where a doctor should accede to a request not to prolong the patient's life, a doctor should not actively intervene to end that life. . . . In the BMA's view, liberalising the law on euthanasia would herald a serious and incalculable change in the ethos of medicine.[5]

I doubt therefore if I am alone in thinking it unacceptable that a Dutch professor of obstetrics and gynaecology should be allowed some 800 words to give further airing to one sided Dutch arguments for euthanasia.[5] For those of us remote from the reality of Dutch euthanasia practice there seems little doubt that acquiescence in euthanasia in the Netherlands has had a corrupting effect on the medical profession there. The official Ministry of Justice and Ministry of Welfare, Public Health, and Culture's *Euthanasia Survey Report* reported that 27% of doctors admitted having carried out euthanasia on patients without any request (p 47, table 6.1) and 72% routinely falsified the death certificate after euthanasia (p 38, table 5.14). The published guidelines for euthanasia are shown to be often disregarded (p 39, table 5.15; p 52, table 6.8).[6]

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Role of depression ignored

EDITOR,—The editorial on euthanasia by A P M Heintz[1] and the personal view by Ray Morrison[2] made me feel concerned that the role of depressive disorders is often ignored in people who request euthanasia or express the desire to die.

Depressive disorders occur in 11·5% of elderly patients hospitalised for medical reasons[3] and in 12·4% of institutionalised elderly people.[4] Heintz quotes Van der Maas and colleagues, who state that 23% of people requesting euthanasia express "tiredness of life."[5] This symptom in itself would be highly suggestive of the possibility of a depressive disorder.

The first patient described by Morrison is "very much in his right mind...neither depressed or distressed." It is not clear whether this is Morrison's opinion or whether the patient had a formal psychiatric interview. I wonder if a better response by the nurse who asked the Reverend Morrison to see the patient would have been to ask a psychiatrist to see the patient.

Morrison states that patients who express a desire to die "may even be treated as if they were depressed. This is not helpful and violates the integrity of such patients." The correct approach is for these patients to be assessed by a psychiatrist, who can determine whether they are depressed or not. Not doing this violates the integrity of such patients by refusing them help which could allow them to spend the rest of their lives free from the mental anguish that depressive disorders cause.

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Predictions of outcomes can be wrong

EDITOR,—Several unsubstantiated assertions and an unsound conclusion make the editorial by A P M Heintz[1] seriously misleading. Few would accept that "the backbone of ethics is respect for human life," and only those with an inadequate ability to reason and reflect would conclude that patients must be kept alive at all costs for as long as possible. Such a view is clearly untenable. It is the high importance rightly attached to individual autonomy (rather than merely human existence) which requires that the best medical evidence be supplied to those who wish to make their own judgments about receiving or rejecting treatment for life threatening illness. In our current state of knowledge, the best medical evidence only sometimes includes valid information about the likelihood of prolonging or shortening life. Doctors often overestimate their ability to predict the outcomes of treatment,[2] and specifically there is no evidence that skilful symptom control is more likely to shorten rather than to prolong life.

Another of Heintz's dangerously false assertions is that euthanasia refers to acts intended to shorten the life of only those who are seriously ill and only at the patient's request. The evidence to refute this also comes from Holland, where "life terminating acts without explicit request" are well documented[3] and where a recent judgment accepted that no physical illness of any sort is necessary to justify euthanasia.[4]

The unsound conclusion that a solid legal basis for euthanasia is required assumes that such a notion is practically possible. A wide ranging, expert and thorough review of the evidence recently concluded that it is not.[5]

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More palliative care is needed

EDITOR,—I disagree with A P M Heintz's view that euthanasia can be part of good terminal care.[1] It is confusing and misleading to associate good terminal care with euthanasia, and the board of directors of the European Association for Palliative Care has made an unequivocal statement of its position.[2] We are strongly opposed to the legalisation of euthanasia, which is both dangerous and unnecessary.

We believe that if the principles and practice of palliative care were more widely recognised and adopted in countries such as the Netherlands, attitudes such as those of Heintz would be much less prevalent. Palliative care aims at achieving "the best possible quality of life for patients and their families" by focusing on a patient's physical, psychosocial, and spiritual suffering.[3] Requests for euthanasia are far less common among patients who have access to special palliative care services than among patients without such access.

I believe that the legalisation of euthanasia would begin a slide into intolerable abuse, with burdensome patients being particularly vulnerable. We should maintain an uncompromising stand against a law that would permit the administration of death.

