Letters

Resuscitation of demented people

SIR

The most surprising aspect of Dr Robertson's paper (1) is the use of the term 'senility' which in the more southerly of our two kingdoms has been extruded from polite and scientific parlance along with 'imbecility' and 'cripple'.

Less surprising is the observation that most people think they would not want to be resuscitated if they became demented. This does not solve the ethical problem for doctors and nurses caring for demented patients.

Dementia changes people; although it may be distressing for friends and relatives to see, say, a sometime professor of physics smiling upon his fingers' ends and delighting in a piece of chocolate, he, and not the man he once was, is the patient.

What if he seems perfectly happy? Our parliaments are not allowed to bind their successors, should our selves be empowered to do so? Demented people are presumably still people even if they are unable to formulate and express their present views on life and death as clearly as could their former selves.

In clinical practice in England demented patients are rarely subjected to cardiopulmonary resuscitation but the issue is not infrequently encountered in deciding whether a demented patient with pneumonia should be offered antibiotics. The underlying problem is therefore a practical one, but Dr Robertson's methodology does not help us to a solution.

Reference

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Response to Daniel Callahan - better ways of rationing

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In the March 1993 issue of the *Journal of Medical Ethics* I criticised Callahan's proposal of using age to ration health care (1). I claimed that a policy compulsorily to withhold life-extending medical treatments from persons who are over a specific age was discriminatory (ageist), that it undermined the autonomy of elderly persons and their right to negotiate in clinical decision-making, that it disregarded other important considerations in life-death decisions (for example, patients' usual state of well-being, the reversibility of conditions, and patients' wishes), and that it treated elderly people as the means to an end (economic savings) rather than as ends in their own right.

In concluding his response, Callahan stated: 'Any serious form of setting limits will be unpleasant and potentially unfair to some. If Mr Hunt does not like my way of setting limits, then let him propose some of his own. Then we can compare his unpleasant way of setting limits with my unpleasant way' (2). This is a reasonable challenge and one I accept.

I argue that egalitarian theory is more likely to achieve distributive justice than the utilitarian or collectivistic method reiterated by Callahan (1,2). Using egalitarian theory, the aim of rationing is not for some 'aggregated good', but rather for the evening out of individual needs and interests. Individuals are regarded as ends in their own right, independently of everyone else, and treated according

to the equal satisfaction of their needs and interests.

Rather than being an unpleasant way of rationing, I believe medical care could be substantially improved and produce greater client satisfaction, while costing less, if the egalitarian principle were applied to the allocation of autonomy and resources. Strategies which emerge, some of which Callahan would probably approve, include:

- 1) *Proper definition of goals of treatment*: The goals of medical treatment should be negotiated with the patient. When faced with an ill patient, physicians see a need or duty to do something. Too often, however, treatments are prescribed without proper regard for what the patient wants or regards as important for the satisfaction of his or her needs and interests. Doctors tend to use expensive, technological interventions because of their familiarity and the lack of knowledge about palliative alternatives. For example, a doctor may treat a patient with advanced cancer as if cure were a possibility, prescribing invasive, aggressive treatments, when the patient, if offered an informed choice, might opt for a palliative approach which would produce greater satisfaction at reduced cost. Also, because of the fragmentation of medical care into specialties, each physician is likely to promote his or her own brand of intervention. For the same cancer patient, a radiotherapist is inclined to prescribe radiotherapy, an oncologist will promote chemotherapy, and a surgeon may advise that surgery is the best option and so forth ('to a hammer everything looks like a nail'), and the patient may end up on a round from one specialist to another.

The paradigm of medical decision-making has been shifting in recent decades, from physician dominance

to patient participation. The enthusiasm of some doctors for unilaterally prescribing treatments, without due regard for the wishes of patients, has had to be curtailed. Policies about informed consent, for example, and the widespread introduction of natural death legislation have enabled patients to have more say in choosing their treatment. Advance directives and DNR policies also encourage the involvement of patients in setting appropriate goals. A more educated and empowered patient population, an improved awareness of the palliative mode of care, a co-ordinated multidisciplinary approach, and improved medical communication skills will lead to treatment that better meets the needs and interests of patients, and at less cost.

