

# The Review

## Choosing to die

Having seen Terry Pratchett's film *Choosing to Die* on *Newsnight*, (13 June 2011), I was deeply moved by its sensitivity, Pratchett's own personal response, and the bravery of Peter Smedly and his wife. I was disappointed by the ensuing debate where rather entrenched positions entangled people's contributions so that real listening or movement of ideas became impossible.

My own views on euthanasia or assisted suicide have shifted over time. Initially I was against, on the grounds that given good palliative care it should not be necessary, and that life is a gift to be received, almost like prayer book matrimony: 'for better or worse', and not a consumerist contract to be ended when it suits. While I still think those arguments are valid, I now feel that in individual circumstances an individual can rightly choose to end their life as a positive act of affirmation rather than one of despair. There is something to be said for leaving an ongoing party, rather than waiting for the bitter end. I can think of a few of my patients who over the years have made that decision, and many more who have expressed concern that they might be unable to do so because of incapacity and the medicolegal process.

The *Newsnight* debate oscillated between two poles. Firstly, one of individual self-determinism: an individual has the right to choose the time and manner of his death, especially if, in doing so, he is seeking to escape suffering. In a caring society that respects individual autonomy we should support and help people who make the choice to end their own life, even if we might personally disagree with them.

The counter argument is based on almost the same belief of independent autonomy, but with a fear that some individuals will be liable to influence or exploitation, and might be persuaded into doing something they did not want to do. Although not raised in either programme there is also a strong view that a person's own life is not his sole personal domain but intrinsically linked to the rest of us. This is well expressed in O'Neill's review of the same programmes.<sup>1</sup>

One concern about the Dignitas route is that because the individual must be able to perform the final act of drinking the fatal draught without assistance, they often die significantly sooner than they 'need'. For patients coming from UK, that also means

being able to get to Switzerland with reasonable autonomy. This poses an almost Catch 22 conundrum which is in itself distressing.

There is also the problem of what do we mean by terminal and how good are we at recognising it? A recent review of deaths in my practice over 6 months revealed that we had only identified a patient as being palliative in about 25% of the cases, principally those suffering from cancer. An even smaller proportion was deemed to be close to dying at the time of death.

Rather than concentrate on the question 'should we permit euthanasia or assisted suicide in the UK?', we should widen the question to: 'How can we allow individuals to die in dignity and comfort, in keeping with their own wishes?'

This poses two further questions: can we control and assuage not just physical pain, but also fear, anxiety, and confusion? For some patients, (I suspect this includes many seeking the Dignitas route), one of their fears is not being in control. Secondly, how can patients express their wishes, particularly in the case of illnesses such as dementia, which affect their decision-making capacity?

Good palliative care can control much of the physical pain of diseases such as cancer. As a doctor it seems right and proper to give dying patients the necessary medication to control physical symptoms, even if it suppresses their breathing to a point that is fatal. It is not determining an outcome rather easing the journey; substantially different from the idea of actively killing a patient as part of routine medical work, a fixed appointment with death. The work of Cicely Saunders and other palliative care pioneers did much to break down taboos around the logical and compassionate use of drugs for pain.

What we now need to do is to extend this to other symptoms, in particularly the mental ones of fear and anxiety. Why can we not see that a patient confused and agitated from dementia even with good nursing care, is suffering as much as one in physical

pain? Currently we are actively warned against using major tranquilisers in these patients due to risk of cardiac events and death. I do not advocate a medical cosh allowing patients to be more easily managed, but ask for a holistic and compassionate approach that recognises the reality of the situation. I have frequently had patients whose agitation and confusion has so exhausted a caring spouse that they have needed admitting to hospital or a care home, only to die a few days or weeks later; leaving their spouse not only grieving, but also with a sense of having failed the one person who meant the most to them. Would it be so wrong or the thin end of an unacceptable wedge, if those patients were given enough sedation instead to allow them to be managed at home, with whatever support was necessary?

