

tion of seeking what is in the PVS patient's best interests.

Finally I would emphasise my principal argument which focuses on the need for clear decision making in PVS, LPT decisions. Existing judgments do not - and cannot - deliver this until relevant criminal, civil, medical, ethical and moral issues are openly debated. Undoubtedly all concerned - doctors, family, nursing staff, lawyers and judiciary - seek the best outcome for the patient. However, the appropriate mechanistic tools are needed to allow decisions to be taken with that objective in mind. Recent judicial semantics and reconstructions show that, in England and Scotland at least, courts are not suitably equipped. A broader, empowered judicial function is therefore needed. Open debate of these issues is the essential first step towards meeting the genuine best interests of patients in this tragic, highly personal situation.

References

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- See for example the notion of "critical interests" in Dworkin R. *Life's dominion - an argument about abortion and euthanasia*. London: Harper Collins, 1993: 199-217.
- See for example the approach to "surviving interests" of Feinberg J. *The moral limits of the criminal law, volume one - harm to others*. New York: Oxford University Press, 1984:83-93.

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Editor's response

The debate between philosophy, ethics and law is one of the ever more flourishing developments in medical ethics. If Ms Fenwick's assertion is accurate that lawyers and judges have concluded that where an agent foresees death to be the "virtually certain" consequence of his action the agent may be inferred to possess criminal

intention; and if this, as she implies, means the agent *must* be inferred to possess criminal intention; and if "actions" include cessation of action (including withdrawals of trials of treatment); then the law is indeed an ass and required the modification that the House of Lords decision in Bland produced. But if we move away from these legal arguments, there seems nothing contorted or illogical in philosophy, ethics or medical ethics in arguing, as I did, that if a doctor foresees a patient's death as being inevitable as a result of that doctor's action or inaction, this in no way *entails* that the doctor intended that death. That question depends, unsurprisingly, on the doctor's intention! There was no need for Bland's doctors to intend the death of their PVS patient when they ceased providing non-beneficial interventions, even though they foresaw that it was inevitable. Similarly a doctor carrying out cardiopulmonary resuscitation (CPR) need not, and normally does not, intend the death of the patient when he stops the CPR, even though he foresees the inevitable cessation of circulation and consequent death that will follow, if the CPR has failed to evoke a spontaneous heartbeat.

Euthanasia in the Netherlands

SIR

Dr Ryan bases his attack¹ on the validity of the "slippery slope" concept on the 1996 paper of van der Maas *et al*.

A careful examination of the data are not so reassuring. While Dr Ryan is concerned only with non-voluntary euthanasia, there are other data which are also problematic, and their plateau may not yet have been reached. By van der Maas's figures there was a 48% increase in cases of active euthanasia over a five-year period. The authors presented the data in terms of a change from 1.7% to 2.4% and indeed an increase of 0.7% seems minimal. But this increase of 0.7% is a 48% increase and represents over 1,000 additional deaths due to active euthanasia, with no obvious explanation. Whereas in 1990 27-32% of requests for euthanasia were acceded to, this increased to 36-38% in 1995. Some physicians, like myself, interpret the data as an all too ready use of euthanasia to solve difficult patient care problems.

But, in addition, as Dr Ryan himself states: "perhaps the damage was done

in the first ten years that the Dutch allowed euthanasia". Indeed much current practice is in unequivocal violation of the strict guidelines that the Dutch advocates themselves articulated very clearly when they first proposed their system, and when they assured us that these rules were to be inviolate. These rules were: patient initiation of request; absolute voluntarism; severe suffering; consultation with another physician, and honest and full reporting to the authorities. The widespread violation of these self-imposed restrictions indeed occurred in the first years of the present system.

As one Dutch physician told me in response to the question of how it felt directly to kill a patient: "The first time it was difficult".

Reference

- Ryan CJ. Pulling up the runaway: the effect of new evidence on euthanasia's slippery slope. *Journal of Medical Ethics* 1998;24:341-4.

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Greek theories on eugenics

SIR

Professor David Galton has written an interesting article on the Greek theories on eugenics, reviewing the works of Plato and Aristotle.¹ Some modern aspects would probably be worthwhile mentioning:

- Plato's suggestions were not limited to healthy persons reproducing but in preventing the sick and malformed citizens bearing children as well. Such offspring would most probably be as wretched as the parents² and should not be reared.
- Beyond infanticide of the unwanted progeny, Plato's suggestions included abortion¹ and transmission to the "other city".³ The latter proposal has led scholars to deny that infanticide was really meant by Plato and probably this passage is not the mentioned one from Herodotus¹ led the late Professor Francis Galton to make the comment about the formation of colonies.
- Morbid genetic material would not only have been undesired by the state but would inhibit individual evolution as well⁴ providing a bad quality of life.⁵ Although it sounds