Faith *in the* Family

ADVOCATE

Issue 4, January 2000

Euthanasia - the real issues

by Dr George Chalmers

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Mental incapacity law in England & Wales

... and in Scotland

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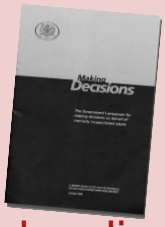

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THE CHRISTIAN INSTITUTE

INFLUENCING PUBLIC POLICY

The pressures for euthanasia

In this special issue of *Advocate* we look at the worrying subject of euthanasia. **Colin Hart**, Director of The Christian Institute, explores some of the contemporary issues:

"Euthanasia is the intentional killing of a patient by act or omission as part of their medical treatment when the patient's life is felt to be not worth living.

Euthanasia is currently illegal in the UK and virtually all countries of the world, but there are strong pressure to make it legal. However, in Holland euthanasia now takes place on a very wide scale. In the UK, in a handful of cases, euthanasia has in fact taken place with the approval of the courts.

There are obviously many ways in which a patient could be killed, but it is important to note that these ways include omitting to do something (such as providing food and fluids).

Economics

Leaving aside all the arguments about the morality, the economic pressure for euthanasia is building. Thanks to the remarkable advances in health care in the last century we now have an ageing population.

People are no longer dying of infectious diseases in anything like the numbers they were. But living longer does not mean living in perfect health. Extended life expectancy means *greater* use of health care resources not less.

The extra years of life may mean extra years of treatment for a chronic disease or disability.

In the developed world a significant proportion of the total healthcare budget is spent in the last year of life.[1] Some argue that the proportion is up to 50% of the total budget.[2]

All these problems are compounded by the fact that, because of the breakdown of the family, more and more people are living alone in their old age. As the past growths in the divorce rate work their way through the age ranges, they will create greater and greater demands on the NHS and other caring services.

Intention

All medical treatment involves risk, however small. It is possible that a treatment may unexpectedly go wrong. In many cases the risks will be clearly foreseen before treatment begins.

The law does not penalise doctors for taking risks, provided that the patient consents to the treatment. As in many other areas, the law makes the crucial distinction between acts where the consequences were intended and acts where they were not.

If a surgeon performs a risky operation, such as a heart transplant, and the patient dies,

then the doctor does not face any charge of murder.

It is common sense that in the ordinary run of events, doctors do not face murder charges when their patients end up dead. This is absolutely essential fo medicine.

■Risk assesment and the withdrawal of treatment

Before a risky operation or medical treatment doctors often seek to quantify the risk. They may say that such an operation has a 50% success rate. The patient then has to decide whether to go ahead. A patient may have a very difficult decision to make as to whether to go forward with a high risk treatment.

An 80 year old man who has had a serious heart attack may be unfit to have a hip replacement, indeed the shock could kill him.

Someone whose cancer was only discovered at an advanced stage may well decide that it is not worth going through chemotherapy.

Doctors routinely withdraw or decide not to start a particular treatment because it is futile or because it is burdensome to the patient.

■Pain

In the public mind, many are concerned that doctors might *overtreat* their patients. The much feared scenario is that patients in agony might be kept alive using high-tech medicine.

In reality dying patients are not treated in this way. It should never occur. When death is inevitable, the professionalism of doctors demands that they must seek to do all they can to make their patients comfortable.

Pain relieving drugs are now so highly developed that most types of pain can be relieved completely.

The UK leads the world in the provision of hospices - specialist hospitals which treat dying patients and relieve pain. St Christopher's Hospice in London reported in 1981 that pain was difficult to control in only 1% of cases.[3]

■Double effect

In some extremely rare cases drugs given to relieve pain have an unintended effect of shortening life. The intention is to relieve pain but, at the same time, it can be forseen that the drug treatment may actually hasten death. This is called double effect.

The law does not prevent a doctor acting this way and Christian theology recognises the moral validity of a doctor taking such action.

Robert Twycross puts it this way:
"Broadly speaking, the principle of double effect states that if measures taken to relieve physical or mental suffering cause the death of a patient it is morally and legally acceptable provided the doctor's *intention* is to relieve the distress and not to kill the patient. This is a universal principle without which the practice of medicine would be impossible. It follows inevitably from the fact that all treatment has an inherent risk."[4]

"The Bland case crossed the rubicon"

■The Bland Case

Tony Bland was a football fan who was a victim of the Hillsborough tragedy. He was left in a coma in a persistent vegetative state (PVS). This condition is not fatal. He could breathe on his own, but he could not feed himself. He required artificial feeding through a tube. His parents asked the courts to declare that it would be lawful to withdraw feeding.

This they duly did and Tony Bland starved to death.[5] This was euthanasia. Whilst doctors can legally use their expertise to decide to withdraw medical treatment, feeding is not medical treatment. We all need food and fluids to live.

The Bland case crossed the rubicon and there have been other cases since where the courts have allowed a patient to starve to death.

Living Alone

The proportion of one person households has increased from 14% in 1961 to 28% in 1998.[13] The principle reason for this is the breakdown of the family.

The number of people who are married and over 65 stands at an all time high, but it is the breakdown of the family which will be particularly significant in the years ahead.

There are now more than eight times as many divorced men in the 65+ age group than there were in 1971.

Only 3% of couples married in 1951 had divorced 10 years later. For those married in 1981, 25% had divorced by 1991. Today if present rates continue, 40% of marriages will end in divorce.[14]

All this is very relevant to the issue of healthcare. With a married couple, when one becomes ill, the other can provide practical care. When people live alone it is much more likely that this care has to be provided by the state through home helps or even through hospitalisation.

Men 65+	1971	1997
Divorced	17,000	147,000
Single	179,000	242,000
Widowed	492,000	593,000
Married	1,840,000	2,417,000

Source: Health Statistics Quarterly 04, Winter 1999 Table 1.6

Philosophers like John Harris from Manchester University and Peter Singer from Harvard argue that the normal rules did not apply to Tony Bland. He may have been human but he was not a person, they say. It is significant that Tony Bland's doctor is a devotee of Harris.

In 1999 the BMA issued guidelines which stated that food and fluids constituted medical treatment, "but the BMA recognises that this definition is not universally accepted". Food and fluids, (technically known as nutrition and hydration) could therefore be withdrawn at the discretion of doctors.[6]

The need to outlaw euthanasia

To close the loophole created by the Bland case an MP, Ann Winterton, is now moving a Private Member's Bill which will outlaw euthanasia. The second reading takes place on 28 January 2000.

Other cases have followed hard on the heels of the Bland case. Already the BMA have re-written their guidelines going far beyond withdrawing food and fluids in PVS cases.

What has happened in Holland illustrates that there is a slippery slope. Initially euthanasia was introduced through a policy of not prosecuting doctors who assisted their patients in committing suicide. Now non-voluntary euthanasia is commonplace. An official Dutch Government report admitted that there were 1,000 cases in 1990 of euthanasia where the patient had never given their consent. There were another 2,700 cases that involved euthanasia or assisted suicide. The Cambridge academic John Keown has shown that in a further 7,000 cases there was an act of omission by the doctor with the explicit intention of shortening life. There were a further 15,800 cases where this was the partial intention. [7]

The situation is out of control in Holland. In 1990 20% of all deaths were the result of euthanasia where it was at least partially the intention of the doctor to shorten life.[8]

In addition to the withdrawal of food and fluids there are also two further routes by which euthanasia could be legalised in the UK.

Incapacity legislation & advance directives

The law must, of course, deal with the situation where a person completely loses their mental faculties or becomes comatose. But here again there have been moves which could open the door to euthanasia.

