perpetuated the myths of the distress of dying, in particular of dying from motor neurone disease. The Motor Neurone Disease Association has been encouraging discussion about the fears of dying and providing information about the care of patients as death approaches. Their Breathing Space Programme has provided leaflets for patients and professionals to facilitate discussion of these fears and the positive ways to alleviate these concerns. This discussion may lead to the provision of medication for use in an emergency, and the Breathing Space Kit can be provided to store this medication and to give details of its use for everyone involved in the patient's care.¹

Euthanasia is an issue that needs to be discussed openly, but a film like "Death on Request" may confuse and frighten, especially when further information is not immediately available at the time of the broadcast. A round table discussion at 11.15, when many of the viewers will have switched off, is insufficient.

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1 Millard PH. Public deaths, private doubts . . . *BMJ* 1995;310:746-7. (18 March.)

2 O'Brien T, Kelly M, Saunders C. Motor neurone disease: a hospice perspective. *BMJ* 1992;304:471-3.

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Euthanasia is an option which alleviates patients' fear

EDITOR,—I find myself at variance with Peter Millard's review of "Death on Request".¹ Cees, the patient, was dying of a dreadful cruel disease which left his mind clear. He wanted to spend his last weeks at home. Under similar circumstances so would I. He feared the continuation of his life beyond the point where it became unbearable, and wanted the option of euthanasia at the time of his choosing and with the choice of changing his mind at any time. So would I. In fact, in many cases the option of euthanasia has not been taken up, but it was an option which alleviated fear. In 29 years of general practice I was responsible, with excellent nurses and latterly with the help of the hospice movement, for providing terminal care: one of the most demanding aspects of general practice. In a few cases, but only a few, I would like to have been able to offer legal voluntary euthanasia.

Peter Millard saw vanity in Dr Wilfred Van Oijen, the general practitioner in the film. To me he seemed a good, self-effacing listener and a model of quiet patience, sympathy, and understanding. I live in Oxfordshire and have an excellent general practitioner; if I moved to Amsterdam, from what I saw on the film I would love to have Dr Van Oijen as the general practitioner for myself and my family.

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1 Millard PH. Public deaths, private doubts . . . *BMJ* 1995;310:746-7. (18 March.)

The choice to live or die should remain to the end

EDITOR,—It is ironic that euthanasia should be causing renewed controversy at a time when our skills at controlling symptoms have never been greater.

Criticising the palliative care movement is the medical equivalent of kicking a spaniel, but on *The Late Show*, which discussed the televised mercy killing of a patient in Holland,¹ Cicely Saunders and Nigel Sykes managed to be patronising and insensitive to both our Dutch colleagues and

our patients. To insist that patients asking for euthanasia are really asking for something else is a self-deluding paternalism. Their rationale seemed to be that any wish to die represented a misapprehension which could be corrected by quality palliative care. This may be true in many cases; fear of dying in pain or alone or in distress is responsible for many patients wishing to die, and we can reassure these patients that their fears are largely groundless. Palliative medicine should be a core subject for all hands-on doctors, and should apply to all terminally ill patients, including those who are not dying from cancer. Even so, no matter how skilled the care, some patients will experience extreme suffering which can be relieved in only one way.

Some of the sophisticated methods for estimating quality of life, which are based on several measures, such as degree of disability and discomfort, can actually show a minus score—literally, a fate worse than death. Would a request from such a patient seem reasonable?

Of course we will have to protect our patients from abuses—the Thatcherite distaste for the old, the sick, the vulnerable, and the uneconomic increasingly pervades the health service, and euthanasia would be a tremendously attractive option to the paymasters; but then we doctors are well used to combating these dark forces.

Life is a matter of choice and that choice should remain ours to the end. Applying broad ambiguous ethical principles to individual tragedies is casuistry of the most pernicious form. If the conflict is between societies' ethical, moral, and legal codes and a doctor's compassion for the patient; if the dilemma is between respect for life and respect for a life, then there can be no reservation of justice.

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1 Millard PH. Public deaths, private doubts . . . *BMJ* 1995;310:746-7. (18 March.)

Should doctors have a dual role, preserving life and assisting death?

EDITOR,—If we ever have formal state approved euthanasia or assisted suicide, is there any need for the doctors looking after the patient to be involved in any way in the actual doing of it? Indeed, is any doctor needed at this final stage?

Serious consideration of this particular option, should the law be changed, has been urged before,¹ but is not considered in articles on euthanasia including those in the *BMJ* of 11 and 18 March.^{2,3} It always seems to be assumed that if you legalise assisted suicide you need a doctor to do it.

One day, in some brave new world (hoped for by some, dreaded by others) assisted suicide may come to be regarded as the right of every citizen purely on the grounds of autonomy. Until then the doctors looking after a patient—and presumably at least one independent doctor—will always be needed to advise on at least three points: firstly, whether every reasonable option for good care and relief of symptoms has been carefully considered; secondly, the likely course of events if life is allowed to continue; thirdly, the patient's mental state, in particular whether there is any evidence of a treatable depression. But, after that, need the medical profession be further involved—either with the final decision or with the actual ending of life?

The state could provide (preferably not anywhere where patients are being cared for, but either in the patient's own home or in some special state euthanasia unit) whichever way of assisted suicide it judges to be the most humane and the preferred choice of all concerned—perhaps just the touch of a switch by the patient to emphasise total autonomy, perhaps some other way.

All those who want to change the law in any way, whether they are moralists or pragmatists, need to think hard about several very powerful and conflicting human emotions. For example, though everyone approves a dual role for the veterinary profession, how many would be happy for a similar dual role to be formally adopted by hospital staff as part of their job?

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1 Brewin T. Voluntary euthanasia. *Lancet* 1986;ii:1085-7.

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Legalised suicide may increase openness in the doctor-patient relationship

EDITOR,—In the editorial about Oregon's plans to legalise suicide assisted by doctor, Melinda A Lee and Susan W Tolle noted that a major advantage of legalisation is that it will increase openness about care at the end of patients' lives, enabling a doctor to improve skills in providing supportive care to dying patients.¹ Data gathered on the attitudes of 57 patients in Scotland, all of whom were HIV antibody positive, suggest that the illegality of euthanasia in Britain constrains communication between patient and doctor.

A cohort of 57 people with HIV infection, which included all major transmission groups, was asked whether they had ever asked or thought of asking anyone for help in ending their life. Sixteen respondents (28%) indicated that they had. Three respondents had spoken about euthanasia with either their general practitioner, hospital based physician, or community nurse; three others said they would have liked to consult a health professional but were unwilling to raise the issue as they felt that it would be unfair to ask them to transgress the law. All six reported that communication on this issue was severely constrained by current legislation. They felt unable to communicate freely, as, according to a gay man with AIDS: "I don't think that there is any way that you could involve anyone in the medical profession. I think it would be unfair to ask them. . . . I would try and avoid compromising them in any way and it's purely because of the legal situation in this country."

The illegality of euthanasia prompted some respondents to make their own arrangements to hasten their death rather than seek assistance from health professionals. Five respondents talked of pacts which they had made with other people with HIV, six had spoken to members of their family or friends about whether they would assist them in the final stages, and three people said they would end their own lives.

At present, a gulf of illegality separates interested patients and willing doctors,² restricting communication about treatment in the final stages. The law not only denies patients the option of euthanasia but also restricts discussion between doctor and patient about when to withhold treatment to prolong life, which is an option in some circumstances under the present law. Were higher status attached to the "living will" and greater use made of it to facilitate communication between doctor and patient, the gap could be bridged.

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