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Stay away from the slippery slope

EDITOR,—A P M Heintz tells us that to be for or against euthanasia "makes no sense."[1] I disagree. I am against euthanasia as Heintz defines it: an act whose primary intention is to cause death.

Heintz is not talking about withholding aggressive treatment in certain circumstances or about giving adequate analgesia, both of which may on occasion speed death. These are legitimate and inevitable in the practice of many doctors. No: Heintz is advocating the deliberate ending of another person's life.

Shall we follow the Netherlands' example in this, as Heintz urges us to do? The Dutch government's criteria for euthanasia include the stipulation that the patient's request to die must be durable and consistent. Yet in 1990 in the Netherlands medical examiner Van de Waal found that the interval between the request for euthanasia and its implementation was less than 24 hours in 13% of cases and no more than one week in 35%.[2]

The Remmelink committee, set up by the Dutch minister of justice and the secretary of state for health to investigate euthanasia, reported in 1991.[3] It found that in 1990 in the Netherlands 2300 officially recorded instances of euthanasia occurred. But, in addition, there were 1000 cases in which life was deliberately terminated without an explicit request from the patient.

Shall we embark on that slippery slope? Heintz advocates regulations to safeguard against the misuse of euthanasia. But the experience in the Netherlands is not encouraging, and there is little reason to believe that Britain would be any different.

If governments want people to be cured and treated and given palliative care then let them continue to employ doctors. If they want people to be killed then let them appoint executioners. I, for one, want no part in that.

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1 Heintz APM. Euthanasia: can be part of good terminal care. *BMJ* 1994;308:1656. (25 June.)
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Natural and unnatural death

EDITOR,—The *BMJ* issue of 25 June contains several articles on our need to recognise the inevitability of natural death, which is not necessarily to be feared. Dominique Florin recognises that we do not need to try to resuscitate every patient after a cardiac arrest and explores how decisions about cardiopulmonary resuscitation should be made.[1]

In their contribution to the debate on withholding and withdrawing life sustaining treatment from elderly people Len Doyal and Daniel Wilsher make the extreme claim that the sentence "to

exercise their rights patients must have some potential ability to formulate aims and beliefs and to choose to act accordingly" means that "without such potential, patients cannot be regarded as 'persons' with any associated rights, including the right to lifesaving treatment."[2] The philosophical presuppositions of this controversial view are not defended in the paper.

Hospital chaplain Ray Morrison would "like everyone to be able to echo the cry of Jesus which he made at the end of his life, 'It is finished.'"[3] Though this example is not one of natural death, it does represent finished business. Health care must recognise the reality and the rightness of natural death and of finished business.

In contrast is the editorial by A P M Heintz, advocating euthanasia.[4] This is unnatural death and will lead to much unfinished business for our patients if Britain is unwise enough to follow the Dutch lead. How can Heintz possibly reconcile the statement that "the basic question is whether we accept the right of human beings to decide for themselves how their lives will end" with the Dutch government's statistic that in 1990, 0·8% of all deaths were due to "life terminating acts without explicit request"?[5] Dutch doctors kill more than 1000 patients a year without gaining their consent. Heintz has quoted from the report that includes this statistic and presumably, therefore, is aware of it. The fact that Heintz chooses to ignore it makes a mockery of the rest of the editorial, which fails to show that euthanasia "can be part of good terminal care."

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Undermines patient autonomy

EDITOR,—A more careful reading of the Remmelink report than that of A P M Heintz[1] reveals that 3700 Dutch deaths in a single year occurred as a result of euthanasia (3300) and assisted suicide (400).[2] This included 1000 patients whose doctors gave them "life ending treatment" without request.

It is difficult to see how this squares with Heintz's concern to "accept the right of human beings to decide for themselves how their lives will end." The House of Lords Select Committee on Medical Ethics unanimously rejected euthanasia,[3] recognising that legalising the practice undermines patient autonomy.

The Royal Dutch Medical Association and the "Dutch Commission for the Acceptability of Life Terminating Action" (a specious euphemism) have recommended that it can be ethically acceptable to terminate the lives of those suffering from severe dementia. Earlier reports have approved similar action for comatose patients and severely handicapped neonates.[4] It seems that Holland is moving rapidly down the slippery slope.