"Let us hope that Ann Winterton is successful in her attempt to outlaw the practice"

The Lord Chancellor has now proposed in a Consultation Paper that the power of attorney should be extended from financial affairs to include healthcare. This raises the clear possibility that one person nominated as a "proxy decision maker" could refuse medical treatment on behalf of another person who was incapacitated.

Proposals from the Scottish Executive are more advanced. A bill is already well on its way through the Scottish Parliament. Originally the Executive's proposals would have allowed a friend or relative to refuse food and fluids on their loved one's behalf. Following much public concern, the Executive have now dropped this proposal.

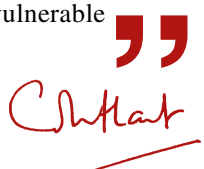
Doctors are used to seeking consent from their patients before medical treatment can go ahead. **Advance directives** enable a patient to state in advance what their wishes would be should certain circumstances arise. Clearly this could be helpful. But what if a patient's wish was suicidal?

Currently advance directives have no legal force, although doctors do take account of them. Doctors could simply ignore the wishes of a patient who wanted to be killed should, for example, he go into a coma or become disabled.

The Scottish Executive originally denied that their incapacity legislation could be used to allow euthanasia. But it meant that a person legally nominated to take decisions on behalf of an incapacitated person would have been allowed to agree the withdrawal of food and fluids. A strong case was put (particularly by The Scottish Council on Human Bioethics who's president - Dr Chalmers - writes in this magazine) and the Executive have had a change of heart. They have promised amendments to prevent this scenario.

The position in England and Wales is that the incapacity legislation would open the door to euthanasia. Let us hope that Ann Winterton is successful in her attempt to outlaw the practice.

As the founder of the modern hospice movement Dame Cicely Saunders says:
"I'm sure there are some people that whatever you do still want to bring their lives to an end. I don't think they can have a law that makes that possible without undermining the needs of a great many other vulnerable people."[9]



An ageing population

Life expectancy for men and women in the UK has increased dramatically over the past 150 years. In 1841 life expectancy at birth was 41 years for men and 43 for women. Today it is 74.6 years for men and 79.7 years for women.[10]

The most important reason for this increase in life expectancy has been the success in combating infectious diseases. These accounted for one in three deaths in the Victorian period but today only account for one death in two hundred. [11]

The extra years of life may mean extra years of treatment for a chronic disease or disability.

In the past twenty years the population has increased by 3 million and is expected to grow by another 2 million by 2020.[12]

MP plans new law to combat "euthanasia culture"

Ann Winterton has introduced a new euthanasia prevention bill

Doctors would be prevented from intentionally killing their patients under a proposed law introduced this January.

If it is successful, the bill, sponsored by Ann Winterton MP, will tighten up the law on euthanasia. It will require doctors to ensure that appropriate care is given to terminally ill patients.[1] The *Medical Treatment (Prevention of Euthanasia) Bill* will be debated on 28 January.[2]

Ann Winterton came first in the annual ballot to decide which MP may bring forward a bill. It is therefore guarenteed proper time for debate, unlike most Private Members Bills.

The planned legislation was announced in December against a backdrop of media reports that elderly and disabled patients were dying in NHS hospitals because of inadequate care.[3]

Mrs Winterton, a Conservative, has cross party support for her proposals and she is hopeful that they stand a real chance of reaching the statute books.[4]

The British Medical Association recently drew up guidelines on withdrawal of food and water at the end of life. In a statement given last June the BMA said medical treatment could be withdrawn or withheld if it fails or ceases to give a net benefit to the patient.[5] CARE say that the BMA guidelines show a growing "Euthanasia Culture" in Britain.[6]

Ann Winterton MP

Speaking at a press conference in December Mrs Winterton said her new bill will not require doctors to strive officiously to keep alive patients who are dying, but there will be a requirement for appropriate care. Mrs Winterton, MP for Congleton in North West England, said: "My Bill will make it abundantly clear to doctors that they cannot intentionally bring about the death of their patients."[7]

Pro-life groups have strongly welcomed the move. Executive Director of CARE, Charlie Colchester, voiced support for the proposals. He said: "CARE, on behalf of the caring Christian community in this country, wholeheartedly supports the intent of Ann Winterton's Private Members Bill, the detail of which we await with interest...This bill provides a valuable opportunity to reaffirm the law in this country and prevent the intentional killing of the most vulnerable members of our society".[8]

Doctors "cannot intentionally bring about the deaths of their patients."

John Smeaton, national director of The Society for the Protection of Unborn Children, also welcomed the proposed bill. He said: "Mrs Winterton's bill is vital in the light of recent moves to weaken legal protection for disabled and elderly people." Mr Smeaton said the planned law would counter what some people fear is "an unwritten euthanasia policy" in British hospitals. "The state should not have the power of life and death over its citizens in this way," he said, "nor should medical people be called upon to eliminate unwanted patients."[9]

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1. 18-26% of healthcare expenditure in Norway is spent on the final year of life. See Nord E, Hjort PF, Heiberg AN *Int J Health Plann Manage* 1989 Oct-Dec;4(4):319-22 ; In Western Countries 30% of healthcare costs for the retired is spent in the last year of life Felder S *Health Policy* 1997 Feb;39(2):167-76
2. Andrew Fergusson argues that up to 50% of the total healthcare budget is spent in the last six months of life in Dunnett A *Euthanasia: The heart of the matter*, Hodder and Stoughton, 1999, page 58
3. Twycross R in Keown J *Euthanasia Examined*, Cambridge University Press, 1995, page 147
4. Robert Twycross Letter to the Editor, BMJ vol 319, 4 Sept 1999, page 639
5. *Airedale NHS Trust v. Bland* (1993) AC 789
6. See BMA Press Release 23 June 1999
7. Keown J *Euthanasia Examined*, Cambridge University Press, 1995, page 270
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9. *Living Dangerously*, Workbook accompanying CARE Video, March 1992, part 2G
10. Health Statistics Quarterly 04, Winter 1999, ONS, Page 53
11. See *Our health - better or worse?* in Population Trends (88), Summer 1997, page 44
12. Craig J *Population Review (9)* in Population Trends (88), Summer 1997, page 6
13. Social Trends 29, ONS, 1999, Table 2.2, page 42
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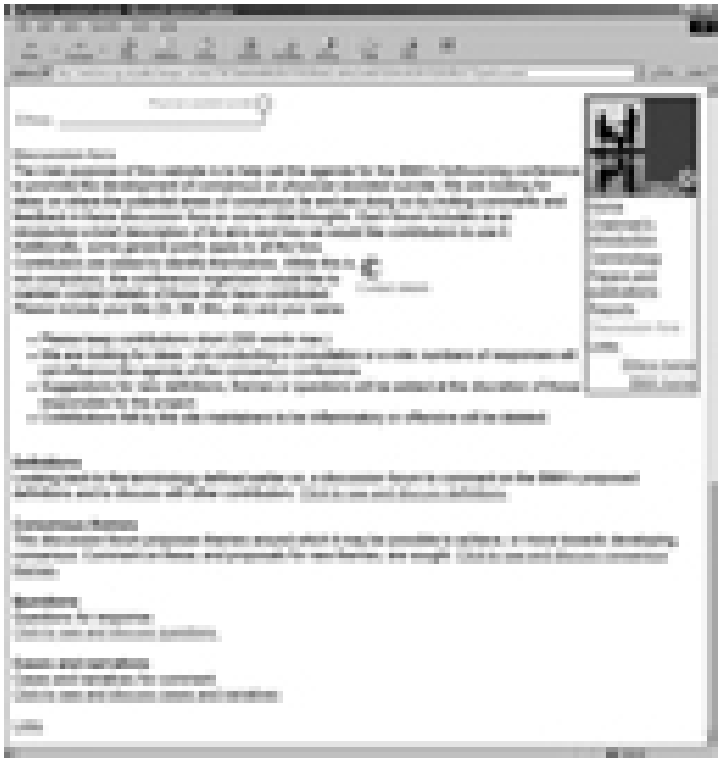
1. *Press Release from Ann Winterton MP*, 9 December 1999
2. *Press Release from Ann Winterton MP*, 9 December 1999
3. *Press Release from Ann Winterton MP*, 9 December 1999
4. *Press Release from Ann Winterton MP*, 9 December 1999
5. *Press Release from the British Medical Association*, 23 June 1999
6. *Press Release from CARE*, 9 December 1999
7. *Press Release from Ann Winterton MP*, 9 December 1999.
8. *Press Release from CARE*, 9 December 1999
9. *Press Release from SPUC*, 9 December 1999

Medics seek views on assisted suicide

The British Medical Association sets up online discussion forum



The British Medical Association wants to hear the views of the public, doctors and other health professionals on assisted suicide.

