END OF LIFE CARE **Raymond Tallis**

Professional bodies should stop opposing assisted dying

The BMA and some royal colleges are publicly opposed to legislation to permit assisted dying for terminally ill mentally competent adults (box). It is not the place here to rehearse what we, as members of Healthcare Professionals for Assisted Dying (HPAD), believe is the powerful case for such legislation, but rather to argue that the proper stance of our professional bodies should be one of neutrality.[1] HPAD was founded by Ann McPherson and her friend Joe Collier in 2010 to challenge the stance of the medical establishment.

At the heart of the case for neutrality is that the decriminalisation of assisted dying should be a matter for society as a whole to decide, and no particular group should have disproportionate influence on this decision. The view of society is clear: the respected British Social Attitudes series, which uses representative samples of the UK population, has consistently shown that more than 80% of the general population, including 70% of those with religious beliefs, support assisted dying.[2] This is not an unthinking or ill informed response: support for assisted suicide for people who have severe illnesses but are not terminally ill is much lower, at about 40%.[3] Our professional organisations, committed to shaking off the paternalism of the past, should not use their influence to impose the beliefs of some of their members on patients: this is inconsistent with the idea of patient centred care and the principle of "no decision about me without me." The analogy with the opposition of the medical profession to the death penalty, which may be at odds with majority opinion, is flawed: those who want to bring back hanging are not asking for execution for their loved ones or themselves.

The publicly stated opposition of some medical bodies to assisted dying has been cited by many opponents of a change to the law, but this ignores the division of opinion within the professions, as shown by the fluctuating positions adopted by bodies such as the BMA and the Royal College of Physicians, which have been neutral in the past. The most reliable information suggests that between 30% and 40% of doctors are in favour of decriminalisation,[4 5] and the result of a recent survey found that a clear majority of doctors think that medical bodies should be neutral. Their voices have been silenced: they are not being represented by their representative bodies. It is interesting to speculate why this should be so: it is possible that those opposed to assisted dying have been over-represented in forums where the matter has been discussed, often because they are supported by well organised groups affiliated with religious institutions.

The primary grounds for the BMA's opposition to euthanasia and assisted dying are that it is alien to the traditional ethos and focus of medicine.[6] Secondary reasons are related to patient safety and a detrimental effect on societal attitudes and the patient-doctor relationship. The monstrous cruelty of walking away from a dying patient who is suffering unbearably seems more obviously contrary to the ethos of medicine. International experience has shown that placing assisted dying within the framework of the law would increase, not threaten, patient safety and have an entirely beneficial effect on trust in doctors.[7-9]

Healthcare professionals, as responsible citizens, are of course entitled and perhaps obliged to express their views on the ethical and clinical case for or against, and the potential social impact of, a law to allow assisted dying for terminally ill people. Doctors' representative bodies, however, should be confined to speaking about those areas where they have an expertise that goes beyond that of the general public, such as advising on safeguards and codes of practice should any law be passed and on matters such as assessing prognosis and setting guidelines for optimal end of life care.

"More than 80% of the general population, including 70% of those with religious beliefs, support assisted dying"

Medical bodies' stances on assisted dying

Opposed
- BMA
- Royal College of Physicians of London
- Royal College of Surgeons of England
- Royal College of General Practitioners
- Association of Palliative Medicine

No position
- General Medical Council
- Royal College of Anaesthetists
- Royal College of Obstetricians and Gynaecologists
- Royal College of Paediatrics and Child Health
- Royal College of Physicians of Edinburgh
- Royal College of Surgeons Edinburgh

Neutral
- Royal Society of Medicine
- Royal College of Nursing
- Royal College of Nursing Scotland
- Royal College of Psychiatrists

Given the overwhelming support for assisted dying in society as a whole—and given also that there are healthcare professionals of good will, different faiths, and expertise in palliative care, with passionate views on both sides of the debate—we believe that the proper stance of healthcare professional bodies is one of neutrality. Members of HPAD therefore ask the BMA and those royal colleges that have declared themselves opposed to assisted dying to reconsider their position.

Competing interests: None declared.

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1 Tallis R. Unbearable suffering, prolonged by medical care, and inflicted on a dying patient who wishes to die, is unequivocally a bad thing. Healthcare Professionals for Assisted Dying. www.hpad.org.uk/the-need-for-change/.
2 Clery E, McLean S, Phillips M. Quickening death: the euthanasia debate. In: Parks A, Curtice J, Thomson K, Phillips M, Johnson M, eds. British social attitudes. The 23rd report—perspectives on a changing society. Sage, 2007:35-54.
3 McAndrew S. Religious faith and contemporary attitudes. In: Park A, Curtice J, Thomson K, Phillips A, Clery E, Butt S, eds. British social attitudes: 2009-2010. The 26th Report. Sage, 2010:87-113.
4 Seale C. Legalisation of euthanasia or physician-assisted suicide: survey of doctors' attitudes. *Palliat Med* 2009;23:205-12.
5 Lee W, Price A, Rayner L, Hotopf M. Survey of doctors' opinions of the legalisation of physician assisted suicide. *BMC Med Ethics* 2009;10:2.
6 BMA. Responding to patient requests relating to assisted suicide: guidance for doctors in England, Wales and Northern Ireland. BMA, 2010. www.bma.org.uk/ethics/end_life_issues/patientrequestsas.jsp.
7 Van der Heide, Onwuteaka-Philipsen BD, Rurup ML, Buiting HM, van Delden JJ, Hanssen-de Wolf JE, et al. End-of-life practices in the Netherlands under the Euthanasia Act. *N Engl J Med* 2007;356:1957-65.
8 Kmietovicz Z. R.E.S.P.E.C.T.—why doctors are still getting enough of it. *BMJ* 2002;324:11-4.
9 Jansen-van der Weide, Onwuteaka-Philipsen BD, Heide A, Wal G. How patients and relatives experience a visit from a consulting physician in the euthanasia procedure: a study amongst relatives and physicians. *Death Studies* 2009;33:199-219.

