would treat them. Does God ever mercifully kill those who ask him? To the contrary, even his most faithful servants are denied their requests – Job, Elijah and arguably even Christ himself are poignant examples (7). His approach is not to kill the sufferer but rather to relieve the suffering. In God's economy suffering is worked for good (8). Does God ever sanction intentional killing of the innocent? Again, no. Even compassionate killing at the sufferer's request is not 'justifiable homicide' according to biblical teaching (9). This is the very reason that compassionate killing and assisted suicide are still illegal. British law was originally based on Judaeo-Christian ethics. To say then that Dr Cox acted in accordance with the Golden Rule in killing his patient at her request is simply not true.

It is one thing to recognise what Christian ethics are and to reject them. It is quite another to reinterpret them to give support to a diametrically opposed thesis. By all means do continue to encourage those with novel views to join the debate. It's refreshing to see Christ and the Bible mentioned alongside Kant and Bentham. Considering the influence of Christianity on our laws, ethics and culture helps to redress a balance perhaps lacking in previous editions of your journal. However, please do try to ensure that such debate is properly informed.

**References**


(3) Matthew 7: 12.


(6) Matthew 7: 21.

(7) Job 8: 6–9; 1 Kings 19: 4; Matthew 26: 39.

(8) Romans 8: 28.


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**Is medical ethics lost? Response from Professor Hare**

**SIR**

If Drs Fergusson and Saunders had read the literature referred to in my guest editorial (1), they would know some of the answers to their objections. There was no room for them in the editorial, but you have kindly allowed me space to make a start now.

Dr Fergusson's arguments are familiar, and mine ought to be too. For the sake of those who treat the words of Christ with respect, as I do, it is worth while asking what they imply for such issues as euthanasia. The Old and New Testaments contain all manner of texts which can be quoted in support of almost any opinion one cares to mention, especially if one begins the question, as Dr Fergusson does, by assuming without argument that voluntary euthanasia is wrong, and therefore murder. If it were not wrong it would not be murder. His unargued-for definition of 'murder' is too simple.

What I was trying to do was to find the core of Christ's moral teaching. This certainly lies in the doctrine of love (agape), of which the passage I cited (the Golden Rule) is one expression. He himself said that on the commandment to love God and our neighbour hang all the law and the prophets (Matthew 22, 40); there is none other commandment greater than these (Mark 12, 31). So the 'jots and tattles' of Matthew 5, 18 are subordinate, and in the next few verses Christ revises the Mosaic law's teaching about killing: the motive matters. St Paul endorses the centrality of love (Gal 5, 14); he likewise says that love is the end (telos) of the commandment (1 Tim 1, 5; see Bishop Joseph Butler, *Sermone 12*), and his invocation of love in 1 Corinthians 13 is well known. Christ also said 'If ye love me, keep my commandments' (John 14, 15); so we cannot appeal to the commandment to love God in order to defeat the commandment to love our neighbour.

I have explained at greater length elsewhere (2) why some clergymen neglect this teaching in favour of rigid rules, as the Pope has recently done. They do it because they want to keep the faithful in order, and that looks to be easier if one lays down extremely simple rules and allows no exceptions to them. But for doctors in real life this is not helpful (hence the casuistry). I am not a supporter of situation ethics, and indeed have pointed out its faults (3). But it is important to have regard to distinctions between cases. Is Dr Fergusson saying that the 4,000 Christian doctors he claims to represent cannot see a difference between Dr Cox's action and typical murders? He ought to ask whether the undoubted difference between the cases justifies a moral distinction. As a moral philosopher I am not allowed to appeal to biblical authority (4), and I have no wish to. But happily, and not surprisingly, rational thought supports the teaching of Christ, as I have tried to show throughout my writings (5).