The BMA wishes to hear the views in the run up to its major conference on assisted suicide to be held in May 2000.

It has set up a special web site where people can voice their opinions through a series of structured discussion threads.

Dr Michael Wilks, chairman of the BMA's medical ethics committee, said: "Doctors certainly do not have a monopoly of wisdom on the subject... The aim of our new web site and consultation is therefore to allow all interested parties to express their views." [1]

[1] Press Release from the British Medical Association, 4 July 1999

Information

Visit the BMA web site at:
http://web.bma.org.uk/public/bmapas.nsf
Written submissions may be sent to:
Physician Assisted Suicide Conference Project
Medical Ethics Department
British Medical Association
BMA House
Tavistock Square
London
WC1H 9JP
E-mail:
pas-conference-project@bma.org.uk

BMA advises doctors on withdrawal of food and water

Doctors who want to withdraw food and water from patients should no longer have to seek court approval, says the British Medical Association.

The BMA published new ethical guidelines on the withdrawal of treatment last June, saying that doctors should seek an independent review by senior medical staff before ending life-prolonging treatment.[1]

Whether the provision of food and water is "medical treatment" or basic humane care has been at the centre of a debate since a case involving a victim of the Hillsborough football disaster.

Tony Bland was left in a coma following the stadium tragedy. He was not terminally ill, but he had been in a persistent vegetative state for four years until a court ruling in 1993 gave doctors permission to stop feeding him. By doing so, the Law Lords defined artificial nourishment as medical treatment and set a dangerous precedent.[2]

However, while the feeding may be artificial, the hunger and thirst is very real. The deliberate ending of life by starving patients to death is not something doctors should be engaged in. The BMA, however, argue that withdrawing nutrition can benefit a patient. Dr Michael Wilks, Chairman of the BMA's medical ethics committee, says: "There comes a point where medical treatments, including artificial nutrition and hydration, are more of a burden than a benefit to the patient."[3]

The guidelines drew condemnation from some doctors. Speaking to *The Times* newspaper in June consultant paediatrician, Anthony Cole, said that death from dehydration was painful and unacceptable.

He said: "We have a responsibility to see that our fellow human beings receive such basic needs as food and fluid if they are unable to administer it themselves. It's only common humanity. If the BMA do not make it clear that food and fluid are basic needs to which people have a right, quite separate from medical treatment, then I am very concerned."[4]

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1. *Press Release from the British Medical Association*, 23 June 1999
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4. *The Times*, 24 June 1999

Euthanasia - the real issues

Dr. George Chalmers looks at the issues involved in the current debate

Much of the debate about euthanasia at the present time takes place on a largely philosophical level. As we weigh the arguments, discussing all the pros and cons in the abstract, we can easily miss the real issues.

■What are the real issues?

This is about PEOPLE, not abstractions.
It is very easy to become taken up with the theories, the philosophies, even the ethical arguments, but in the last analysis we are discussing the end of life for individual people. Our responsibility is to meet their real needs, not to justify an opinion or to support a position. Each individual is different, and needs a different answer. We need to get alongside each person and to respond to the challenge of their specific life-situation with life-affirming responses. Death is no answer to any need.

It is about the MANY, not the few.
The number of cases from which the extreme measure of euthanasia may be argued is very small. If it were to be introduced as an available answer, even to difficult clinical problems, there would be a strong temptation to save resources, time and involvement by bringing life to an end sooner, rather than later. It is the many who will be at risk from such poor decision-making.

It is about the ORDINARY, not the extraordinary
The arguments about euthanasia often revolve round the difficult cases, some of them very real and intensely problematic, some of them largely hypothetical. Any lawyer will tell you that 'hard cases make bad law'.

The important issue is that decisions made in the light of extraordinary situations are likely to affect a much broader spectrum of ordinary clinical practice. They could and would be applied to many situations which are currently, and appropriately, handled without recourse to the deliberate ending of life.

Dr George Chalmers is a former consultant geriatrician and former Clinical Director at Glasgow Royal Infirmary. He is a fellow of the Royal College of Physicians and Surgeons of Glasgow and Edinburgh; and President of the Scottish Council on Human Bioethics.

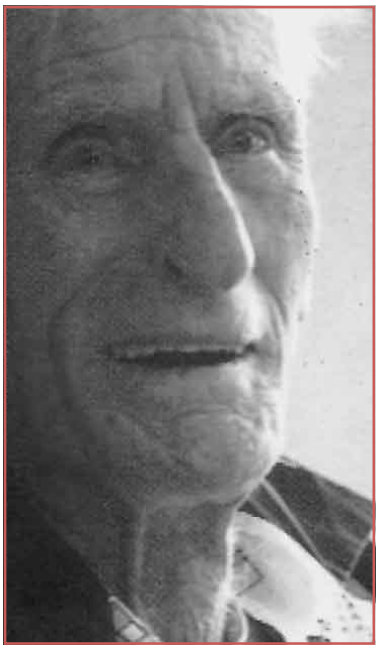
It is about compassion, as a STANDARD, not as an exception
Some time ago a paper appeared in the British Medical Journal[1] which reported a study, in which the care of dying patients in four West of Scotland hospitals had been observed. With the full cognizance of medical and nursing staff, a non-participant observer monitored directly the clinical interaction between dying patients and the staff of the wards in which they were treated. The observer was an experienced nursing tutor.

The abstract reads as follows: -
"More than half of all patients retained consciousness until shortly before death. Basic interventions to maintain patients' comfort were often not provided: oral hygiene was often poor, thirst remained unquenched and little assistance was given to encourage eating. Contact between nurses and the dying patients was minimal; distancing and isolation of patients by most medical and nursing staff were evident; this isolation increased as death approached."

Not all of the observed practice was poor. Four of the fourteen consultants and seven of the twenty-two senior nurses were seen to have a greater number of encounters with dying patients than the average. These spent time with the patient, used their name, established eye contact, took steps to meet their clinical and personal needs and maintained contact with them until death.

The others, however, concentrated on the disease process, the physical deterioration and the attempted relief of some of their

"To kill cannot, ever, be a substitute for caring"



symptoms. Personal contact was minimal or absent, and it was observed that, as death came nearer, they distanced themselves from the patient. The time spent at a patient's bedside related directly to the continuation of active medical intervention. When this was scaled down and death became imminent, the time given significantly diminished.

The paper cited above reminds us that compassion in the sense of involvement of caring staff is, perhaps less of a standard than we should like to think. Until there is a level of personal involvement like that demonstrated in the better units, in all caring establishments and situations, dare we risk introducing a "way out" for the person who does not want to be compassionately involved – even a way out which may be presented as "compassionate". We need to ask ourselves:

Are our standards of care all they might be?
Are they all we think they are?
Are they all we claim them to be?