2) *Futile treatments should be curtailed:* The medical options presented to patients for consideration should not include futile treatments. If a patient requests expensive yet futile treatments then the doctor is obliged to discuss the situation with a view to refusing the patient's request. The principle of patient autonomy cannot be regarded as absolute, and it must be tempered with medical reasoning and consideration of the opportunity-cost to other patients. If futile treatments are withheld and withdrawn, the cost-effectiveness of medical care will be improved.

3) *Voluntary euthanasia:* A small but significant group of terminally ill persons want medical aid to die, even despite the optimal provision of palliative care. Respect for their autonomy and compassion for their suffering are crucial features of voluntary euthanasia. Although euthanasia should never be performed for economic reasons, savings would clearly result from its practice.

4) *Minimise physician conflict of interest:* The referral of patients to clinics or laboratories in which physicians have a financial interest, the referral to hospitals which offer incentives, and the prescription of brand-name drugs produced by companies that ply physicians with gifts are examples of conflict of interest. Also, physician ownership of medical technologies and fee-for-service reimbursement structures create vested financial incentives and the potential for abuses. This can lead to over-treatment, erosion of the integrity of the medical profession, and the excessive use of resources (3). Medical establishments should prohibit certain kinds of activities,

monitor and supervise conduct, and penalise improper conduct.

5) *Control the influence of lawyers:* The practice of 'defensive' medicine has increased, particularly in America, where lawyers have a vested interest in medical litigation. Defensive medicine is not necessarily good medicine. It tends to distort the doctor-patient relationship and to escalate costs. Control of the influence of lawyers on the practice of medicine is indicated.

6) *Evaluation of new technologies:* The extensive and routine use of new technologies frequently occurs before their cost-effectiveness is properly researched. Costs can be contained if new developments are scrutinised for their effectiveness and indications before being widely introduced.

7) *Democratic allocation of resources:* The egalitarian principle demands universal and equal access to services. In determining the priorities for service provision, the experience in Oregon provides an interesting model and suggests that resources can be allocated based on 'community values' (4). Essentially, the areas of health care to be funded are ranked according to their importance as perceived by the community. Such a method of allocation at a macro level is likely to maximise the satisfaction of the needs and interests of members of the community.

These types of strategies, unlike the proposal for age-based rationing, are morally just, and they guard against the dehumanising effects of bureaucratic systems. The above strategies respect and enhance the autonomy of individuals while encouraging the cost-effective distribution of health care resources for the equal satisfaction of individual needs and interests.

References

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- (2) Callahan D. Response to Roger W Hunt. *Journal of medical ethics* 1993; 19: 24-27.
- (3) Rodwin M. *Medicine, money and morals: physicians' conflicts of interest*. New York: Oxford University Press, 1993.
- (4) Garland M J. Justice, politics and community: expanding access and rationing health services in Oregon. *Law, medicine and health care* 1992; 20: 67-81.

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Autonomy and the akratic patient

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I am flattered that my worries about autonomy were selected for criticism by Raanan Gillon in his December editorial (1). One of the criticisms misses the mark, I believe. Gillon writes: 'because there can be very few – if any – people in real life who always act for the best, all things considered, by Mr McKnight's argument all the rest of us should be regarded as weak-willed and therefore irrational (in his sense) and therefore non-autonomous'. But it was no part of my argument that only someone who is never weak-willed (some Kantian superman?) could be counted as rational. I assumed, without thinking that it needed any argument, that most of us most of the time do act in accordance with what we think to be best, all things considered, and thus count as rational in my sense. 'Rational' can be used in the sense of 'capable of rational thought' or in the sense of 'thinking and deciding rationally on a particular occasion'. It is possible for someone who is rational in the first sense, to think and decide irrationally on some occasion. Someone (and perhaps only someone) who is rational in the first sense could be irrational in the second way. That is how I propose to describe an akratic person. There is a corresponding distinction between the question whether someone is autonomous in that he/she is capable of thinking and deciding autonomously in general and the question of whether he/she is thinking and deciding autonomously on a particular occasion. It is the second question that interests me in the case of the akratic patient.

Gillon also attacks my argument (which he spells out far more carefully than I did myself) on the grounds that it depends on the implicit premise that akratic action is irrational action and that premise is false. 'Rational', he thinks means simply 'based on reason' rather than 'based on the best reason' and as long as the akratic agent has reasons of some sort he qualifies as