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ETHICS MAN **Daniel K Sokol**

How to be a cool headed clinician

Imperturbability is an essential characteristic for doctors, but how compatible is it with empathy?

At law school, as at medical school, however hard you study nothing quite prepares you for the real thing. In court, when your opponent rises to invoke an unfamiliar and potentially killer point, the mind tends to panic: "Where did this come from? Did I miss something in my preparation? What am I going to say?" Searching frantically for a response, you watch in despair as your opponent sits down. The stern looking judge nods expectantly in your direction: it is your turn to rise and speak. The world is now a lonely place, with nowhere to hide. Although stressful, this experience is central to professional development.

Experience alone, however, is of little value. The psychologist Anders Ericsson, an expert on experts, declared in a recent book that he had been "unable to find any evidence showing that experience has any benefits unless people pay attention to feedback and actively adjust."[1] For it to be effective, experience must be reflected on. This article is part of my reflection, but I have also got into the habit of jotting down key lessons after an eventful day in court. Recently, I simply wrote: "imperturbability."

Although empathy, compassion, and kindness are buzz words in medical schools (so much so that some clinicians associate ethicists with bleeding hearts and sentimentality), the great William Osler told medical students in 1889, "In the physician or surgeon no quality takes rank with imperturbability. The physician who has the misfortune to be without it," Osler continued, "who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients." This appears at odds with the modern focus on empathy, but does Osler's view have a place in medical practice today?

It is often said that before the past few decades medical ethics emphasised manners, etiquette, and decorum, with empathy having only a small part to play. The importance of empathy today can be ascribed, at least in part, to the unprecedented use of technology in medicine; the limited time available to see patients; and the integration of communication skills, ethics, and the humanities in the medical curriculum. Empathy emerged as a counterpoint to the "stranger at the bedside" phenomenon, attempting to give the stranger a human face. The focus on empathy in the training of medical students has made the Oslerian virtue of imperturbability unfashionable.

A key problem with empathy is that it cannot readily be taught to those who are not, by nature, empathetic. You cannot teach empathy as you teach how to perform a lumbar puncture. In that respect, there is much to be said for focusing on less nebulous qualities, such as courtesy and politeness. As I have argued previously, these are undervalued traits in medicine, and although their importance may be obvious their application is more challenging in the heat of a busy clinic, when frustration and fatigue can test even the most patient doctor.[2]

Aside from the difficulty in teaching empathy, it is debatable whether it is a desirable quality for doctors.[3] Indeed, the ill effects of empathy underpin the reason why doctors should not treat loved ones. A degree of dispassion is needed to maintain a medical gaze not blurred by too great a concern for the patient as a person. Yet, the questionable benefits of empathy do not derogate from the importance of kindness, which is a less demanding emotion. Few patients would object to a kind doctor. Many more would have concerns about an empathic doctor, fearing this shows either inexperience or a lack of mental fortitude. In the debates on the acceptability of doctors crying in front of patients, praying with them, or displaying outward effusions of emotion, at the risk of appearing heartless, I side with Osler. There must be an outward calm, a reassuring coolness, although it must not veer into indifference. Imperturbability is compatible with showing concern for the patient, and Osler himself is a case in point.

The questionable benefits of empathy do not derogate from the importance of kindness, which is a less demanding emotion

The million dollar question is how to develop the quality of imperturbability, and here lessons can be gleaned from the world of elite performance. According to the Yale psychiatrist Andy Morgan, who has conducted research on stress in military trainees in the United States, perception is key: "How you frame something in your head has a great deal to do with your neurobiological response to it. Once you start saying to yourself, 'Oh my God, this is awful,' you begin releasing more cortisol and start this cascade of alarm."[4] Neuroscience is deepening our understanding of stress and decision making, but it is clear that the poise of those doctors we admire is more than innate disposition. It requires repeated gritty experience and subsequent postmortems to discover what went right and wrong and to find ways to improve. This appreciation of the potential value of experience may, in itself, be reassuring next time an unexpected difficulty arises in the clinic, the operating theatre, or in Uxbridge County Court in front of a stone hearted judge.

1 Clark T. *Nerve*. Little, Brown and Company, 2011:121.
2 Sokol D. Manners maketh the doctor. *BMJ* 2011;343:d6073.
3 Smajdor A, Stöckl A, Salter C. The limits of empathy: problems in medical education and practice. *J Med Ethics* 2011;37:380-3.
4 Clark T. *Nerve*. Little, Brown and Company, 2011:112.

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