Until they are, whether we like it or not, a case will be made for euthanasia.

It is about HOW WE CARE for ALL, not just about the dying.
There is, in fact, little difference between the needs of any seriously ill person and those of the person who is terminally ill. The best answer to complaints of poor care on the one hand, and demands for euthanasia on the other, is the setting of standards of care, which will respond personally and compassionately to the individual, rather than apply a blanket solution to every similar situation. To kill cannot, ever, be a substitute for caring.

Part of the problem lies in quite significant changes in society's attitude to dying. When compared with former attitudes, three such changes are apparent.

■Changed attitudes to Dying

Non-acceptance
When medical intervention, especially in acutely critical illness, was less likely to be effective, it was more widely accepted that death was likely, and often inevitable. As life-support and resuscitation measures have become more prevalent and effective, this acceptance has been replaced by the expectation that "Medicine must do something about it", whether the technology or the resources are available or not.

The extension of this idea may be "If Medicine can't do anything about it, let's get it over quickly".

Secularisation
As religious faith has been eroded by increasingly secular and materialistic philosophies, the view is expressed, "There is no life, therefore no responsibility after death". The loss of the idea of personal responsibility for the outcome of life and of a future beyond death, has led to a cheapening of life and a trivialization of death to the point that it is perceived as merely the end of existence for that individual. The view of the secular agnostic becomes "If there is nothing after death and no responsibility, there is no reason not to end life."

Increase in anxiety
One might have expected that such an attitude might reduce anxiety regarding death, but in fact the fear of death persists and has been supplemented by a well-established fear of dying, notably of the process, rather than the fact. This fear relates to the symptoms which the person may suffer, the fear that suffering may be unrelieved, and the fear also that the process of dying may be unduly prolonged. Many people when put to it, still fear death and its consequences on the basis of a deep uncertainty about what may lie beyond, an anxiety which can only be relieved by the assurances and the positive hope of faith. Without such faith one might argue "If dying is the thing people fear, then it is better to reduce the length of the process."

Given such reasoning, euthanasia is made to appear as the ultimate in compassionate acts, and the suicide of the terminally ill is given a rationale. The problems that face the introduction of the death option to medical practice are too serious to be set on one side as irrelevant.

■Practical Problems

The risk of ABUSE
The reality of possible abuse of power and of clinical freedom is inherent, of course, in all clinical relationships, and the overall

risk of deliberate abuse is probably quite small. There is a much greater risk of careless abuse, or of abuse of such a provision by default. If the option to kill the patient were to be available doctors who would not deliberately break the law but interpret it freely will use it inappropriately. It is easier to "go along" with the expressed opinion of patients or well-meaning relatives, even if it is expressed under severe emotional duress, than to carefully analyse the clinical options and make a better decision.

Change in RELATIONSHIP

The clinical relationship, by definition, is one of trust. The question must be asked whether it will remain so if the doctor is perceived as one who may bring life to an end.

The doctor's traditional, historic and moral commitment is to LIFE, and the doctor may be most helpful when asserting the value and the meaning of life, when that has been lost to the patient or those around him or her. It is, therefore, a very major change to introduce death as a legitimate clinical option. At present the patient, however distressed, expects the doctor not to suggest death as an option. With legalisation of euthanasia, the fear that he or she might do so introduces further anxiety to the already tense situation of serious illness in a disabled person.

Change in the NORM

Legalisation of life termination, under whatever guise, would not only decrease the consideration given to other treatment options, but would also introduce the idea that this is the right, the normal, or indeed the obligatory means of bringing serious illness to an end.

The analogy with the effects of abortion law reform is self-evident. The alternatives available to a teenager or a single woman faced with an unwanted pregnancy are seldom presented when the immediacy of termination is so attractive. The negative consequences are ignored or played down, and the "easy" way out is accepted as the norm. The girl who opts for any alternative is made to feel abnormal, and indeed may be openly criticized for such a decision. Already there are elderly and disabled people who feel that they are a burden to their relatives or to society as a whole, and who feel an obligation to remove that burden. It is a very sad reflection upon our reputedly compassionate society that such people have such a negative mind-set reinforced by the proposal that the doctor should be free to remove the burden.

How much better would it be to reassert their intrinsic human value by the affirmation of life?

Looking to euthanasia as a primary means to relieve suffering implies losing hope when we most need help to find it. It means concentrating on the loss of one's life instead of on finding meaning in life and turns the focus upon self and suffering at a time when we most need to look beyond them.

There is, then, a real risk that the debate may obscure these issues. We may begin to see withdrawal of treatment, or the assisting of suicide, as the only solution where other valid measures are available. We may see death as the best answer, when asking the wrong questions, or it may seem the easiest solution when the problem of relief becomes demanding.

If we are interested only in winning the debate, having lost sight of the priority of caring for people, the victory will be barren and our society will become less, rather than more, compassionate.

■Mere opposition to euthanasia in the context of debate is not enough!

If we are to be active it must also be in the establishment of good, involved, personal care for the ill and disabled, whether terminally ill or not, and of better standards of terminal care in ordinary practice.

Hostel, hospice, community and other supportive care provisions need our support. There is a major need to train and educate doctors, nurses and healthcare workers of every kind, whether in general practice, hospital or nursing homes, towards better supportive care for patients and for relatives. ■

[1] Mills M et al, *Care of Dying Patients in Hospital* BMJ, 1994; 309:583-586

"How much better would it be to reassert their intrinsic human value by the affirmation of life"

Inherent dangers of "living wills"

By Dr George Chalmers

Much has been said and written about so-called "living wills", now more frequently referred to as "advance directives" or "advance refusals". This concept has gained a measure of acceptance both to the public and in medical circles.

■Defining our fears

Much of the motivation in setting out our preferences in such a form relates to fears and anxieties over the mode of our dying. It is clearly useful to the doctor and, indeed to other carers as well, to have the priorities, desires and attitudes of the patient made plain. It may even be useful and helpful to write them down. One practitioner of my acquaintance, when asked about a living will, asks the patient to write down the things they are afraid of. The exercise of defining our fears and concerns in this way is often helpful in facing up to them, and in many cases they may be allayed by the doctor, who is quite likely to wish, equally, to spare the patient the very things of which they are afraid.

■Restricting the options

Such a document, however, cannot be made binding to cover all possible future events since these cannot be accurately foreseen. Changing circumstances may render it irrelevant, inappropriate or even obstructive to the best care indicated for new circumstances. Where mental capacity has been lost, if such a directive were made binding, the best management may be precluded. To illustrate this I share a recent personal experience.

A dear friend has been suffering progressive weakness and disability from widespread cancer with deposits in bone. At one point in his illness he experienced severe acute pain in one hip, and was found to have a fracture, which had occurred at a point of cancerous infiltration. He was already on high dosage of pain-relieving medication, but this event pushed the pain level through the threshold of relief.

On consultation with an orthopaedic surgeon it was decided, despite his advanced cancer and his debilitated condition, that he should have an operation to "pin" the fracture and make

Living wills would be open to abuse and extremely difficult to make safe

the hip stable again. He agreed, the operation was done and the extreme pain in his hip was removed.

Had he been incapable of consenting to surgery, and, in particular, if he had previously signed a binding advance refusal of any surgical intervention, he would have been denied the best management of his problem, and would have remained in agony, despite pain relief measures. Euthanasia might then have seemed the only option.

The dangers of binding directives

Like legalised euthanasia, such directives, if held to be binding when applied by others would be open to abuse and extremely difficult to make safe.

