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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,[1] and original article[2] 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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Persistent vegetative state

Mick Leach, commenting on David Jewell's editorial on assisted dying,[1] writes that 'we are part of a wider global society that is in many ways becoming more uniform ... that does not mean that we should necessarily always take the same route as other countries'.[2]

I would like to underline two key cases that happened in the UK and Italy that have been described in their different aspects by Paquita De Zulueta and myself.[3] I'd invite you to read them.

In April 1989 in England, Tony Bland, aged 17, was trampled and crushed by a stampede at the Hillsborough football stadium — a disaster in which 95 people were killed. Nearly 3 years later, in January 1992 in Italy, Eluana Englaro, aged 21, lost control of her father's car while driving at night on an icy road and crashed into a lamp post fracturing her skull and neck. When these young people were admitted to hospital, both of them were found to have suffered devastating anoxic brain damage and both were later diagnosed as being in a permanent vegetative state. This situation lasted for many years.[4,5]

We had two young people disastrously brain damaged and incapacitated provoking a painful and public debate regarding their future. In both cases the families wished treatment to end and were supported by the law, and in the UK case also the medical profession (but not the nursing profession). In Italy, the medical profession was divided and Italy appeared to be in danger of sliding into a constitutional mayhem and theocracy. The religious stance, however, is relatively new (since 20 March 2004, when Pope John Paul delivered a papal allocution on the subject) and with the Catholic tradition in fact offering two competing viewpoints on the ethics of withholding or administering hydration.

Debates about permanent vegetative state vary greatly between countries, revealing the different visions of what constitutes the 'Good Life' and what it is to be human. In both cases mentioned some kind of legal compromise was reached: in Italy there was an acceptance that the individual's prior wishes are determinative, even though arguably, that person no longer exists, and in England a subjective quality-of-life assessment was made that permitted treatment to be discontinued in the full knowledge that death would follow. Both decisions aimed to reflect a compassionate and holistic view of what it means to be fully human.[6]

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Circumcision

In answer to the article's question — a religious obligation or the 'cruellest of cuts'? — neither.[1] No-one is obliged to be religious, and if they choose to be, there are plenty of religions where non-

therapeutic amputation of the foreskin is not obligatory.

It was disappointing to see this one-sided article which appears to suggest the taxpayer should support this barbaric and inhumane practice. The two articles in the *BMJ* last year were far better.[2,3]

I look forward to eventually seeing a legal case against this affront on the right of a child to bodily integrity.

And please — call it what it is. 'Circumcision' sounds so euphemistically innocuous.

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Doctors Anwar, Munawar, and Anwar plead for NHS resources to be diverted towards increasing the provision of religious circumcision.[1] Apart from their theological justifications, their main arguments seem to relate to the risks associated with the procedure being carried out by inexperienced practitioners and that 'it is not our duty to tell a patient which decision to make, but merely to carry out said decision to the best of our ability.' This is an extraordinary argument, and we are left wondering how the authors would respond to a request for amputation of a healthy limb, female genital mutilation, or assisted suicide.

There is no medical justification for circumcising healthy neonates in the UK. While some argue that there might be a small health benefit in countries with endemic HIV infection, and possibly some reduction in risk of urinary tract infection, there is no doubt that the risk of harm greatly exceeds the health benefits in the developed world. Infants cannot give consent to surgical procedures, and there is no ethical argument for performing an irreversible procedure which might impair later sexual function (or at least sexual pleasure) before a child is old enough to give consent. Prioritising parents' religious beliefs over the health needs of their child disregards fundamental ethical principles of non-malificence and respect for patient autonomy.

The only argument for the involvement of the NHS in religious circumcision is harm reduction, and it is for that reason that I refer patients to paediatric surgeons when parents request it. There is a strong argument for the practice of male infant circumcision being treated by the law in the same way as female genital mutilation.

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The essay on circumcision in the January 2010 edition of the *BJGP* clamours for 'the right to ensure that the procedure is carried out by an experienced surgeon ...'.[1] If circumcision is indeed a quintessentially natural act of human cleanliness obliged by the religious tenet of Fitrah, why should it need a well-trained surgeon (or Rabbi) to perform what is purported to be one of five simple acts of human hygiene? And why is there an absence of agitation — on religious grounds — for the State to provide intensive regulation of people performing the other four Fitrah acts (nail-cutting, shaving of pubic hair, plucking of axillary hair, and beard trimming)?

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Stevens–Johnson syndrome secondary to oseltamivir (Tamiflu®)

We write to highlight a serious cutaneous side effect of the drug oseltamivir or Tamiflu® which has recently been in widespread use due to the swine influenza epidemic.

A 17-year-old male presented to hospital with an erythematous rash over his limbs and trunk, oral ulceration, facial swelling, and blurred vision. He was well with no significant past medical history. Two weeks previously he had experienced a viral illness of headache, fever, and myalgia which was treated with oseltamivir (Tamiflu®) in the community. The day after completing the course he developed these symptoms. Other than paracetamol he had taken no other medication. Stevens–Johnson syndrome secondary to oseltamivir was diagnosed. He was found to have corneal ulceration requiring steroid eye drops and required admission and other supportive treatment before eventually recovering several weeks later.

Stevens–Johnson syndrome is a rare but recognised complication of oseltamivir (Tamiflu®) and the condition does have an associated mortality. To date there are no figures regarding adverse reactions of this nature, as most information comes from small previous studies.[1] The most common events recorded are nausea and vomiting. A Cochrane Review showed that oseltamivir (Tamiflu®) slightly reduces time to alleviation of symptoms and is of use as post-exposure prophylaxis, but concludes low effectiveness.[2] There have been recent calls for caution in extensive