Letters

Editor’s choice

Special needs for us or assess and treat all patients as individuals?

Ephrem Bogues, perhaps to a point beyond repair. Topped up than to repeatedly drain it flat, our patients, not just for our colleagues as ourselves properly, what hope is there of today’s NHS are not allowed, to look after ourselves, what is to be respected. Indeed, Oregon has had an identical bill for 18 years, and this year Canada and California, with combined populations of 73 million, joined Oregon, Washington, and Vermont in passing the same Assisted Dying Bill.

I believe that Dr McEvoy may wish ‘the profession to uphold its ethical stance’ but the pressure for change has now become inevitable and the RCGP should now engage with this reality.

Philip Hartropp,
Retired GP, Board Member of Dignity in Dying.
E-mail: phartropp@aol.com

REFERENCE

Competing interests
Dignity in Dying campaigns for a change in the law on assisted dying.

DOI: 10.3399/bjgp16X683593

Euthanasia: providing optimal terminal care

I agree with McEvoy that the medical profession should not become social agents in direct action to end life and should aim to achieve optimal terminal care. Unfortunately this situation does not exist at present. Perhaps if more attention was paid to the experience of dying patients and the views of their relatives and carers as suggested by the Leadership Alliance for the Care of Dying People then we as a profession would be better equipped to provide optimal end-of-life care.

Ian J Hamilton
Retired GP
E-mail: ijdhamilton@doctors.org.uk

REFERENCE

Assisted dying: the pressure for change

McEvoy in his editorial is clearly not in favour of the proposed legislation to enable assisted dying for the terminally ill, mentally competent patient whose suffering is unbearable. Unfortunately, he, along with other prominent medical and political opponents, seeks to mislead your readers by repeatedly referring to euthanasia. This is where a doctor administers a life-ending medication as in the Benelux countries, whereas with the proposed Falconer/Marris Assisted Dying Bill it is the patient who must take the life-ending medication themselves, placing them firmly in charge of their own death. It is their ultimate choice that is to be respected. Indeed, Oregon has had an identical bill for 18 years, and this year Canada and California, with combined populations of 73 million, joined Oregon, Washington, and Vermont in passing the same Assisted Dying Bill.

I believe that Dr McEvoy may wish ‘the profession to uphold its ethical stance’ but the pressure for change has now become inevitable and the RCGP should now engage with this reality.

Philip Hartropp,
Retired GP, Board Member of Dignity in Dying.
E-mail: phartropp@aol.com

REFERENCE

Competing interests
Dignity in Dying campaigns for a change in the law on assisted dying.

DOI: 10.3399/bjgp16X683593

Access to primary care

I read this article today in the surgery with a wry smile. In the room next door we have our first clinic from our visiting cardiologist, and in 2 hours the same seat will be filled with our visiting gastroenterologist. Quality is maintained and waiting times are short; continuity is guaranteed. Rurality alone does not have to delay access to diagnosis and treatment. This has been achieved by swimming against the tidal gates controlled by the CCG. As a rural practice with a forward view that is already 5 years old, we would like to shape the provision of medical services to the local population for the next 5 years, preferably by swimming with the tide.

Robert William Howe,
GP, Lostwithiel Medical Practice, Cornwall.
E-mail: william.howe@nhs.net

REFERENCE

DOI: 10.3399/bjgp16X683809