.

Permanently disabled people may have curable depression

EDITOR,—Madeleine Simms would do well to look more closely at what she is advocating.¹ Her suggestion that euthanasia should be legal provided that the patient is suffering from an incurable physical condition would merely establish in law the view that incurably disabled people are right to want to die and should be helped to kill themselves while apparently able bodied people are wrong to want to die and should be helped to live. This ignores the fact that suicidal people in both categories may suffer equally severe depression with much the same cause.

This not only singles out disabled people for discriminatory treatment; it also suggests that their depression must be caused by their disabling condition and that there is no remedy for this depression other than death. Depression in disabled people, as in able bodied people, can and

should be treated, and support should be given to enable the person suffering it to recover. As but one example I cite my own case.

I have severe spina bifida. I was suicidally depressed for many years, and, had euthanasia been legal, I would have availed myself of it. My suicidal feelings were not, however, connected with my disability but were caused by personal problems. Those feelings were alleviated, slowly, by people who were prepared to invest their time and energy helping me to rediscover a more positive outlook.

The availability of legalised euthanasia would militate against such help. It would condemn disabled people to death not because of their depression but solely because of their disability and would establish the view that death is in the best interests of those with incurable conditions. The House of Lords Select Committee on Medical Ethics is to be congratulated for recognising this danger and for recommending that it does not become a reality.

ALISON DAVIS

Milborne St Andrew,
Blandford Forum,
Dorset DT11 0LE

1 Simms M. Ethics and euthanasia. *BMJ* 1994;308:1165. (30 April.)

Accidental ingestion of methadone

Child resistant containers are needed

EDITOR,—I was annoyed to read J M Binchy and colleagues' report about accidental ingestion of methadone by children, which in some cases, led to death.¹ Last year I published a letter about accidental self poisoning with a cough syrup in a child.² Several letters were published from people who agreed with my identification of the need for legislation to make child resistant containers for liquid dose prescribable medications compulsory. Among these letters was one from the Royal Pharmaceutical Society of Great Britain; apparently a design for a cap for child resistant containers for liquid medicines was awaited, after which legislation should be introduced.³

Having heard nothing further, I wrote to the Royal Pharmaceutical Society last November. I received a reply informing me that there were still "one or two problems" with the introduction of child resistant containers but that "it will not be long before [such containers] are introduced for dispensed oral liquid medicine." What do we have to do to expedite this action?

I am due to start a post as senior house officer in a busy accident and emergency department in August and intend to collect data on cases of accidental self poisoning with liquid medicines in children. I hope that before I have completed the six month post something will have been done.

MICHELLE JACOBS
House officer in general surgery

Trafford General Hospital,
Manchester M41 5SL

1 Binchy JM, Molyneux EM, Manning J. Accidental ingestion of methadone by children in Merseyside. *BMJ* 1994;308:1335-6. (21 May.)

2 Jacobs M. Child resistant containers needed for liquid medications. *BMJ* 1993;306:145.

3 Odd RW. Child resistant containers for liquid medications. *BMJ* 1993;306:460.

Consider child abuse

EDITOR,—J M Binchy and colleagues discuss the continuing problem of methadone poisoning in children.¹ Having seen several children with methadone poisoning recently, we believe that

histories of accidental ingestion of methadone should not always be taken at face value. One child with such a history had been seen drinking a green liquid from an infant's feeding cup on the day before presentation, and some of the other children, like those in Binchy and colleagues' series, were under 12 months old. Furthermore, forensic scientists found methadone in the blood of a 2 year old boy who had been found dead in bed, having been seen in the accident and emergency department during the previous evening with a viral illness.

Although many cases of methadone poisoning undoubtedly are due to accidental ingestion, we believe that child abuse should be considered in the differential diagnosis. Appropriate action can thus be initiated. As in some other forms of child abuse, a precipitant may be that the child is crying. It would be interesting to learn by how much the incidence of this problem changes in Liverpool after the introduction of child resistant containers.

Giving a disturbed child methadone to drink is certainly child abuse, although any harm that results is probably accidental. Nevertheless, a crying child, a bottle of methadone, and a rudimentary knowledge of pharmacology may sometimes prove to be a fatal combination.

CHRISTOPHER MOULTON

Senior registrar

ALISTAIR GRAY

Consultant

DAVID HODGKINSON

Consultant

Department of Accident and Emergency Medicine,
Stockport Infirmary,
Stockport SK1 3UJ

1 Binchy JM, Molyneux EM, Manning J. Accidental ingestion of methadone by children in Merseyside. *BMJ* 1994;308:1335-6. (21 May.)

Doctors should supervise administration of methadone

EDITOR,—In their letter about maintenance treatment with methadone Robert T A Scott and colleagues show a bias towards retail pharmacy.¹ Businesses currently promote the misconception that their pharmacist employees can provide quasi-medical services at less cost to the taxpayer than the services provided by qualified and registered medical practitioners. I find it alarming that the supervised administration of a controlled drug could be delegated to non-medical employed staff with no regard for the privacy or confidentiality of the client. The NHS management should look at this proposal afresh.

The reasons for the suggested supervised maintenance scheme are the risks of misuse and the lack of security in the current system, which requires a hand written prescription before a patient can receive methadone from any number of pharmacies. This makes the doctor's prescription pad the target of theft, and the system is clearly impossible to police.

Every patient, however, is entitled to receive all treatment direct from his or her registered medical practitioner without prescription, and, indeed, controlled drugs may be provided only by or on the instructions of a registered medical practitioner.² I fail to understand, therefore, why NHS regulations enforce the separation of prescribing and dispensing in methadone maintenance programmes.³ I believe that the doctor should supervise the administration of methadone, as is the case in private clinics and rural NHS dispensing practices. This could be achieved overnight at no cost to the taxpayer by the simple expedient of including methadone for reimbursement under paragraph 44.5 of the NHS statement of fees and allowances.⁴

I have no doubt, however, that the current NHS