

## Assisted dying: what it really means

**Sir,**

Elaine Murphy (vol 69(8), 2008, p. 432) is absolutely right when she argues that 'each individual decides what he/she believes is a dignified death'. But her assertion that: 'For some, having the autonomy to choose when their suffering has become too much, and to be able to choose an assisted death if they wish, is a fundamental aspect of a good dignified death' goes too far. Autonomy should mean the ability, if one desires it, at the end stage of terminal illness, to kill oneself. That may mean being given the wherewithal to do it – it emphatically does not mean being able to ask others to effect the act. Although I cannot myself see a huge objection to physician-assisted suicide as practised in the US state of Oregon, I worry considerably about active euthanasia, when doctors or nurses kill their patients deliberately.

Drs Stone and Minton (vol 69(8), 2008, p. 434) say we should question why 'suicidal terminally ill patients' should be 'valued any less by our society', so that we permit them to have help acquiring the drugs to kill themselves. The point is a different one. The people concerned are dying anyway. All they seek to do is choose the time of their dying, often seeing the prescription as a safety net.

But there are two provisos here. One is the fear (not unreasonable, given Lord Joffe's own remarks) that this is the first step in a much broader campaign to get euthanasia into UK law. Second, there will undoubtedly be hard cases. If the only people allowed to receive these drugs are those who can use them themselves, without assistance, as it must be, then people who have terrible strokes or have end-stage motor neurone disease will not be able to avail themselves of these provisions, however desperate. Hard cases make bad law, and we should resist the temptation. The line should still be drawn at health professionals deliberately killing their patients. Giving dying patients the wherewithal to kill themselves, in very limited circumstances, is a very different thing.

**Baroness Julia Neuberger**

*Liberal Democrat*

*House of Lords*

*London SW1A 0PW*

**Sir,**

Those who want to see a law to legalize what they call 'assisted death' invite us to see it as nothing more than a therapeutic option or an extension of patient choice. In reality, it is far more than that. We are talking here about amending the law that prohibits intentional killing or aiding and abetting suicide. We are also talking about something that flies in the face of good medical ethics and that most doctors find repugnant.

Society rightly goes to great lengths to prevent suicides. Yet here we have a suggestion that, for one group of people (the terminally ill), we should be prepared to aid and abet it. And why? Not because the clinical symptoms can't be controlled (as they can with modern palliative care) but because a small number of terminally ill people can not come to terms with feelings of loss of control and personal autonomy.

We are told that Oregon's experience of assisted suicide is reassuring. We are not told that few Oregon doctors will touch the practice, so there is 'doctor shopping' to find a compliant physician. We are told that covert euthanasia is common in Britain. But a parliamentary report cast serious doubt on such allegations (Select Committee on the Assisted Dying for the Terminally Ill Bill, 2005), and a study 2 years ago by Brunel University (Seale, 2008) found no assisted suicide and concluded that covert euthanasia was very rare in Britain – and significantly rarer than in countries where 'assisted dying' has been legalized.

This is a dangerous road on which we should not embark.

**Baroness Ilora Finlay**

*Professor of Palliative Medicine*

*Cardiff University*

*Cardiff CF10 3AT*

Seale C (2006) National survey of end-of-life decisions by UK medical practitioners. *Palliat Med* 20(1): 3–10

Select Committee on the Assisted Dying for the Terminally Ill Bill (2005) Assisted Dying for the Terminally Ill Bill [HL]. Volume I: Report. The Stationery Office Limited, London: paragraphs 237–9

**Sir,**

After working in the Netherlands for 25 years, both in oncology and in palliative care, I moved to the UK, where I now work as a consultant in palliative medicine.

From a distance, I have followed the debate on assisted dying in this country. First of all, the law, as Drs Stone and Minton correctly state, is there to protect the vulnerable, state what is permitted and what is criminal, but also to establish the balance between the interests of the individual and those of society. An individual's autonomy is maximal and infinite only in one situation: when one is alone in the desert. In practice, we live in a society and our autonomy frequently collides with that of others.

