

or

Ensuring the best quality of end-of-life care

Sir, Dr Forest's portrayal of legalised assisted suicide in the US (letter, Feb 17) omits to mention that palliative care in Oregon is not the same as in the UK. Only recently did it become a specialist branch of medicine there: it has been a speciality here for 30 years. A British parliamentary committee was told on a visit to Oregon that the state's assisted suicide law had been in some respects a vote of no confidence in end-of-life care there.

Most Oregon doctors refuse to engage in assisted suicide, leaving a minority to provide lethal drugs to patients they hardly know. In 2017 one doctor wrote 29 prescriptions for lethal drugs. And the death toll is rising: in 2017 it was the equivalent of 2,000 assisted suicide deaths here.

Palliative care specialists here do not, as Mr Scheffer asserts (letter, Feb 17), claim to work miracles. But we should not forget that Britain has been ranked first in international surveys for quality of end-of-life care. Doctors can and do have open and honest conversations about dying with seriously ill patients. There is, however, an important difference between end-of-life and ending-life discussions.

Pain relief is a sophisticated science. Morphine dosages need to be titrated

carefully to control an individual's pain. That does not shorten life.

PROFESSOR ROB GEORGE

Medical director, St Christopher's Hospice, London SE26

Sir, Nowhere in the assisted dying argument have I seen the chief drawbacks addressed.

How do we know the prognosis of a disease is correct? How do we know the patient who wishes to end his or her life is not suffering from reversible depression? How can a change in the law offer protection to a patient who may feel obliged to request assisted dying to avoid burdening relatives, friends or society?

It is not the opinion of others, even the General Medical Council, which trumps our duty of care but the law, passed by our legislators who, two and a half years ago, voted by a majority of nearly three to one to keep the present law.

PROFESSOR PETER DO DAVIES

Wirral, Merseyside

Sir, The argument about rights is removing focus and therefore funding away from the needs of those who die in unnecessary pain each year.

According to *The Lancet* Commission's October 2017 report "Alleviating the

access abyss in palliative care and pain relief — an imperative of universal health coverage", more than 25.5 million people (45 per cent of recorded deaths worldwide) died in unnecessary pain in 2015 due to a lack of available palliative care, 80 per cent of whom lived in low- and middle-income countries. Surely they also had a right to be heard.

GAIL FEATHERSTONE

Sevenoaks, Kent

Sir, Bullying is not a term usually associated with end-of-life care. But when I was a district nurse, two of the 200 terminally ill patients I nursed made a serious request for a quicker assisted death, which was denied them. One gentleman did not want the prolonged death nor the sedation which he was forced to endure. In both cases I felt more like a bully than a nurse and I apologised to these patients during my care of them.

I look forward to the time when a kinder, safeguarded doctor-assisted dying law similar to the one described by Dr Forest is in place here, and when my personal treatment of such terminally ill people will be considered to have been assault.

PAULINE CARROLL

Bath