

## Reference

- (1) Tew B J, Laurence K M, Payne H, Rawnsley K. Marital stability following the birth of a child with spina bifida. *British Journal of Psychiatry* 1977; 131: 79-82.

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## Reply to Simms

SIR

The two questions Madeleine Simms asks have got simple answers which I will be pleased to provide. Less happily, they also show that she has missed the point of my earlier correspondence, so a final reiteration of basic positions also seems necessary.

But facts first.

1) Who is to provide care for handicapped children if their parents cannot be 'dragooned' into it? Or even coerced, conscripted, blackmailed, or bludgeoned into it? The answer is the care and nursing staff of local authorities, the National Health Service (NHS), and the voluntary sector, along with foster parents and volunteers.

2) On the question of the raising and deployment of revenue: yes, I am advocating cuts in defence expenditure; yes also to increased taxation were it to be necessary and also not regressive; no to prioritising health care according to subjective and unverifiable criteria such as - 'quality of life'. Of what does this concept consist, how is it to be measured and operationalised, and what is its logical relationship to other concepts such as handicap and rights to life?

Now back to issues again. Ms Simms consistently attempts to justify the

killing of handicapped children (which under present British law would be infanticide or murder) by portraying it as the lesser of two evils. Either we kill someone, or worse things happen, such as mothers being dragooned into drudgery, divorce, etc. . .

I have not, as Ms Simms appears to think, argued that she has merely applied incorrect moral weighting to the horns of this dilemma. What I have done is to consistently argue that this is a false dilemma, and that neither of these immoral alternatives is necessary. Not killing, nor yet dragooning etc. . . It is therefore disconcerting to be labelled as one who is not very bothered about the quality of life of the carers, when an understanding of my position would surely preclude this. Perhaps Ms Simms thinks that the ethics of debate are, like the ethics of killing, 'matters of individual judgement'.

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### Editor's note

The editor feels that these two letters should end this particular correspondence.

## The Patient Advocate as Adversary

SIR

The relationship between physician and patient realises unequal information and skill between them; by agreement the physician is to use his skill on the patient's behalf. The physician must foremost maintain the role of patient advocate; physicians are to guide the public, and not become agents of the state or any other employer (1).

However, medicine is becoming a business tuned to the government, hospitals and other employers. The danger lies in the loss of control - for the physician as advocate and the patient as an agent of free choice. One path is the development of the physician-employee, with loss of self-determination and ability to respond for the patient (2).

In America the Public Health Service has produced outstanding results in health care; other public sectors employing physicians however, have allowed just this loss both of self-determination and ability to respond for the patient to occur. This has been through the aggrandisement of a non-medical administrative cadre who both act as patient advocates and are appointed as such. With scant medical knowledge, an adversarial role can be taken towards the physician. While this situation is not the norm, it is a trend.

The international nursing code supports the view of those nurses who perceive themselves as that of patient advocate (3). In the conflict generated by administrative versus professional roles for advocacy, one solution may be that the physician and nurse advocate together for their patients.

### References

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- (2) May W E. On ethics and advocacy. *Journal of the American Medical Association* 256, 13: 1786-1787.
- (3) Beauchamp T L, Childress J F. *Principles of biomedical ethics* (2nd ed). New York: 1983: 249, 332.

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