And here is my personal dilemma. As a future patient I do not know if I would not scream for help in dying. I have never been in pain myself and I do not know what suffering is. But as a doctor and professional I need to think of the good of the whole society and not only this one patient of mine. At the moment of health and wellbeing I think that assisted dying is not in the interest of the society and is potentially damaging to its social structures and cohesion. But I never can be sure that this would not change if I were the patient myself.

For the time being the tradition but also moral laws are for me the only sense of security. Baroness Murphy states that euthanasia in the UK already happens and that this should be the most powerful argument for changing the law. I have my doubts about this reasoning. Will the fact of soaring knife crime in large cities ever be an incentive to decriminalize the possession of knives by the young? Why not? Because we also have moral norms, among which 'thou shall not kill' is not the least important.

At the beginning of this year I took part in a live debate between Dr Stone and Baroness Murphy. Before the debate, the members of the audience, most of whom were doctors and nurses, were asked whether they were in favour of or against assisted dying. I was not surprised when about 30% of the delegates appeared to be in favour. After the debate, which was as interesting as those printed in this journal, there were only a few delegates still in favour. What happened? I think, intuitively, many of us are in favour of assisted dying. Who would not like to help those who are in such need? However, weighing up all the arguments, in favour and against, individual and societal, makes a significant difference for intelligent people.

Baroness Murphy states that politicians ignore the majority of people (80%) who would like to introduce an assisted dying bill. When I read the survey to which the Baroness referred, it appeared that, yes, 80% of people would agree with euthanasia for patients with an incurable and painful disease from which they will die. Only 60% would opt for assisted suicide in this situation. However, when the same people were asked about a patient with an incurable and painful disease but not one that would lead to the patient's death, they were less permissive. Only 34% of the respondents were in favour of a self-chosen death in that case.

The problem is that in the first situation, when the disease leads to death, the consoling possibilities of palliative care are significant and usually underestimated by the general public. Not absolute, but significant. The real problem, where we, palliative care physicians, are in trouble is the incurable disease which does not lead to death. Significant pressure towards permitting euthanasia comes specifically from this group of patients.

In the Netherlands, but also in Oregon, rapid progress in palliative care resulted in only very few patients asking for euthanasia because of intractable pain. Most of the requests come not only because patients have lost perspective in their lives and fear losing their dignity but also because they have experienced arrogance and negligence in their health care and because they are tired of living and would prefer to depart. The answer to these fears should never be 'legalisation of knife possession' but improvements in the whole chain of care including that given at the end of life. There should be more of an attempt to decrease the fear of death, to provide explanation and widen discussion about this, not kill.

Researchers in the Netherlands evidence article after article in which there is nothing like a slippery slope and the situation is stable and may even be improving. When they were finishing their A levels in The Netherlands, my oldest son's class was told by the head teacher that 'nowadays only idiots and uneducated people are against euthanasia'. Did the researchers take this kind of slippery slope into account?

**Z Zylicz**

*Consultant*

*Dove House Hospice*

*Hull HU8 8DH*

## Pituitary apoplexy should be considered in pituitary failure

**Sir,**

Although not mentioned by Thorogood and Baldeweg (vol 69(4), 2008, p. 198) pituitary apoplexy is an important precipitant of pituitary failure in patients with pituitary adenoma, apoplexy being haemorrhage or infarction involving an adenomatous pituitary gland. A consecutive series of 560 cases operated on over 30 years found a major attack of pituitary haemorrhage in 6.8% of pituitary adenoma patients, a minor attack in 2.3% and a subclinical episode in 7.5% (Wakai et al, 1981). Exceptionally, pituitary apoplexy may involve non-adenomatous tissue. Predisposing factors have been identified in about 50% of cases of apoplexy involving pituitary adenomas, and these include head trauma, hypertension and anticoagulation, among others (Verrees et al, 2004).

