Physician Assisted Suicide

The British Medical Association, has rejected a motion attempting to tighten the association's policy on physician assisted suicide. At its annual representative meeting in London on 27 June delegates welcomed the conclusion of the 3-4 March BMA consensus conference[1,2] to reject moves to change the law on physician assisted suicide, but rejected calls for this to be 'the settled opinion of the BMA for the forseeable future'. Michael Wilks, BMA ethics committee chairman, said that in order to 'lead the debate' the association should not be 'tied to any one position'. The BMA's failure to give a clear signal is further evidence that growing numbers of its members, not least leading members of its ethical committee, are unsure whether it is wrong for doctors to help patients kill themselves.

Medical technology and palliative care have now advanced to a level where most people in this country are able to die comfortably.

However, on rare occasions, patients' fears about distressing symptoms and loss of dignity or control over death can prompt them to request help in committing suicide. These fears may be potentiated by depression or a false sense of worthlessness and are often heightened by anxiety about overzealous and inappropriate medical intervention.

As well as treating physical and psychosocial symptoms, doctors have a duty not to administer intrusive medical treatment when the burden of that treatment outweighs its therapeutic benefit. Neither should they give treatment forcibly to competent patients who refuse it, even if that treatment is life-saving.

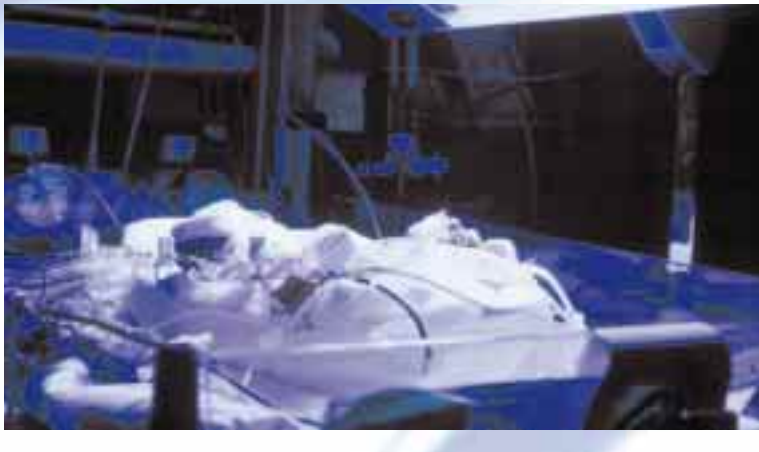
However, while upholding respect for patient autonomy, doctors must never intentionally give their patients advice or the means to commit suicide, either directly or indirectly. Any law allowing physician assisted suicide would threaten the trust necessary for the doctor-patient relationship to function, place pressure on patients (whether real or imagined) to request early death, and introduce a slippery slope to voluntary and involuntary euthanasia. Such legislation would also be impossible to police, might well undermine the development of palliative care services and could lead to patients being pressured to request suicide for economic reasons by family, carers or society at large.

Human beings are made in the image of God,[3] and belong to God.[4] Only God has the right to take life – and the taking of innocent human life (even if the life is 'one's own') is always wrong regardless of the wishes, circumstances or motivations of those involved.[5] In the same spirit the Hippocratic Oath enjoins that doctors 'give no deadly medicine to anyone if asked, nor suggest such counsel'. Despite the many changes in medicine these time-honoured values must be reaffirmed by the profession.

Accordingly, whilst as doctors we have a responsibility to provide appropriate treatment, palliation and support to patients who are suffering from distressing symptoms (whether in the context of terminal illness or not) – we must continue to resist any change in the law to allow physician assisted suicide.

Peter Saunders
CMF General Secretary and Managing Editor of Triple Helix

1 BMA Consensus Statement on Physician Assisted Suicide. *web.bma.org.uk/public/pubother.nsf/webdocsvw/PASConf*
2 Physician assisted suicide:consensus reached on key issues. *BMJ* 2000; 320:946 (1 April)
3 Genesis 1:27, 9:5,6
4 Psalm 24:1
5 Exodus 20:13



BMA guidance endangers doctors

Doctors who act in accordance with the BMA guidance on Withholding and Withdrawing Life-prolonging Medical Treatment may be breaking the law according to the Scottish Deputy Minister for Community Care, Iain Gray. The BMA guidance, issued on 23 June 1999, condones the withdrawal of artificial nutrition or hydration from patients who have suffered a 'serious stroke or have severe dementia', providing a 'senior clinician' agrees. In a parliamentary debate on the Adults with Incapacity Bill, Mr Gray commented, 'To withdraw hydration and nutrition from a non-PVS patient with the purpose of hastening death would leave a medical practitioner open to criminal prosecution. Let us be clear about that.'1 Despite this, the BMA, at its annual representative meeting on 27 June, has rejected a motion calling on the BMA Council 'to reconsider those parts of the guidance document... which are incompatible with Scottish Law'. The BMA, rather than reviewing its recommendations, seemingly prefers to have the courts decide whether doctors, in any particular instance, have gone too far. The General Medical Council has not yet given its opinion on the guidance.

Peter Saunders

1 Scottish Parliament Justice and Home Affairs Committee, 1 March 2000

Surrogacy fiasco

A lesbian couple from Hollywood have adopted twin girls in a transatlantic surrogacy fiasco involving six other adults. An Italian businessman and his Portuguese wife living in France had commissioned a British surrogate, Claire Austin, to have embryos, produced from the eggs and sperm of two strangers, implanted by a Greek doctor in Athens. On discovering that the twins were girls the couple cancelled their order and demanded an abortion. The surrogate located the adopting parents through a gay and lesbian agency.

