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CORRESPONDENCE

Correspondents are asked to be brief

Suicide and Euthanasia

SIR,—Dr. S. L. Henderson Smith in his letter (10 April, p. 111) commented on the B.M.A. report[1] and made the suggestion that the question of voluntary euthanasia would be considerably eased if the Suicide Act (1961) were amended to allow a doctor to help a patient, if he so desired, to take his own life. I am sorry that Dr. Henderson Smith did not amplify this suggestion when he and other doctors who support voluntary euthanasia gave evidence before the panel who were drawing up the B.M.A. report. As chairman I think I did not give as much attention to this suggestion as the matter deserves.

While it is true that in England and Wales there are penalties up to 14 years imprisonment for anyone who abets or counsels suicide, nevertheless while suicide and attempted suicide were once a crime in Scotland neither is recognized as such today. Since there is no principal crime of suicide in Scotland, presumably there is no art and part guilt for the individual facilitating the other's suicide.[2] In Scotland there appears to exist a liberty to facilitate suicide which is broader in scope, since it includes the laity as well as the medical profession, than that proposed by Dr. Henderson Smith for England and Wales.

What evidence is there that doctors, friends, and relatives avail themselves in Scotland of their liberty to assist suicide? There have been several communications concerning suicide in Scotland in recent years, but I have traced no reference to assisted suicides, by either doctors or friends. Has anyone information on this point? I am endeavouring to write a book about voluntary euthanasia and information on this point would be received gratefully.

There is one practical point if doctors or friends assisted suicide. Someone would have to watch by the comatose body until death lest another caller rushed the person off to hospital where modern methods of resuscitation save almost everyone who arrives in time. I have always felt that anyone desiring euthanasia should discuss matters with the nearest of kin, possibly a few friends, and obtain if possible their agreement. If this does not occur they will be deeply hurt by the unexpected death. This practical point might ensure this agreement.

Dr. Henderson Smith advocated that a doctor should be allowed to help his patient yield up his life if he so desires. Does this mean that a doctor could assist suicide only if there was a painful incurable physical disease or would it also allow him to assist a person considered to be sane who had a determined wish to take his own life because of mental distress, say from domestic unhappiness? The latter proposal was apparently actually made recently by the head of the Social Welfare Board of Denmark.[3] I find this suggestion alarming to say the least of it, but I do not know if it would be supported by any doctors who are members of the Voluntary Euthanasia Society.—I am, etc.,

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1 Special Panel of the Board of Science and Education of the British Medical Association, *The Problem of Euthanasia*. London, British Medical Association, 1971, and leading article, *B.M.J.*, 23 January, p. 187.
2 D. W. Meyers, *The Human Body and the Law*. Edinburgh, University Press. 1970.
3 *Daily Telegraph*, 20 January 1971.

Pathogenesis of Myasthenia Gravis

SIR,—The wider concept of myasthenia gravis (leading article, 3 April, p. 1) may be usefully extended. Goldstein and his associates[1] produced experimental thymitis by using Freund's complete adjuvant, and spontaneous myasthenia in man may well arise in a similar way. The associated disorders (immune thyroiditis, Addison's disease, and other endocrinopathies) are occasionally complications of sarcoidosis.[2]

Both Freund's adjuvant (killed mycobacteria) and the sarcoid agent[3] can induce local defensive antibodies. The latter eventually may also be shown to contain mycobacterial debris. It is therefore likely that myasthenia with, for instance, Hashimoto's thyroiditis sometimes results from sarcoid inflammation. Usually sarcoidosis heals in a year or two, leaving at most some lymphocytes and perhaps a few giant cells in fibrotic scars.

Rarely, these secondary changes progress, and immune disease will then become evident. The syndrome of giant-cell myocarditis with myasthenia (of which less than 30 cases are reported) may be an example. Not only does the histology of this condition include Langhans giant cells, asteroid bodies and lymphorrhages in the heart,[4] but also chronic lymphadenitis and giant-cell granulomas in the lungs and liver.[5] Mononuclear and giant cells are also found in the two organs in Addison's disease with hypoparathyroidism.[6]

A case showing chronic inflammation and giant-cells in the heart, with interstitial fibrosis of the lungs, had in life evidence of renal tubular acidosis and thrombocytopenia.[7] The illness resembled "hyperglobulinaemic