The empowerment of third party proxies to refuse treatment, as suggested in currently proposed legislation would carry significant risks, especially if the person given such responsibility is not made accountable for the decisions made.

In any system of binding advance directives or refusals, there is no room for change of mind in changing circumstances.

The problem of execution.

Like any "will" type of declaration, a living will would require the agreement and action of the "Executor", ultimately the doctor with responsibility for the person's care.

Where treatment is refused by someone who can understand, their autonomy must be respected, but where the consequences are likely to be grave or even fatal, it is essential that they understand fully what they are doing.

For such a decision to be made by a third party, when the person is unable to understand or to consent, the whole area of understanding, motivation, and even of technical knowledge comes into the equation. We cannot say with certainty of anyone else, "This is what he/she would have wanted".

While I would never claim infallibility for myself or for any clinical colleague, and while I would never take the position that "Doctor always knows best", I do believe that a trained and experienced professional person is more likely to make a sound clinical judgment than someone without such knowledge. There is much also to be said for the "second opinion", or even for the third, fourth or fifth, but these should be informed opinions. A good relationship in which clear communication takes place between doctor and patient is consistently better than any piece of paper, no matter how well drafted it may be.

Why do people express the wish to die?

The terminally ill person who feels, or states, "I want to die, I have nothing to live for!" will usually do so for definable reasons. It may be because their illness involves severe pain or other symptoms. They may be depressed, lonely, or feeling a sense of worthlessness. Sometimes it may be a response to the unwanted effects of ineffective "Curative" therapy. Most, if not all of these problems may be addressed by other means than agreeing to kill them.

To change the "I want to die" attitude will involve giving adequate symptom relief, the drawing of strength from others, providing treatment and support for depression and the introduction of hope to the hopelessness of dying.

In dying we need the love and support of others, who will assert our personal value and we need balanced palliative care with reduction or cessation of redundant treatment. Where such a regimen is applied relief is obtained and hope restored. The application of the well-established principles of terminal care is an entirely valid alternative to death as a clinical option.

Euthanasia and the drift from Christian health care values

By David Holloway

On 11 May 1999, Dr David Moor, a doctor, was acquitted at Newcastle Crown Court, after facing charges of murdering a terminally ill patient by a lethal drug overdose. The case had national significance.

In court he argued, contrary to what he had said earlier to the press and TV, that all he tried to do "in treating Mr Liddell [the patient] was to relieve his agony."[1] So the jury did not convict him of murder - which would require an intention to kill. According to *The Guardian*, the turning point in the case came when the judge, Mr Justice Hooper, excluded key toxicological evidence leaving the prosecution with no proof that the drug injection had caused the death. The Judge decided that Dr Moor should pay a third of the defence costs, saying Dr Moor had partly brought the prosecution on himself by "very silly remarks to the press" and lying to the NHS and police.[2]

This case highlighted two things: one, the vigorous campaigning by the Voluntary Euthanasia Society (Dr Moor's supporters in the 30,000 strong petition came from 19 countries of the world); and, two, the confusion over euthanasia. This case has not changed the law one wit. The case maintained a critical distinction. Doctors may administer drugs to relieve the pain and distress of dying patients, even if such a dose might, as a side effect, hasten death. That is known as the "double effect". What is prohibited is for doctors to give patients lethal doses *intending* to kill them.

Christian and anti-Christian views

The Bible is clear that God is our creator. Human life is not our "property" - it is held in trust or on loan. We may not just "dispense" with it. As Job said: "The Lord gave and the Lord has taken away" (Job 1.21). Our lives are meant for the service of God. It is not for us to "take" life. We should think of our lives in the spirit of Jesus' parable of the talents (Mat 25.14-15). And you have the fundamental prohibition on killing, and the basis for it, set out in Genesis 9.6:

> Whoever sheds the blood of man, by man shall his blood be shed; for in the image of God has God made man.

Our significance, and so the claim to protection, derives not from our "quality of life" or gifts and abilities, but on our status as being made in God's image. We have the worth that he put on us when he "so loved the world, that he gave his one and only Son, that whoever believes in him shall not perish but have eternal life" (John 3.16).

But the world is drifting from that understanding.

Dr Jim Howe was Tony Bland's consultant neurologist. Tony Bland had been injured during the Hillsborough disaster in 1989 and it resulted in him being in a "persistent vegetative state". The Law Lords made a controversial ruling to allow the withdrawal of food and water on the basis that this was "medical treatment" and not a normal right - in this case. Tony Bland was then allowed to die. Jim Howe has now gone public for the first time in an interview. One question was, "Did he see Tony Bland as a person?"

Revd David Holloway

"There is an assault on Christian Values"

> "No, his personhood had gone when his chest was crushed; he was not a person in the sense that I understand it, in an ethical sense. A person is someone who has the capacity to value their life: that's the definition given by Professor Harris from Manchester, and I think it's the best one I have seen.
> A person is that creature, that sentient creature, which has the capacity to value its own life, so by that definition chimpanzees and gorillas are persons; we should not kill them, any more than we should kill other human beings who don't want to be killed."[3]

The next question was: "Does a young baby have value as a person?"

> "A newborn baby probably doesn't."[4]

Dr Howe continued

> "One of the things that irritates me about people who believe in the sanctity of life is that they don't extend that sanctity of life to higher primates and dolphins and so on - or maybe they do - because I think they should. They think that we have a God-given sanctity of life. Well, I don't believe in God so I don't see any divine imprint."[5]

That is the problem. And there are hidden agendas. There is an

assault on Christian values. In Australia, the Northern Territory - with a tiny population - voted for euthanasia in 1995. That vote has subsequently been overturned, but not before Dr Nitschke, one of the Bill's proponents had helped eliminate four people, with his laptop "deliverance" machine that administered the poison. He admits, however, "I had little contact with terminally ill patients until I became involved in the political struggle to try and get the legislation through up here."[6]

It is all part of his support for "libertarian-type issues" as he calls them. And who is stopping and overturning his efforts? He says, "the Church ... I think we can win against the [medical] profession but we didn't win against the Church. The Church is the force making the politicians crumble."[7]

The solution

"Thou shalt not kill; yet needst not strive, officiously to keep alive"[8] is an excellent rule of thumb for doctors. What is wrong is *intentional* killing. There is a clear distinction between, on the one hand, taking action with the specific intention of shortening life; and, on the other hand, withdrawing medical treatment that is of no further benefit or that is so burdensome to the patient that it far outweighs any benefits it might produce. Yes, sometimes there are difficult decisions. But, no, this is not "killing" or euthanasia. Given a Christian framework, policies and practices can be worked out for new types of problem when they occur. But lacking such a framework there will be (and is) chaos. In Holland, where euthanasia is tolerated, this already is the case. The elderly now carry "passports for life" in their wallets to avoid euthanasia if they should happen to end up in hospital.

A main problem is inadequate palliative (pain reducing) care. The solution, therefore, is wider knowledge and the wider use of the available resources of good palliative care - or so argues George Chalmers, a consultant geriatrician, elsewhere in this publication.

If palliative care is not well taught in medical schools or researched there will be pressures for euthanasia. A report to the Health Council on Palliative Care in Holland concluded that 54% of cancer patients who were in pain, suffered unnecessarily because doctors and nurses had insufficient understanding of the nature of the pain and the possibilities for its alleviation (the culture of euthanasia in Holland may also explain the lack of provision of hospices for children).[9] Kathryn Mannix, consultant in Palliative Medicine at the Marie Curie Centre in Newcastle claims:

> I have seen about 6,000 patients in the last 13 years, but in all that time I can only remember three occasions when a patient has begged me to take their life.[10]

And we must beware of myths - especially the myth that drug relief invariably means a shortening of life. It does not. Sadly this myth means some patients refuse help. But drugs often extend the patient's life by relief of debilitating pain and other symptoms.