While everyone knows they are going to die, many people appear to regard it as some distant unthinkable event let alone an imminent one. As doctors we often shy away from discussing the proximity of death and are poor at predicting it. The patients shown in Pratchett's film, both with Dignitas and in the hospice, had confronted the fact of their own death as an imminent reality. If as a society we want choice and self-determinism regarding end-of-life decisions, we need to have a much more realistic understanding of the realities and how they apply to us both collectively and as individuals. We need to be more open in discussing death as our final outcome and that we should not undertake medical procedures with a poor (<10%?) chance of restoring us to a reasonable standard of health.

The General Medical Council suggests we should have in-depth conversations with our patients about end-of-life care, if we deem them to be approaching death.<sup>2</sup> Given that we are bad at identifying patients in a terminal phase, and by then it may be too late, at what point do we initiate this process? Financial advisers and lawyers discuss their clients' provisions in the event of death, at any review of their affairs.

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*"Should we as GPs be inviting our patients to discuss end-of-life care at a milestone birthday ...?"*

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## Exhibition review

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Should we as GPs be inviting our patients to discuss end-of-life care at a milestone birthday, because they are entering a relevant phase of life; in much the same way as we are encouraged to discuss sexual health with teenagers? Has death replaced sex as the taboo subject?

Unless we die suddenly, we are likely to undergo an episode of ill health, frailty, and dependence in the run-up. For those that cannot face this loss of personal power, the knowledge that they can end their life if they wish to may provide sufficient reassurance (according to the *Newsnight* programme, only a fraction of patients who register with Dignitas have gone through with it). A society confident in its care for those dying naturally, could also be confident in allowing the few who wanted to be instrumental in their own end to do so. Until the debate moves from either/or to both/and, recognising that different people have different needs, we are likely to continue with the anxiety and suffering of the dying who do not feel that their country can provide the care they need.

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DOI: 10.3399/bjgp12X625247

### REFERENCES

1. O'Neill D. Assisted dying: we are not alone. *BMJ* 2011; **342**: d3772.
2. General Medical Council. Treatment and care towards the end of life: good practice in decision making. [http://www.gmc-uk.org/guidance/ethical\\_guidance/end\\_of\\_life\\_care.asp](http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp) (accessed 19 Dec 2011).

### LEONARDO DA VINCI: PAINTER AT THE COURT OF MILAN

**National Gallery,**

**9 November 2011–5 February 2012**

The exhibition *Leonardo da Vinci: Painter at the Court of Milan* fully booked at the National Gallery, reveals how much Leonardo believed in the importance of sight in the workings of the human mind.

In cross sections, the exhibition shows how the eye is attached to three ventricles, or chambers, in the brain. The first chamber gathers data, the middle one contains the *senso comune* (common sense) which processes data and houses the human soul, imagination and intellect. The third chamber stores memories. We can see diagrams of the head as if Leonardo had conducted an anatomical dissection but we know these largely depended on received opinion and his own imagination.

At the same time he sets out the measurements for the ideal proportions of the human head and intended his anatomical studies to form part of a treatise

**Leonardo da Vinci (1452–1519)**

***The Virgin of the Rocks, 1483 – about 1485***

***Oil on wood transferred to canvas. 199 x 122 cm***

***Musée du Louvre, Paris, Département des Peintures (777)***



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which he later hoped to write. Gazing at these two simple sketches your eyes are opened to the notes in the artist's characteristic left-handed mirror writing which refer to the layers of the scalp and are compared to an onion.

The most shocking emotion I experienced at the exhibition was when I entered room 4 and could see simultaneously for the first and the last time in my life both the paintings of the divine *The Virgin of the Rocks* (on loan from The Louvre and housed at The National Gallery): together they are outstanding and every other painting in the room and the crowd itself ... seem like nothing in comparison.

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DOI: 10.3399/bjgp12X625256

**Leonardo da Vinci (1452–1519)**

***The Virgin of the Rocks, about 1491/2–99 and 1506–8***

***Oil on poplar, thinned and cradled. 189.5 x 120 cm***



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