Letters

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Editor's choice

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

Tuffrey-Wijne nicely highlights some of the issues arising when a healthcare professional becomes a long-term patient.[1] The older we get, the more relevant her experience will become. In days of yore, through instruments such as Mental Health Officer status, doctors' 'special needs' were acknowledged and addressed by a caring NHS employer. Today, thankfully, we are no longer seen as special, but alas neither are we looked after as different. All patients are different, yet medical training lumps us all together, using the medical model, under descriptors of convenience called diagnoses. We are dehumanised in training in order to become 'better/detached' doctors and we pay a price for that when we become patients ourselves.

Instead of shielding ourselves from the individual humanity of our patients, it would be better to have personal insight development, self-care skills, and resilience-building at the core of our training. This would enable us to open up our humanity to work better and last longer. We would make much more efficacious use of that metaphorical drug, the Doctor. If we never learn how, or worse still in today's NHS are not allowed, to look after ourselves properly, what hope is there of becoming the best doctor we can be, for all our patients, not just for our colleagues as patients? Much better to keep the battery topped up than to repeatedly drain it flat, perhaps to a point beyond repair.

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1. Tuffrey-Wijne I, Williams E. Healthcare professionals have special needs when they become patients. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X687949.

DOI: 10.3399/bjgp16X683581

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.[1] 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.

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1. McEvoy P. Euthanasia, ethics, and the Gordian Knot: is the Hippocratic Code obsolete? *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X687721.

Competing interests

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

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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.[1] 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[2] then we as a profession would be better equipped to provide optimal end-of-life care.

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2. Leadership Alliance for the Care of Dying People. *One chance to get it right: improving people's experience of care in the last few days and hours of life*. London: Department of Health, 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf (accessed 11 Jan 2016).

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Access to primary care

I read this article today in the surgery with a wry smile.[1] 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.

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1. Jones R. Access to primary care: creative solutions are needed. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X687697.

DOI: 10.3399/bjgp16X683809