There are other problems that generate support for euthanasia. Demographic changes mean that people are living longer, but with the break down of marriage and the family there are fewer potential carers for older and disabled people. This means higher expectations from the State. All this inevitably leads to a resource question - "who will pay and provide?" But this question of "who should care?", which is a legitimate one, should never turn into "why care?" or "should we care?"

"What is wrong is intentional killing"

Also there are now higher expectations of cures generally in medicine and the non-acceptability of illness. This means people are less able to cope with illness, and indeed the approach of death.

But the most important practical problem is that people are less and less aware of the claims of God. Less believe that life is his gift; they think it is a human right, to be disposed of as any one will.

Conclusion

It is urgent we fight these pressures for euthanasia. If it ever became legal, it would be used as an easy option for doctors, for patients and for relatives; it would inhibit the development of palliative care; it would entail a slide from voluntary to involuntary euthanasia as is happening in Holland, where according to Dr Anthony Daniels, "many doctors admit that they have killed their patients because they thought their patients would be better off dead;"[11] it would, therefore, break down trust between doctors and patients and especially elderly patients.

Some words written 200 years ago are still relevant:

> The physician should and may do nothing else but preserve life. Whether it is valuable or not, that is none of his business. If he once permits such considerations to influence his actions, the doctor will become the most dangerous person in the state.[12]

David Holloway is Vicar of Jesmond Parish Church, Newcastle upon Tyne and author of "Church and State in the New Millenium", published by HarperCollins in January 2000.

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4. *Ibid* page 79
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6. *Ibid* page 18
7. *Ibid* page 32
8. Arthur Hugh Clough, 1862, originally biting satire. Cf *Daily Telegraph* 24 June 1999
9. The Law and Practice of Euthanasia in the Netherlands' in *Ethics and Medicine:* Keown J (1992), 8.3, 34-48, as cited in *Euthanasia - A Christian Perspective* The Board of Social Responsibility, The Church of Scotland p28
10. *Evening Chronicle* 12 May 1999
11. *Daily Mail* 12 May 1999
12. Hufeland C writing in 1806 as quoted in *Euthanasia - A Christian Perspective,* The Board of Social Responsibility, The Church of Scotland p28

Lord Chancellor announces new policy that could legalise euthanasia

A Licence to Kill?

The Government has announced new proposals that could open the way for euthanasia in England and Wales.

Labour wants to extend the power of attorney from dealing with financial affairs to also include healthcare. This means that people can appoint a trusted friend to make healthcare decisions should they become unable to make choices for themselves. Under the proposed legislation, people given such power could refuse the feeding of food and water to the person concerned – which would lead to their death. The proposals come in a new report, *Making Decisions*, published on 27 October by the Lord Chancellor, Lord Irvine.[1]

The planned new laws have drawn wide condemnation from pro-life groups who say it is a step toward legalising euthanasia.

Other proposals include giving courts the power to appoint healthcare "managers", modernising the Court of Protection, and giving day-to-day general authority to healthcare professionals. Similar plans are proposed by the Scottish Executive, which has introduced legislation in the Scottish Parliament.[2]

The Government has, however, rejected calls to put 'living wills' on the statute books.

Key points of the Government's policy

- Introducing Continuing Powers of Attorney (CPAs) to include health and welfare, not just financial affairs.
- New power for the Court to appoint welfare and health "Managers".
- Modernising the Court of Protection to resolve disputes about the new CPAs.
- New 'general authority' for health care professionals to act reasonably in the care of an incapacitated person.
- New statutory test of "capacity".

'Living wills', or 'advanced directives', would have given people the power to leave legal instructions with their doctor about their future healthcare. Lord Irvine argues that legal precedents already exist for 'advanced directives' under case law and there is no need to legislate for them.

He outlined the Government's commitment to introducing the new laws in a speech given to the Law Society in November.

Lord Irvine said: "We have decided to legislate, when Parliamentary time allows, to provide a key range of principles to give clear guidelines to those making decisions about the care and welfare of the incapacitated... We will legislate to establish Continuing Powers of Attorney (CPAs), so that people can give a trusted attorney the power to make decisions on their behalf."[3]

Lord Irvine insists the new laws do not open up the way for euthanasia. He said: "neither CPAs, nor the general authority, nor advanced statements, can authorise a doctor do anything which is illegal...I repeat the Government's complete opposition to any deliberate intervention with the express aim of ending life." said Lord Irvine. Euthanasia "is and will remain illegal."[4]

However, pro-life groups are not convinced. Phyllis Bowman, of the Right to Life organisation, said: "Sleight of hand is the best description of the manner in which the government are trying to consolidate a practice of euthanasia."[5]

The Society for the Protection of Unborn Children (SPUC) says the new law is seeking to introduce euthanasia by deception. Martin Casey, speaking as SPUC Manager of Parliamentary Campaigns, said: "These proposals contain much that is welcome and positive about caring for adults with incapacity. But the Government is trying to pull the wool over the public's eyes".[6] Referring to the decision not to legislate for living wills Mr Casey said: "The other measures included in this policy statement make this apparent concession meaningless."

"Even worse, however, the Government proposals would give unscrupulous 'proxy

Information

The full text of the Government's proposals can be obtained from

The Publications Centre
PO Box 276
London
SW8 5TD
Tel. 0845 023474
Fax. 020 7873 8200

Or from the Lord Chancellor's Department Website:
http://www.open.gov.uk/lcd/

decision makers' the power to refuse medical treatment as well as food and fluids on behalf of the sick, elderly and disabled. ...By giving statutory force to the Tony Bland judgement," said Mr Casey, "the government will give those who support euthanasia one of their most cherished goals and put onto the statute book the deliberate ending of life."[7]

Judgements in the Tony Bland case by the House of Lords and the Court of Appeal meant that the feeding of food and water was deemed to be medical treatment.[8]

Tony Bland was left in a coma following the Hillsborough football stadium disaster. He was allowed to starve to death after court's rulings.

References

1 Lord Chancellor's Department, *Making Decisions: The Government's Proposals for Making Decisions on Behalf of Mentally Incapacitated Adults* Cm 4465, The Stationary Office, 27 October 1999

2 *Press release from the Scottish Executive*, 23 August 1999

3 Speech by The Lord Chancellor, Rt Hon Lord Irvine, to The Law Society Conference on Mental Incapacity, 10 November 1999

4 Speech by The Lord Chancellor, Rt Hon Lord Irvine, to The Law Society Conference on Mental Incapacity, 10 November 1999

5 *Daily Mail*, 28 October 1999

6 *Press release from the Society for the Protection of Unborn Children*, 27 October 1999

7 *Press release from the Society for the Protection of Unborn Children*, 27 October 1999

8 Airedale NHS Trust v Bland [1993] AC 789

Scottish Ministers rethink policy

Executive announces changes to close euthanasia loophole

The Scottish Executive has announced amendments to the Adults with Incapacity (Scotland) Bill to clarify that it is not intended to allow euthanasia.

It was feared that proposed legislation would open the way for people in Scotland to help their relatives die.

The bill will give people the power to choose a trusted friend or relative to take medical decisions on their behalf should they later become unable to make decisions themselves. The trusted friend or relative is known as a 'medical attorney'.

Under original proposals, a medical attorney would have the power to refuse medical treatment - including food and water.

