

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

- (1) Robertson G W. Resuscitation and senility: a study of patients' opinions. *Journal of medical ethics* 1993; 19: 104-107.

J GRIMLEY EVANS
*Clinical Geratology Division,
The Radcliffe Infirmary,
Oxford OX2 6HE*

Response to Daniel Callahan - better ways of rationing

SIR

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