Meanwhile Britain's first gay couple to father surrogate children are planning to have another baby. Tony Barlow and Barrie Drewitt, who spent £200,000 paying a Californian surrogate to carry their twins, have just spent a week with another American woman who has agreed to carry their next child.[1] These extreme cases are a poignant reminder that God had good reasons for instituting marriage as a life-long, heterosexual, monogamous relationship;[2] thereby providing a stable base for imparting wisdom to the next generation.[3]

Peter Saunders

1 *Evening Standard*, 8 & 31 May 2000
2 Genesis 2:24
3 Deuteronomy 5:6-9

Educating African Doctors: Showing how it can be done

Prof 'Rab' Mollans and students

It is shameful that about 45% of the people of sub-Saharan Africa live on less than one dollar a day, a proportion that has scarcely changed in the last eleven years, the very period when the structural adjustment programmes of the World Bank and the IMF should have been having some effect.

The loss of skilled people from Africa continues, whether in the overseas diaspora or into more lucrative private employment at home, so that training institutions find it hard to recruit staff and even harder to retain them. The difficulties seem insuperable and, even worse, they are now compounded by the HIV/AIDS epidemic.

Is this fair? Should it be allowed to pass unchallenged? Can not something be done? If the morale of countless health care workers in sub-Saharan Africa is to be strengthened, if their vision is to be enlarged, and if their hope is to be sustained, they must be given the opportunity to have continuing training and a chance to develop their skills. Then, they will be able to approach their work, not with despair and bewilderment, but with growing confidence, resourcefulness and effectiveness.

Eleven years ago a group of friends decided that we could indeed make a difference, however small: we therefore established the Tropical Health and Education Trust (THET); to relieve this disadvantage where we could, and to strengthen training for health care. Our policy is to work with those who are responsible for training health workers, for example the Dean or the Director of Nursing, and then to plan programmes, which are specifically designed to strengthen local training and meet local needs, over at least three and preferably five years.

We do not prescribe what should be done: rather, we respond to needs and requests. One of the best methods has been to link an overseas hospital or training school with a counterpart in the United Kingdom, and such links cover a wide range of subjects and staff. Other examples of our work include: continuing education for rural medical officers and support for psychiatric clinical officers in Uganda, students' field work and training of ophthalmic field workers in Ethiopia, training of medical officers for life saving surgery in Ghana, a students' prize for the best project report in seven countries, and support of a course for orthopaedic clinical officers in Malawi.

Many of these activities depend on the time and skills of short term visitors from the United Kingdom, who are often prepared to use their leave or give up holiday to share their skills and do something practical for those whose responsibilities are so great and yet whose opportunities are so slender. We have seen morale raised, skills strengthened and hope kindled. We're working to see more.

Eldryd Parry

Eldryd Parry OBE is a Visiting Professor at the London School of Hygiene and Tropical Medicine and Chairman of the Tropical Health and Education Trust (THET), 24 Eversholt Street, London NWI 1AD.
Tel: 020 7611 8705. Fax: 020 7611 0683.
Email: epthetl@aol.com

Appraisal, governance, revalidation: nothing but aggro?

Every doctor in the UK is about to face unprecedented quality control under the processes in the title. What's going on? And how should Christians respond? Clinical governance is about quality in institutions and was recently defined[1] as 'a framework through which NHS organisations are accountable for the quality of their services and the environment in which clinical care is given'[1]. Similar systems will apply to the private sector and other non-NHS institutions.

Each individual doctor will have to maintain a folder, describing what they do and containing such evidence of performance as educational activity, audit, and the views of their patients. As part of an annual appraisal, another registered doctor will review this folder, identify problems, and make constructive remedial suggestions. Every five years there will be a more formal process of revalidation, based on these appraisals. Most will sail through but the tiny minority who are not automatically revalidated, or who refuse to take part, will be referred into the General Medical Council's fitness to practise procedures. No revalidation – no registration. No registration – no work as a doctor.

It sounds draconian, but the need for such an emphasis on quality was being identified long before high profile cases in the mid-1990s. Many are understandably sceptical and have concluded these processes are not the whole answer to deficiencies in the NHS: 'It is all very well to proclaim the merits of revalidation and of clinical governance, but most practising clinicians have little confidence that either of these projects, as yet unfunded and somewhat ill defined, will improve the lot of the patient, or indeed maintain confidence in the profession'.[2] For example, more resources and more improvements all round in attitudes might help. But the reality is, these changes will be here a year from now. So how should we respond?

Christians will play their full part because of respect for authority: 'Everyone must submit himself to the governing authorities, for there is no authority except that which God has established'.[3] As with every aspect of their work, Christians should give this their best shot: 'Whatever you do, work at it with all your heart, as working for the Lord, not for men'.[4] Christians of all people should support accountability: 'man is destined to die once, and after that to face judgment'[5] and should care about the quality revealed at that ultimate audit: 'work will be shown for what it is, because the Day will bring it to light'.[6]

Let's pray about the quality of our medicine, practise as best we can, play a full part in the continuing consultations before the above becomes enacted in law - and let's start preparing those folders!

Andrew Fergusson

Andrew Fergusson is Head of Policy at the Centre for Bioethics and Public Policy, and an elected member of the General Medical Council

References

1 Smith R. The GMC: where now? *BMJ* 2000; 320:1356 (20 May)
2 Toft A. Has humanity disappeared from the NHS? *BMJ* 2000; 320:1483 (27 May)
3 Romans 13:1
4 Colossians 3:23
5 Hebrews 9:27
6 1 Corinthians 3:13