However, the new changes mean that doctors can continue treating patients against the wishes of medical attorneys if they can get a second medical opinion. Also, reference to the feeding of food and water has been removed from the definition of medical treatment.[1]

The changes to the Adults with Incapacity (Scotland) Bill were announced following a review by Scottish Parliament committees. It is believed that pressure from pro-life campaigners and church leaders led directly to these changes.[2]

However, pro-life campaigners continue to be concerned because the proposals will still take a patient's prior wishes into consideration when deciding on a course of treatment. This may include the expression of a wish to die.[3]

In an additional change, the Executive has also allowed homosexual partners to be included as the nearest relative of an adult with incapacity.[4]

Other proposals in the bill include creating "Public Guardians" to keep registers of attorneys, and extending the powers of Sheriff Courts.[5]

The bill has now passed stage one in the Scottish Parliament. In stage one, the committees of the Parliament discussed the general principles of the proposed legislation.

The bill now moves into its second stage in the Scottish Parliament where the planned laws will be scrutinised line-for-

Key points of the Scottish bill:

- The creation of attorneys and guardians to look after welfare.
- Legally authorising banks to release the funds of mentally incapacitated adults.
- "General authority" given to healthcare professionals to treat adults incapable of giving their consent.
- Sheriff Courts to make one-off intervention orders to deal with decisions of mentally incapable adults.
- New Public Guardian to keep register of attorneys and intervention orders.

Information

The full text of the proposed bill "Adults with Incapacity (Scotland) Bill" may be obtained from
Public Information Service,
The Scottish Parliament,
Edinburgh,
EH99 1SP
Tel. 0131 348 5000
Alternatively, the full bill may be viewed at:
http://
www.scottish.parliament.uk/
parl_bus/legis.html

line. It is not planned to receive submissions from anyone outside parliament during the second stage but suggestions can still be made through Members of the Scottish Parliament (MSPs) themselves.

The exact wording of the amendments have not yet been published and pro-life groups are waiting to examine the revised proposals. ■

Arguments against the new mental incapacity legislation

With legislation currently planned for Westminster it is vital that people are informed of the arguments against proposals for mental incapacity in England and Wales. Pro-life groups - including CARE, Right to lLife and SPUC amongst others - have joined together to produce the following report:

"Although the Government insists that it is opposed to euthanasia, its document 'Who Decides?' published in December 1997, and the present document, 'Making Decisions', clearly show that it accepts the practice of medical killing by the withdrawal of assisted food and fluid from mentally incapacitated patients who are not dying.

Assisted food and fluid (tubal feeding) was first legally claimed to be 'treatment' in the case of Airedale NHS Trust v Mr Anthony Bland [1993], commonly known as the 'Bland judgement'. The Court accepted this definition; as a result tubal feeding was withdrawn from Mr Bland, a permanent vegetative state (PVS) patient who was not dying and his death was brought about by dehydration and starvation (see below).

Until then, tubal feeding - like all other forms of feeding - was always regarded as basic care. Everybody is entitled to food and fluids as a basic human right.

It was clear that the only reason for tubal feeding to be defined as 'treatment' was to enable doctors to withdraw it from patients whose lives they considered should be ended. The Bland case created tremendous public concern. The present Government has promised that they would not enshrine the judgement in statute law.

In 'Making Decisions', however, the Government uses the Bland Judgement (the very case it promised not to enshrine in statute law) as the basis for accepted medical practice. The document would consolidate - even promote - the practice of medical killing in a wide range of cases.

Everybody is entitled to food and fluids as a basic human right.

'Making Decisions' refers to the withdrawal of assisted food and fluid from PVS patients and those in "similar conditions". The term is not adequately defined in the document and could relate to an ever-widening section of patients - those who have had severe strokes, new-born disabled babies, and people suffering from conditions such as Alzheimer's Disease or Huntington's Chorea. In reality, there can be no difference between selecting 'PVS patients' and those who are profoundly disabled by other conditions.

■Court of Protection

Whereas many people accept that the new Court of Protection could certainly help in relation to financial (and other) arrangements for mentally incapacitated people, there is little doubt that one of its main outcomes would be to facilitate medical killing. Nobody opposed to medical killing could adjudicate in such a court: no Orthodox Jew, Muslim, Roman Catholic or other traditional Christian could fulfil the requirement of condemning a patient to die by dehydration and starvation. (This is not to be confused with withdrawing assisted food and fluid when it is too

■References:

1. *Press Release from The Scottish Executive*, 9 December 1999
2. Personal communication with Gordon Macdonald, CARE's Scottish Parliamentary Officer
3. *Adults With Incapacity (Scotland) Bill [As Introduced]*, part 1, S1(4)(a)
4. *Press Release from The Scottish Executive*, 9 December 1999
5. The Scottish Executive, *Making the Right Moves: Rights and Protection for Adults with Incapacity* SE/1999/24, The Stationery Office, August 1999, pages 24 and 25

futile or too burdensome for the patient.)

Nearly all such cases would be heard in private as is the usual custom. This would make it almost impossible to carry out inquiries into the deaths of patients over which the Court had adjudicated even where those making the application were known by others to have a self-interest. According to the document, this is to protect the patient and the patient's 'privacy'. In reality, however, there would be no possibility of 'justice (or, for that matter, injustice) being seen to be done'. 'Privacy' could protect those applying to the courts and the court itself rather than the patients.

The role of the Court of Protection and Proxy Decision Makers as outlined in 'Making Decisions' would de-professionalise medicine. Best Clinical Practice could be over-ridden as would the Hippocratic Ethic as expressed, for example, in the Declaration of Geneva (December 1948).

■Legally binding advance directives

The Government has constantly stated that it supports the Report of the House of Lords Select Committee on Medical Ethics. This opposed giving statute force to advance directives. In 'Making Decisions', however, the Government claims that advance directives are *already* legally binding according to Common Law in support of which they cite three cases which are highly questionable authority - Airedale NHS Trust v Mr Anthony Bland; Re T and Re C.

The application of the **Airedale NHS Trust** to end the life of Mr Anthony Bland had nothing to do with advance directives. The Court admitted that at no time had Mr Bland given 'any indication of his wishes'. It was simply **felt** that he would not have wished to continue living as a PVS patient. There was no way of confirming this which is a clear indication of the dangers of citing such a case as the basis for a law making advance directives legally binding. The application to the court was that assisted food and fluid was a form of treatment which could be withdrawn.

The Document would consolidate - even promote - the practice of medical killing.

Re T related to the refusal of a blood transfusion by a Jehovah's Witness on religious grounds. The aim had nothing to do with deliberately ending a patient's life: neither did it involve a general refusal of treatment made in advance of the time when the patient was subject to the relevant condition.

In **Re C** it was decided by the court that the patient was competent to make his own decision. He was fully aware of the specific condition for which he was refusing treatment (amputation of a gangrenous leg). While the Court ruling was binding on the doctors for the future - the patient could change his mind and he knew the possible consequences of refusing treatment. This, like Re T, was not a case about general refusals of treatment, made in advance of the time when the patient was subject to the actual condition for which he refused treatment.

It is worth asking why the government should persistently claim to support the House of Lords Select Committee on Medical Ethics which opposed giving statute force to advance directives; and state that it has 'no plans to enshrine (the Bland) judgement in statute law' (Hansard. 2.11.1999, col 105) yet, introduce a Report, 'Making Decisions' which claims that, de facto, advance directives are already legally binding and citing as justification for this, Bland, the very judgement they promised not to enshrine in statute law.

Furthermore, 'Making Decisions' would enable Proxy Decision Makers to enforce advance directives which maybe written or oral without even applying to the Court of Protection. The one exception relates to the withdrawal of food and fluid for which written authority 'must be specifically given' in the Continuing Power of Attorney.

