

BOOK REVIEW

Going Against the Stream: Ethical Aspects of Ageing and Care

P Jeffery. Gracewing, 2001, £14.99 (pb), pp xxi + 282. ISBN 0 85244 541 5

This book is challenging and sets itself up as “going against the stream”. But which stream? Perhaps there is a distinction between the stream in medical ethics and the stream in clinical practice. One impressive feature of the book is the detail of the references and footnotes. This gives me the impression that Jeffery is swimming in the stream of academic medical ethics. It is also true that he has first hand experience of clinical practice, but I suspect it is the flow towards euthanasia in the literature that alarms him (page 10). Whereas in practice, however slow moving and stagnant in so many places, my perception is that the tide runs towards person centred care based on a compassionate commitment to meeting individual needs. In the National Health Service (NHS) nursing home for people with severe dementia with which I am involved, the talk is not of euthanasia, but of engendering the sort of holistic view and palliation found in hospices.

One substantial argument put forward by Jeffery concerns the ethical basis for foregoing treatment. He argues that decisions, in order to be ethical and compassionate, must be based on the need to avoid disproportionate treatment. His concern is that using “substituted judgments” or criteria such as “best interests” and “quality of life” might not necessarily show respect for life and might be subjective. Instead, “disproportionate treatment” stresses the quality of treatment and is based on “a clinical judgment that the treatment is either burdensome or the results out of proportion” (page 176). That Jeffery regards such clinical judgments as more objective may be naïve as to the extent that values permeate seemingly factual decisions. He gives a good account, however, of the doctrine of ordinary and extraordinary means and emphasises the importance of the physical realities that mean trying to preserve life at all costs must sometimes be wrong.

Nevertheless, I wonder whether it really is so illicit to use the criteria to which Jeffery objects. “Best interests”, as numerous documents concerning capacity being produced in

the UK by legal bodies now constantly remind us, does not mean solely “best medical interests”. Instead the person him or herself must be consulted, with all others concerned, and decisions must be the least restrictive when deciding on a person’s best interests. Such broad consultation and careful negotiation, it seems to me, are likely to lead to good decisions if undertaken with genuine openness and concern. Similarly, whilst there is a simplistic move from “poor quality of life” to “therefore terminate treatment”, an alternative approach might be to argue that we need a more sophisticated understanding of “quality of life”. We need better conceptual analysis to appreciate that quality of life is not in essence a measurable *quantity*, but that elements of quality of life might still be maintained and manifest in severe disability, dementia, or in terminal conditions.

Actually, I found this sort of conceptual analysis very convincingly displayed in Jeffery’s argument that respectful autonomy could readily become a form of selfishness. Instead he highlights an ethic of “authentic autonomy” found in “the web of relationships of the person” (page 102). Autonomy requires a respect for the person, but also respect for society. Our notion of the person itself involves some idea of interconnectedness. In moral life, as Jeffery asserts, we need to acknowledge “the essential social nature of the human person” and recognise “dependence as a non-accidental feature of the human condition” (page 83).

One unarguable consequence of this sort of analysis is that the care of older people should show more clearly an attention to individual wishes and needs. It is not just professionals who can override the authentic autonomy of an older person; families can do so too. Some of the most challenging passages highlight the often illegitimate use of the word “home” for institutions providing long term “care”. Nevertheless, homes are not all bad and (at least in my experience) local authority homes, despite what Jeffery suggests (page 225), are sometimes better at being person centred than the private alternatives.

Whilst standing up for local government, it should also be pointed out that, at a national level, agism has not “been adopted in England” (page 16). Indeed, in line with the *National Service Framework for Older People*, clinicians and administrators up and down the country are busy rooting out agism. Some clarity is also needed with respect to psychiatry. For instance, I do not agree that “depression can only be dissipated when shared”

(page 201). In fact, Jeffery is probably talking about an “adjustment reaction” rather than a depressive illness. This is a mere detail, but the inaccuracy could cause distress.

Jeffery is on surer ground when he talks of the ways in which human needs are best met within the context of love and compassion (pages 25–28). His background here is the Judaeo/Christian tradition (page 61), although he acknowledges that respect for life is not a uniquely Judaeo/Christian insight, but might be seen by even non-religious people as “the basis of society and morality” (page 146). This raised for me two further thoughts. First, Jeffery is a Catholic Priest and large portions of the book stem from this perspective. There is nothing wrong with this, but he sometimes appeals directly to this background in a way that might, I fear, lose some of his more secular readers. The arguments stand on their own, even if religious concepts support them. Otherwise it can look as if he needs to justify his religious assertions (which he does not), or justify his emphasis on the Judaeo/Christian tradition rather than on Islamic or Buddhist beliefs. Secondly, therefore, who is the book aimed at? Is it aimed at believers working with older people? Or is it aimed at the largely secular public? Or is the aim somewhere in between? Having this clear might have focused the argument in places.

In addition, to revert to the original theme, it might have helped to make clearer the extent to which Jeffery really is going against the stream. From my (albeit inevitably limited) perspective, from one bit of the UK’s NHS, I can see a commitment to “a person model of care . . . where the patient is not just centre stage but participates in his or her care” (page 47). To claim that this has been achieved would be a huge exaggeration, but it seems to be the direction of the rather slow and broad stream of practice, despite the writings of some medical ethicists. Encouraging this “ethic of care” in practice, with respect to older people, is probably the best way to stave off the thought that the lives of older people are worthless. This book is on the side of older people and contributes, therefore, to the stream’s flow towards person-centred care. I think, and hope, that many of us are swimming in the same direction.

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