Dr Saunders also misconceives my purpose, I am not seeking 'the ultimate in brevity'. What he does not understand is that moral thinking takes place at two levels, that of the simple principles that we need in everyday life, and that which we have to do in difficult cases where they conflict, and also when we ask, what are the right principles. I have recommended a method for this second kind of thinking. Has Dr Saunders any? In my view it has to be based on agape, on which the principles of the lower level hang. That the principles will conflict is evident in many fields; euthanasia is one of the most obvious. We all, like you, Sir, accept a principle of beneficence, requiring us to help other people and do the best for them. We also accept a principle forbidding killing. But in cases like that of Dr Cox's patient these excellent principles conflict, and we have to do this second kind of thinking and decide which of them to follow, and whether to modify one of them by admitting exceptions. It is no use in such cases dogmatically sticking to just one of the principles.

Dr Cox might have been wrong to think there was no way of relieving his patient's suffering and keeping her alive. But suppose he was right; or suppose we were speaking of a case in which there was no way. Dr Robert Twycross, whom I greatly respect, appeals in his article (6) to the principle of double effect, to cast doubt on which was the main purpose of my editorial. The principle of double effect affords no let-out, because if giving potassium chloride is a sin, so is giving larger and larger doses of diamorphine, if one knows that either will kill. Better thinking is needed.
Resuscitation policy

SIR

There has been much debate since the circular sent from the Chief Medical Officer, reference PL/CMO (1991) of 20 December 1991, regarding resuscitation policy, following a complaint from a relative who discovered his mother was assessed as being unsuitable for cardiopulmonary resuscitation (CPR) (1). Accurate and detailed medical reports are required in this era of litigation in which we find ourselves, particularly since the Parliamentary Act of 1991 which permits review of medical notes by patients and their next-of-kin.

There were no formal guidelines regarding the assessment of patients for CPR at our District General Hospital. On a single day in March 1992, the notes of all medical in-patients at our hospital were examined to ascertain which type of patient had been deemed unsuitable for CPR (not for 333s) by their supervising team. In particular, information concerning:

- reason for not considering patient for CPR.
- how it was stated.
- indication of who had been involved in the decision and, in particular, if either the patient or the close relatives were knowledgeable of the decision.
- if the original resuscitation policy was reviewed during the course of the patient’s stay in hospital.

Further, it was to be established if the nursing staff were also fully aware of the patient’s resuscitation status. At that time the hospital held 178 medical beds supervised by 8 consultant physicians on 6 wards, the majority of bed occupancy being patients received from the general acute medical take (greater than 85 per cent); routine admissions accounted for only a small percentage. The specialty of acute geriatric medicine was managed at other sites in the city.

Of 133 patients (86 per cent bed occupancy), ages ranging between 17 and 92, only 8 (6 per cent) were apparently not suitable for CPR according to the medical documentation. In others, no decision or mention of appropriate action in the event of cardiopulmonary arrest was given. Out of this total of 8, the nurses were apparently unaware of this instruction in 4 cases.

This random survey showed that reasons for a policy not to resuscitate were not actually documented in the notes and that, at times, decisions had apparently been left to a pre-registration house officer. Although consultant advice may, indeed, have been sought, this was not clearly documented in the notes.

- Of the 8 entries ‘not for 333s’ was recorded in 7 cases. The remaining one read ‘patient not for ventilation’.
- It would not have been clear to an outside observer as to who had made the decision, or on which specific day or hour this had been entered.
- The nursing staff in 4 (50 per cent) of cases were unaware of the medical decision.
- There were 9 patients (7 per cent) who were actually deemed suitable for resuscitation, despite having terminal disease who would, at least initially, be put through the trauma and indignity of a resuscitation procedure in the event of cardiac arrest.

Individuals are rarely consulted, even in an indirect way, about their own resuscitation policy. Surprisingly, one survey of elderly patients found that only 7 per cent requested full CPR in the event that they were found to be in asystole (2).

Since 1974 in the USA institutional policies for CPR have been introduced (3). In Britain formal policies are rare, as noted by the Ombudsman in his report.

This study clearly emphasises that there is an urgent need for a directive, either at hospital or national level, regarding the delicate decision of whether to resuscitate. The Clinical Medical Board is at present considering specific guidelines for resuscitation policies in Britain.

References


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