assisted suicide

The debate on assisted suicide will surely run for many months, if not years to come. Opinion may be divided but, as the BJGP’s recent letters, editorial, and original article demonstrate, the closer doctors are to the work of caring for the dying, the less they tend to support a change in the law. If we owe our dying patients any kind of debt, it is to afford them the same value and standard of care as those that live on.

Opinion polls may show a majority in favour of euthanasia or assisted suicide, but they also favour the death sentence, and our representative democracy allows us to reach a consensus in other ways than a simple head count.

As a GP for 13 years and a consultant in palliative medicine for the following 13, I am perfectly aware that the technology of controlling symptoms and alleviating distress still fails a few patients with severe terminal illness, as well as a few more whose illness will not be likely to kill them anytime soon. However, this should be a spur to a greater effort in researching, organising, and practising better terminal care. Our duty to society is to do our best and clearly state the threat that legalised assisted suicide would bring to vulnerable and compliant patients, already so devalued by our society that many no longer benefit from the standards of care mandated in the state sector. Care of the old and chronically sick is likely to be further eroded and outsourced to commercial enterprise as economic and political conditions change. This is no time to introduce suicide as any kind of therapeutic choice. The Association for Palliative Medicine continues to oppose a change in the law.

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REFERENCES


5. Airdale NHS Trust v Bland [1993] 1 All ER 821.


Circumcision

In answer to the article’s question — a religious obligation or the ‘cruelest of cuts’? — neither. No-one is obliged to be religious, and if they choose to be, there are plenty of religions where non-