A retrospective analysis of 40 patients admitted to one centre with the diagnosis of pituitary apoplexy yielded the following presenting features: headache in 63%, vomiting in 50%, visual field defects in 61%, ocular paresis in 40%, mental deterioration in 12%, syncope in 5%, and hyponatraemia in 12%. Symptoms and signs suggesting antecedent hypopituitarism were identified in seventeen patients. Thirty four of the 40 patients underwent transphenoidal decompression, and the others were managed conservatively. Long-term hormonal outcome in the entire group was characterized by hypogonadotropic hypogonadism in 79%, central hypothyroidism in 54%, central hypocortisolism in 40% and permanent diabetes insipidus in 8% (Lubina et al, 2005).

The impairment in water excretion caused by cortisol deficiency can mask symptoms of co-existing diabetes insipidus, so a high index of suspicion for the latter is needed, especially during glucocorticoid replacement therapy, which can unmask occult diabetes insipidus in patients with pituitary apoplexy (de Heide et al, 2004).

Some patients with pituitary apoplexy can be managed solely with replacement therapy (de Heide et al, 2004; Sibal et al, 2004), but most authors favour surgical intervention (Verrees et al, 2004). In a retrospective analysis of 45 cases 27 (60%)

were managed by surgical decompression and 18 (40%) were managed conservatively. Patients with visual field defects were more likely than those without those signs to be managed surgically ( $P=0.01$ ), but complete or near complete resolution of reduced visual acuity, visual defect and ocular palsy occurred in all conservatively treated patients whereas complete or near complete resolution of these parameters occurred in 93%, 94% and 93% of surgically treated patients (Sibal et al, 2004).

In typical pituitary apoplexy, oculomotor nerve paralysis is accompanied by visual defect but a few cases have been reported where the presenting feature was oculomotor nerve paralysis without visual field defects. The most striking example was an acromegalic patient with pituitary apoplexy in whom bilateral total ophthalmoplegia was not accompanied by any visual field defect. Magnetic resonance imaging showed a large heterogenous mass extending into both cavernous sinuses and sphenoid sinus but there was no compression of the optic chiasm. Owing to haemodynamic instability he was initially managed conservatively with glucocorticoid replacement therapy and thyroid replacement therapy. During the subsequent 2 months, in spite of improvement in his general condition there was no improvement in the ophthalmoplegia. He then underwent transphenoidal excision of the pituitary mass, followed, 3 months later, by complete resolution of ophthalmoplegia (Tanriverdi et al, 2007).

**Oscar Jolobe**

*Retired Geriatrician*

*Manchester Medical Society*

*c/o John Rylands University Library*

*Manchester M13 9PP*

de Heide LJ, van Tol KM, Doorenbos B (2004)

Pituitary apoplexy presenting during pregnancy. *Neth J Med* **62**: 393–6

Lubina A, Olchovsky D, Berezin M et al (2005)

Management of pituitary apoplexy: clinical experience with 40 patients. *Acta Neurochir (Wien)* **147**: 151–7

Sibal L, Ball SG, Connolly V et al (2004) Pituitary apoplexy: A review of clinical presentation, management and outcome in 45 cases. *Pituitary* **7**: 157–63

Tanriverdi F, Karaca Z, Oner A et al (2007)

Complete surgical resolution of bilateral total ophthalmoplegia without visual field defect in an acromegalic patient presented with pituitary apoplexy. *Endocrine J* **54**: 681–4

Verrees M, Arafah BH, Selman WR (2004) Pituitary tumor apoplexy: characteristics, treatment, and outcomes. *Neurosurg Focus* **16**: 1–7

Wakai S, Fukushima T, Teramoto A, Sano K (1981)

Pituitary apoplexy: its incidence and clinical significance. *J Neurosurg* **55**: 187–93