■Best interests and proxy decision makers

In healthcare the principle of 'best interests' has always

been based on a clinical assessment of what is best for the health of the patient. In more recent years the euthanasia lobby has constantly promoted the idea that best interests should be interpreted as the 'wishes' and 'feelings' of the patient. The latter concept has been adopted in 'Making Decisions'.
An advance directive would not necessarily have to be written. The 'statutory guidance' put forward in 'Making Decisions' suggests that court assessments would include 'the views of other people whom it is appropriate and practical to consult about the person's wishes and feelings....' Much was made in the Bland judgement of what people **thought** Mr Bland would have wanted in the circumstances although it was admitted that at no time had he ever discussed serious illness or disability.

Proxy Decision Makers (with Continuing Powers of Attorney) would be appointed by the patient in advance. However, in the absence of a Proxy Decision Maker, 'Making Decisions' gives the Court of Protection the Right to appoint a manager. As the new Court of Protection is pre-disposed to the concept of medical killing, it is probable that a 'manager' appointed by them would be in sympathy with their views; in his position he would be able to cause the patient harm by refusing treatment - for example, following a stroke, because he thought it was not worthwhile.

The Court of Protection also has the right to dismiss a Proxy Decision Maker if it is felt that s/he is not acting in the patient's 'best interests'. While this could be of help in protecting a patient financially, it might also mean that a person opposed to medical killing would be dismissed

"We consider that terminal care of patients... can only be safeguarded by a statute"

because of failing to call for the withdrawal of tubal feeding for a patient who was not dying if the court decided that is what the patient might have wished. What would be the position of a Proxy Decision Maker who refused to call for the withdrawal of assisted food and fluid or other treatment? Has s/he any right of appeal to other courts.

In both 'Who Decides?' and in 'Making Decisions' much has been made of the claim that neither advance directives nor proxy Decision Makers could require a doctor to bring about the death of a patient by means which are unlawful. This, however, provides no real protection for the patient as can be seen by the Bland judgement. This changed the law overnight by defining assisted food and fluid as 'treatment' which could be withdrawn thus causing death by dehydration and starvation. The Government has pledged not to enshrine the Bland judgement in statute law. Nonetheless, it now puts forward the recommendation in 'Making Decisions' that a Proxy Decision Maker may require the withdrawal of tubal feeding (without even reference to the Court of Protection) to cause the death of the person for whom s/he is acting, albeit that the authority for such non-treatment must be 'specifically given' in the Continuing Power of Attorney made in advance by the patient.

The recommendations of 'Making Decisions' regarding Proxy Decision Makers and advance directives ignore the conclusions of the House of Lords Select Committee on Medical Ethics. This Committee stated that

although advance directives could be helpful in the treatment of patients, they opposed the concept of giving them greater legal force stating that it would risk 'depriving patients of the benefit of the doctor's professional expertise and of new treatment and procedures which may have become available since the advance directive was signed'.

The necessity to protect the vunerable in statute law

In summary, we consider that terminal care of people in PVS and others with profound disabilities can only be safeguarded by a statute to outlaw doctors bringing about the death of, or causing harm to, patients by deliberate omission or commission. ”

Information

Copies of the Government consultation paper: *Making Decisions* can be obtained from:

The Publications Centre
PO Box 276
London
SW8 5TD
Tel. 0845 023474
Fax. 020 7873 8200

Or from the Lord Chancellor's Department Website:
http://www.open.gov.uk/lcd/

The Government has requested that comments on policy should be sent to:

Simon Vinogradoff
Family Policy Division
Lord Chancellor's Department
Room 5.16
Selborne House
54 - 60 Victoria Street
London SW1E 6QW
Telephone 0171 210 0668

Comments can also be e-mailed to the following address:
svinogradoff@lcdhq.gsi.gov.uk

Responses should be received by
25 February 2000

Glossary of terms

Continuing Powers of Attorney (CPA)

Powers of Attorney is where a person gives another person the power to make financial decisions on their behalf. The Government proposes to introduce Continuing Powers of Attorney (CPA) which would include healthcare and personal welfare decisions, as well as financial matters. These powers could 'continue' after any loss of mental capacity.

Court of Protection

The court of protection is an office of the Supreme Court. It exists to protect the property and affairs of persons who, through mental disorder, are incapable of managing and administering their own financial affairs.

Mental Incapacity

An individual is deemed to be mentally incapable when:
(a) unable to make decisions;
(b) unable to communicate decisions;
(c) unable to understand or retain the information needed to make decisions.

Advanced Directives

Advanced Directives are when an individual communicates specific healthcare decisions in advance, anticipating that they may become unable to make the decision known at a later time. Also known as 'Living Wills', 'Advanced Statements' and 'Advanced Refusals'.

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Summary

■Planned law to stop doctors intentionally killing patients

Ann Winterton has introduced a Private Members Bill to outlaw euthanasia. She wants to make it illegal for doctors to intentionally end the life of their patients. The euthanasia protection bill has its second reading in Parliament on January 28 when MPs will take a vote on whether the bill should become law. She has cross party support for her proposals.

■The Bland case says food and water is "medical treatment"

Tony Bland, a victim of the Hillsborough stadium disaster, was allowed to starve to death following a decision by Law Lords. The Law Lords' judgement in 1993 defined artificial feeding of food and fluids as a "medical treatment". Tony Bland was left in a persistent vegetative state following the football tragedy, but was not fatally ill. However, the judgement led to his death by starvation. This case set a precedent that has been followed in other cases.

■BMA advises doctors on withdrawal of treatment

The British Medical Association has issued guidelines following the Bland case. They say that doctors should not have to seek court approval before withdrawal of treatment – including the feeding of food and fluids. The BMA say that senior doctors outside the treatment team should make the decision in consultation with the patient and/or relatives. They confirm their belief that food and fluids constitute "medical treatment".

■Mental Incapacity bill could legalise euthanasia

The Lord Chancellor, Lord Irvine, has outlined the Government's proposals for new mental incapacity legislation in England and Wales. The plans would give people the right to delegate their healthcare decisions to a trusted friend or relative should they later become unable to make the decisions themselves. Because the Bland case has enshrined feeding of food and fluids as medical treatment, friends or relatives could decide to withdraw nourishment and end the life of the patient. Similar plans were proposed for Scotland…

■Scotland rethinks bill

The Scottish Executive has made amendments to adults with incapacity proposals, stressing that they do not intend to allow euthanasia. After hearing evidence from pro-life groups the Executive made two key changes. First, they removed reference to the feeding of food and fluids from the definition of medical treatment. Second, they said doctors would be allowed to continue medical treatment against the wishes of relatives if they could get a second medical opinion. The bill is in its last stage in the Scottish Parliament but suggestions can still be made via MSPs.

■Arguments against mental incapacity legislation

The proposed legislation for England and Wales contains loopholes that could legalise euthanasia. Pro-life groups from around the country have joined together to produce a detailed point-by-point defence against these issues. The report concludes that: "terminal care of patients…can only be safeguarded by a statute."

■The real issues

Dr George Chalmers, geriatrician and bioethicist, looks at how euthanasia affects real people and real lives. He argues that too much detached theorising ignores the real issues. Dr Chalmers says that attitudes to death have changed and this change has led to practical problems, not least the danger of "living wills". He calls for a positive approach to healthcare not just opposition to euthanasia. "To kill cannot, ever, be a substitute for caring," he says, "How much better would it be to reassert their intrinsic human value by the affirmation of human life."

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THE CHRISTIAN INSTITUTE
INFLUENCING PUBLIC POLICY

The Christian Institute, 26 Jesmond Road, Newcastle upon Tyne, NE2 4PQ
Tel: 0191 281 5664 Fax: 0191 281 4272
http://www.christian.org.uk info@christian.org.uk