rely on what he knew of the patient's wishes from past encounters or conversations.

It might be more reasonable to expect a doctor to assist a patient *before* the patient was placed in an emergency situation. Certainly the patient would find it easier to get information and assistance where needed, while still retaining the responsibility for his own death. In contrast, the non-intervention clause would in some cases not really have helped the patient whose weakness and physical incapacity made his need for such legislation the greatest.

The terminally ill patient's decision to accelerate his own death is not always a result of 'transient depression or despair', as Dr Twycross would have us believe. Essentially this is not a medical decision. Rather it is one which must be made and carried out by the patient himself. But with appropriate legislation enacted – which could only happen with the support of the medical community – a doctor would be able to offer assistance, as well as his honest prognosis and advice, to a patient who sought it.

References

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(2) 368 Parl deb HL 1976: 196–214, 226–229, 249–285.
(3) Williams G. *The sanctity of life and the criminal law.* Knopf, 1957: 322.
(4) 300 Parl deb HL 1969: 1229.
(5) Kennedy I. The legal effect of requests by the terminally ill and aged not to receive further treatment from doctors. *Criminal law review* 1976 Apr: 222.
(6) See reference (5): 219.
(7) Barrington M. Voluntary euthanasia act 198–?. (*Sic*) In: Cole M, ed. *Beneficent euthanasia.* Buffalo, New York: Prometheus Books, 1975: 209–210.
(8) *British medical journal* 1935 Nov 2: 856–857.
(9) Suicide Act 1961, s. 2.
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(11) 368 Parl Deb HL 1976: 235.

Response

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I have read with interest Nancy Ludmerer's comments in response to my paper. Unfortunately, she completely misunderstands my intention. I did not set out to address current thinking within the euthanasia lobby. Rather, I sought first and foremost to describe the principles of medical care in relation to the dying. Those discussed are in the tradition of Hippocrates and of Judaeo-Christianity. I was not seeking to establish anything new; merely to re-state the time-honoured.

Ludmerer is wrong when she states that the physician's 'duty of care' implies, even when a patient is clearly dying from an incurable, irreversible and progressive disease, that it is the patient alone who may cry, 'Stop!' in relation to life sustaining (death prolonging?) measures. When deciding *any* treatment the doctor considers, among other things, the patient's 'biological potential'. There comes a point when life supporting measures become biologically futile. In such circumstances, it is part of the doctor's responsibility gently to dissuade the patient who remains eager to cling to life despite being irreversibly at death's door. As always, the treatment finally decided on, and put into effect, depends on a subtle ongoing process of negotiation between doctor and patient.

Ludmerer accepts, seemingly without question, that men and women have an ultimate right of self-determination and, therefore, of self-deliverance. This of course, presupposes a universe that has evolved through chance alone. Once God is introduced, unless he is a disinterested landlord, Man cannot claim an inalienable right to choose the moment of his death. For many, including myself, God is a vital basic presupposition without which nothing can have ultimate meaning or purpose. Ludmerer's stance is, therefore, fundamentally false.

After the presentation of my paper at the international conference organised by EXIT, Oxford 1980, several of those present said to me: 'If all doctors practised as you do, I should not need to be a member of this society'. There is, therefore, a continuing need to re-state traditional medical principles so that the public may not be misled into supporting a radical alternative which will be difficult to implement, to monitor and to prevent from abuse. That the dying are frequently ambivalent as to what they want is well known to those who work with them. Also well recognised are the emotional conflicts within the family. The longer I work with the terminally ill, the more I realise that the final solution of the euthanasia lobby just does not match the complexities of real life. It is simplistic and naive – at least in relation to cancer patients. And if it is so for these, I have no doubt that the same is true for people dying from other forms of incurable, progressive disease. It is difficult to document this conviction.

Perhaps Ludmerer should spend a year or two on the staff of a hospice. If she does, she will see what I mean. Certainly, there can be no compromise: hospice care and euthanasia/assisted suicide are mutually exclusive.