

understanding of biological process seems beyond reason.

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'Unprincipled QALYs'

SIR

There's just one point of theoretical interest in Mr Cubbon's response to my Unprincipled QALYs (1,2). He complains that since his approach is utilitarian and since utilitarian approaches are as old as the hills he 'cannot believe that the essence of the approach for which I was arguing can be satisfactorily attacked with ephemeral slogans such as "ageism", "sexism" and "Thatcherism"'.

I think Cubbon must have meant to complain that the slogans were 'contemporary' rather than 'ephemeral'; but of course his approach was not attacked with slogans but with arguments to the effect that it could be fairly characterised by those slogans, that they represented its ideology and that the ideology was flawed. In so far as Thatcherism is an ideology, some of the Greeks (ancient) could have been Thatcherite, just as there could have been fascists among them. There were certainly sexists among them.

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Response to Saunders and Singh

SIR

I was pleased to read the comments about my article Enforced death: enforced life (*Journal of Medical Ethics*, 1991; 17: 144) by Dame Cicely Saunders and Surinder Singh and I should like to say something about their interesting remarks.

I was, as Saunders correctly surmised, unaware that both the Association for Palliative Medicine and the European Association for Palliative Care '...consider that the direct and intentional killing of patients is unacceptable'. However, I would have been surprised to hear otherwise and being aware of this fact does not incline me to change my views in the slightest, since it is people with such views that I am primarily interested in influencing. I would have been interested to know whether these organisations consider that the *indirect and intentional* killing of patients is acceptable; do they consider that it is OK to kill one's patients provided that one can say with hand on heart that all one was really aiming at was relieving their pain?

As far as intentional killing goes I can see no moral distinction between direct killing and indirect killing or 'allowing to die' as it is sometimes sanitisingly called. To my mind, anyone who considers that even in the kinds of circumstances I described, the direct killing of those who request to be killed is wrong, and yet would condone indirect killing in such circumstances, has to explain why one is acceptable while the other is not. And they have to do so in a way that does not refer to the spurious moral distinction between killing and letting die.

I note with interest that Saunders seems to agree with me both that there are cases where palliative care is unavailable and that there are cases where it is unavailing (ie ineffective)

and hence that there will be people who will have life *enforced* on them, unless they are killed at their request. Naturally, as Saunders rightly points out, in such circumstances patients will have to rely on the compassion and understanding of their doctors and other carers. It's just that I think understanding and compassion in such circumstances, would lead palliative carers to kill their patients; to fail to do so would, in my opinion, be indicative of a failure of real understanding and a lack of genuine compassion.

Turning now to Dr Singh's remark, let me first of all deny that it is disingenuous of me to have said that doctors who refuse, in circumstances such as I have described, to kill their patients, 'guard their own quality of life at the patient's expense', since I believe it to be true. A doctor who fails to kill a terminally ill patient who is suffering irremediable pain or distress, who would prefer to be dead and has rationally asked to be killed, cannot claim to be doing so out of compassion for the patient. She cannot refuse help to such a patient and claim in good faith that she has done so because she understands that patient's distress and suffering. My guess is that it is a naive adherence to the idea that direct killing is always wrong (though indirect killings may not be) that persuades doctors who wish to remain 'good guys', to refrain from killing even in *in extremis*.

It could be claimed that it is because they believe that to enter into the practice of killing certain patients in order to help them could result in their becoming the kinds of people who might kill other patients against their will, that doctors do not want to add killing to their battery of clinical skills. But then to do this is to place the absolute against killing above the absolute against causing suffering (in this case by the omission to kill) and this seems to me to be questionable.

I agree with Singh that it is legitimate that requests for death from patients on account of poor quality of life, should 'be treated with the utmost caution and fully explored'. I also agree with him that the implementation of acts of euthanasia must 'be treated with great circumspection and caution'. Indeed, given that I only believe that doctors should kill patients who, in devastatingly awful circumstances, autonomously and rationally request to be killed, I hope that it was obvious in my article that my attitude to euthanasia is probably as cautious as it is possible to be, without being absolutist. I do not, as