adopting a rule of 'proxy refusal'. For example, I can easily conjure the spectre of the apparently concerned but in fact self-interested and greedy, son or daughter refusing treatment for an elderly patient with the words, 'Mommy specifically said she would rather be left to die than run the risk of being paralysed', when it is the inheritance which is really in mind. I would thus oppose acceptance of this part of *Quinlan's* case as English law.

IAN KENNEDY
London

Author's response

SIR,

I am sorry that Mr Kennedy should find my commentary misleading. My three different codes, which were not intended to be mutually exclusive, were designed to illustrate general propositions which might help practising doctors examine some of the values which lie behind their actions. As such they are obviously open to the criticism of detail in which Mr Kennedy has indulged.

Similarly, his strictures on my interpretation of the law relating to homicide are no doubt correct. I would argue however that many doctors believe that the law favours the first position, and that this therefore rather than legal statute or case law will be the framework in which they make their decisions. The fact that a statute (The California Natural Death Act) is necessary 'to allay any doubts as to the state of the existing law' would seem to support this view, and the change in the *status quo* therefore becomes a change of interpretation or of emphasis.

Mr Kennedy's more detailed presentation of the law seems to provide little help when applied to the case in question.

First, 'a patient may refuse treatment – provided he is lucid and competent to do so'. This patient was not in fact lucid or competent and treatment was refused by proxy. Mr Kennedy while stating that there is no real guide available yet in English law feels that 'proxy refusal' is unacceptable because of 'the spectre of an apparently concerned, but in fact self-interested and greedy, son or daughter who only have the inheritance in mind'. My own judgement is that belief and trust in the good faith of the relatives is a better and more dignified basis for action, and that a general practitioner who may have known the individuals involved for several years is in a good position to assess their motives.

Second, 'a doctor is not obliged to give nor a patient to receive treatment which can be categorized as "hopeless" or "heroic" according to established principles'. Mr Kennedy would no doubt assert that the definition of 'hopeless', 'heroic' and 'established principles' are all normative issues. In this case however the two medical participants, albeit from different cultures, presumably disagreed about established principles and about whether or not treatment was hopeless. So who is to decide?

Third, 'a doctor may not, with the primary intention of bringing about death, by any act or omission precipitate the death of a patient'. 'Intention' is here the crucial issue and presumably one has to ascertain whether the doctor was acting in good faith in the best interests of the patient. But in whose interests am I acting when I arrange to admit a patient with dementia to hospital, because the relatives can no longer cope, if I know that it is not uncommon for such patients to deteriorate and die when removed from a known environment.

Ultimately Mr Kennedy and I disagree about the extent to which such issues can or should be controlled. Regulation by reference to normative systems would seem to deny the uniqueness of each and every terminal illness, and the sensitivity and flexibility which is required in the management of such illnesses.

CHRIS DRINKWATER
Newcastle-upon-Tyne

J Med Ethics: first published as 10.1136/jme.4.1.50 on 1 March 1978. Downloaded from http://jme.bmj.com/ on February 3, 2023 by guest. Protected by copyright.