Leo Alexander, a psychiatrist who worked with the Office of the Chief Counsel for War Crimes at Nuremberg, described a similar transition of values in a 1949 paper which deserves much wider circulation: "The beginnings at first were merely a subtle shift in emphasis in the basic attitudes of the physicians. It started with the attitude, basic in the euthanasia movement that there is such a thing as a life not worthy to be lived. This attitude in the early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans."[5]

The Hippocratic Oath states, "I will give no deadly poison to anyone if asked, nor suggest such counsel." The *BMJ* would do well to promote ethics which have stood the test of time rather than granting editorial space to contemporary iconoclasts with short memories.

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1 Heintz APM. Euthanasia: can be part of good terminal care. *BMJ* 1994;308:1656. (25 June.)
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Do not change existing law

EDITOR,—It is surprising that, after the extensive and informed debate in Britain over the past 18 months, the *BMJ* has decided to publish an article from a Dutch obstetrician as an editorial on terminal care.[1]

In 1993 the House of Lords convened a Select Committee on Medical Ethics to look at issues surrounding ethical decisions at the end of life, including euthanasia. Evidence was sought widely and was received in writing and orally from various groups and professional bodies, including the BMA, pro-euthanasia groups, and the hospice movement.

The Association for Palliative Medicine, whose members in hospitals, hospices, and the community work daily with patients facing death, stated that "persistent rational requests for euthanasia are extremely rare. The potential for misinterpretation, hasty inappropriate action, pressure on the vulnerable, and straightforward abuse is such that the direct intentional killing of a person at their request should remain illegal."[2]

The select committee also visited the Netherlands, where specialist palliative care services are less well developed than in Britain. They returned "feeling uncomfortable, especially in the light of evidence indicating that non-voluntary euthanasia —that is to say, without the specific consent of the individual—was commonly performed," and they concluded that "it would be virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the United Kingdom could not be abused." They were "also concerned that vulnerable people—the elderly, lonely, sick or distressed—would feel pressure, whether real or imagined, to request early death."[3]

The Dutch Physicians' League has become increasingly concerned about events in its own country. The outcome of the judgment on Dr Chabot in the Netherlands shows that abuse of the Dutch guidelines is already being sanctioned. The BMA, in its authoritative text *Medical Ethics Today*[4] and in its evidence to the select committee, stated the dangers of the "slippery slope": by removing legal barriers to the previously unthinkable and permitting people to be killed, society would open up new possibilities of action."[5] The BMA opposes the legalisation of voluntary euthanasia.

The select committee's considered and unanimous conclusion was to "recommend that there should be no change in the law to permit euthanasia."[5]

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Responses to poll are telling

EDITOR,—The MORI poll on euthanasia commissioned by the World Federation of Doctors who Respect Human Life in 1987, quoted by Tim Helme, was even more telling than he suggests.[1] It revealed widespread ignorance about the possibility of pain control.

A total of 1808 people were asked, "In how many cases would you say that a person who is terminally ill could be almost totally free of pain through the use of drugs?" The answers were: in all cases, 9%; in most cases, 41%; in about half the cases, 14%; in a few cases, 20%; in no cases, 4%; don't know, 13%. These replies shed some light on the 49% support for the proposition (given in full by Helme[1]) that "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." There was 71% agreement with the statement, "If euthanasia was available on request to patients who are permanently dependent on others for medical or nursing care, some would choose it so as not to be a burden to others."

In a sample of 849 respondents, 59% agreed with the statement: "If euthanasia was practised in Britain, more elderly people would be afraid to go into hospital."

We would be glad to supply all the replies to this poll to any interested reader.

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Author's reply

EDITOR,—Anne Rodway mistakes both the purpose and results of our paper on euthanasia.[1,2] She criticises the "imprecise definitions" used in the survey. Although precise definitions of active or passive euthanasia are indeed important in moral discussion and in law, they are less vital within the confines of our survey. The questionnaire used was phrased in simple language, asking, for example, "In the course of your medical practice, has a patient ever asked you to hasten his or her death?" In this way, we hoped to be as confident as possible that each doctor surveyed understood exactly what each question was asking. It was not an ethical or philosophical discussion, but an attempt to find out what doctors actually *do*.

Rodway further reproaches us for addressing only doctors' difficulties. We had neither the intention nor the means of investigating attitudes in the general population or in other health workers, relevant as these attitudes may be. The paper's title clearly set its scope, and we drew no conclusions beyond these limits. It seems unfair to be criticised for not undertaking a different piece of research.

We disagree with Kenneth Collins and colleagues, who suggest that, in view of their results, Scots law with regard to euthanasia is "not unsatisfactory."[3] From their survey, it would seem that some 40% of their Glasgow respondents had received a request for euthanasia in the past three years. Whatever the actual percentages, some