In his editorial on the ethics of terminal care, Professor Roger Higgs (*Otago Bioethics Report*, October 1995) urges that the public should know that accepted practice would not allow the patient to suffer in terminal illness, even if the dose of morphine required to achieve control of suffering would make death probable, rather than just a possibility". This interpretation is consistent with Professor Skegg's law summary elsewhere in the Report. Higgs then elaborates:

> Is this situation satisfactory? Certainly both experience and such studies as have been done show that, in terms of symptom control, for most patients it appears to be so. There remain, however, some important concerns. It is hard for a doctor at present to be open about what she is actually doing. There will be a few cases where symptom control is not satisfactory. There are situations, for instance in some terminal neurological disease, where the symptoms would not naturally be seen as requiring morphine. The decision making lies mostly with the doctor. And there remains with me, I have to say, a fear that some foolish pharmaceutical company will find a method of severe pain relief that lacks the beneficial "side" effects of morphine.

In the last sentence, Higgs inverts the legal reasoning discussed by Skegg. Jurists quoted by Skegg say that the lethal side effect of pain palliation is not homicide because the patient's death is not intended. But Higgs seems to be saying: given this opinion, doctors may intend the patient's death provided that they do not tell jurists what they are "actually doing". His reference to the hypothetical "foolish pharmaceutical company" that deprived doctors of double effect morphine seems to leave this meaning beyond doubt.

Higgs also conveys this sense in his statement that "it is hard for a doctor at present to be open about what she is actually doing". He seems to say that doctors do and should practice euthanasia by stealth. Indeed, involuntary euthanasia, for he also says that "the decision making lies mostly with the doctor." What ethica' criteria justify euthanasing patients in the absence of legal permission? This vital ethical question is not discussed. There are other disturbing things about Higg's lecture. It was delivered after the New Zealand Parliament rejected, by a wide margin, a voluntary euthanasia bill. He makes no reference to the deliberations that informed Parliament's decision. He makes the extraordinary statement that "from being for all purposes a taboo subject until a few years ago, euthanasia has suddenly leapt centre stage." This obliterates a century of thought and experience, most notably the deliberations in New Zealand. In view of the legislative context of which the audience will have been acutely aware, Higg's silence seems to insinuate defiance of due process of public deliberation.

Legislative bodies have resisted voluntary euthanasia because, among other things, its practice in the Netherlands suggests that it cannot be insulated against abuse. Higg's voluntarism and disregard of evidence adds a new reason for that apprehension. Medical associations are having second thoughts because they fear that allowed euthanasia would spread mistrust among patients. The emphasis now is on palliative care. Higgs does not discuss the palliative care movement although it originated in his own country. He does make the important admission that with good terminal care "most people will be able to die well without resort to euthanasia", If so, what is the basis of the claimed need for a euthanasia bill?

In jurisdictions that retain capital punishment, the lethal injection is rapidly becoming the sole method of execution. The use of medical means for criminal punishment could alter the public perception of an act of mercy to a sinister, cold-blooded killing, particularly as the elderly become more aware that younger people think they have a duty to die. There is abroad today considerable mistrust of doctors. Increasing legal belligerence and massive recourse to alternative therapies illustrate. We should ponder what might be the effect on public confidence of adding euthanasia, legal or cryptic, to medical duties.

Professor Higgs replies

Professor Caton raises some important issues, but also some others which should not need a reply. Amongst the latter are my commitment to the principles and practice of good palliative care. These are part of my daily work and I know of no doctors now for whom they are not. Professor Skegg's approach carefully defines mainstream legal thinking. My own struggle is with situations which appear to take us precisely into those areas where "legal belligerence" may arise. My experience is that it is because some doctors are nowadays *more* trusted with patients' own feelings and desires about their mode of dying that there is now more open discussion about both outcome and about appropriate processes. When an individual's values are taken into account a troubling complexity may be added to the elegant and relatively simple thinking of the law. I am aware of the careful legal debates which have been undertaken in many countries about policies towards assisted death, but none of it seems yet, anywhere, to have "touched the spot" when seen from the perspective of patients and clinicians trying to make good sense of the management of difficult terminal illness.

The important issue to respond to here are Caton's problems with the concerns expressed at the end of my article. The first of my concerns is that it is hard for a doctor at present to be open about what she is actually doing. I say this because at the point where a patient is dying but also faces potentially great suffering, no caring clinician can possibly be unaware of the uncomfortably close convergence of those two very different intentions - to relieve suffering or to hasten death. Clinicians and patients struggle to maintain dignity and clear consciousness but some symptoms are so severe that they cannot be helped except by reducing the patientís conscious level to such a point that he or she cannot experience them, and that this will be necessary for the remainder of that life. Thus the only way of helping patients is to make them unconscious both of the symptoms and also of their

surroundings. In this sense, as one relative recently said to me, "we must accept, doctor that for us, she has already died". Where it is necessary to render someone unconscious to prevent them suffering, we are in a territory where the distinction between these two different intentions risks becoming a clinical, but also, perhaps, a legal nonsense. The patient is in a *process* which clinicians can influence but not reverse.

What these symptoms exactly are may in the future become more important. Morphine is used to combat pain, and works at the psychic level to do so. There are some neurological conditions where the suffering is not easily conceived of as pain, but morphine is nevertheless currently used to reduce the psychic suffering. It is theoretically possible (although here I may be revealing my deep ignorance of the frontiers of pharmacology) that a pain killer may be introduced which does not relieve this type of suffering; and also perfectly possible that an unsympathetic court might challenge the use of a particular drug in relation to a specific symptom.

The penultimate concern I expressed was in many senses the main one, that decision making in terminal care continues to lie mostly with the doctor. I believe that should not be. Death is a natural process and as it approaches I believe that decisions about the "management" of the life that remains should be as much as possible in the hands of the person who is living that life and dying that death. Hence, if rendering the patient unconscious is the only way to help some severe forms of terminal suffering, there is a clear need for the greatest amount of openness and sharing between patients and their clinicians before that point, so that the patientsí wishes may be responded to. Trust is, as my correspondent would probably agree, one of most effective therapies and particularly so at this moment in a person's life. I may be wrong, but I believe that trust is increased by looking at an issue honestly, and probably also by fitting the law to the clinical facts, not the other way round. As I see it, Professors of Applied Ethics, as well as General Practice, have the duty of increasing this openness and trust. The deliberate introduction of irrelevant issues about capital punishment reveals an aspect of Professor Caton's argument which we, his readership and his public, neither need nor deserve.

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