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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Ethical dilemmas of brain failure in the elderly

SIR,—Dr George S Robertson's thesis (10 December, p 1775) is a simple one. The thesis goes like this; firstly, the incidence of senile dementia is rising to the point where the sheer numbers of sufferers threaten to overwhelm existing services: this is because of the rising numbers of those over 85 years old. Secondly, senile dementia is synonymous with a loss of dignity. Thirdly, doctors working with this group of patients are unnecessarily prolonging their lives. Lastly, Dr Robertson maintains that the solution to this problem is for members of the general public to make a prospective written declaration when young, fit, and mentally alert to the effect that in the event of their developing dementia they do not wish to have their lives prolonged by medical treatment. I would like to suggest that Dr Robertson's thesis is based on several false premises and that his solution totally ignores the fundamental character of a dementing illness.

It is an inescapable fact that the numbers of the very old are growing and that an appreciable minority of them suffer from dementia.

However, there is not a "bottomless pit" of cases to be unearthed. Epidemiological surveys consistently show a finite number of cases. An average health district of 200 000 will have about 2500 cases, most of whom will have relatively mild conditions. I do not wish to minimise the problem but would emphasise that the numbers are containable. We simply need to plan effective services for a larger number of people than before. The tone of panic that pervades Dr Robertson's paper is unnecessary. The response to a rising birth rate in the late 1940s and the subsequent need for increased school and university places in the '50s and '60s was a building programme of expanding educational facilities. Demographic changes in the proportion of elderly people in our society have been projected for many years and we can now forecast how many there will be by the turn of the century. We do not need to feel overwhelmed by the problems of the elderly if we plan effectively now for provision of services for this group.

Dr Robertson's second point was that dementia is synonymous with a loss of dignity.

He described well the offensive picture of nakedness and incontinence in a geriatric ward causing distress to close relatives. He remarks that the features of dementia and stroke disease are disturbing and offensive to those approaching old age and to patients' relatives. He is confusing two issues here. A traditional geriatric ward, inadequately staffed, smelling of urine, where rows of indistinguishable patients lie unstimulated in regimented beds is offensive to everyone, not only the patients' visitors. Loss of dignity derives from the way we care for our sufferers from dementia, not from the illness itself. Dependence on others for day to day care as a result of mental frailty need be no more undignified than dependence as a consequence of physical disability if facilities for care are provided that maintain the identity of each patient. More than at any other time of life the sufferer needs his personal identity preserved. To do this he needs his own room, his own personal bathroom where intimate chores of personal care can be supervised in private, his own clothes designed for his particular personal

handicaps, photos and personal possessions around him, his own furniture, a place to meet his visitors, a pleasant place to walk and exercise, a sitting room to meet friends and a room to be on his own. Pie in the sky? Not necessarily. A great many of these assets are enjoyed by the elderly inmates of the residential homes in Denmark. They are, after all, the minimum requirements for daily living that most of us hope for in old age.

I recently visited a cottage hospital in Norfolk where all the patients were suffering from dementia. The enterprising nursing officer had organised a central bar where relatives could take patients for a drink at lunchtime. Instead of the usual gloomy embarrassed silence of the run of the mill visit to a geriatric ward, a mutually agreeable activity was shared by patients and visitors; the scene was as dignified as the average pub. Who are these patients living a "cabbage-like existence" whom Robertson describes? Go to any long stay dementia ward in our mental hospitals and the nursing staff will be able to describe the personalities, foibles, and idiosyncrasies of each patient separately. In good units nurses do not see a row of cabbages but unique human beings.

I do not deny that it is distressing for relatives to witness the mental decline of those close to them. Anxiety and grief are normal reactions to this tragedy, but the same reactions are felt by relatives with physically dependent, terminally ill patients who present a nursing burden at home. Relatives need professional help to cope with the practical problems and a sympathetic response to their emotional difficulties, but it is not the job of the medical profession to relieve suffering in one person by encouraging the death of another.

Dr Robertson seems to believe that doctors working with the elderly preserve human life at all costs. This is a fundamental misconception of what geriatricians and psychogeriatricians are trying to do. Usually we see our role as improving the quality, not the quantity, of life. The aim is to maximise physical and mental condition to allow the patient to live a more comfortable and contented life. It should be said, however, that patients with dementia are often physically fit. They may be ambulant, able to eat and sleep well, and often take no medication at all. Dr Robertson implies that if left "untreated" these patients would die but many patients have nothing medically wrong to treat other than nutritional deficiencies and the symptoms of self neglect. Psychogeriatric wards are not full of people being kept alive by medical intervention. Similarly, in geriatric medical wards, immobility and severe physical dependence on others arise from crippling diseases that are not necessarily life shortening. A severely disabled arthritic patient with a coincident dementia may spend many months or years in need of nursing care without necessarily having any other medical intervention than analgesia.

Dr Robertson is right that sometimes in treating a medical condition we prolong life in patients with severe dementia nearing the end of their life. The ethical dilemma is how far to improve someone's general comfort if it means prolonging their lives in mental distress. This dilemma does arise from time to time. Would Dr Robertson suggest, for example, that we stop antidiabetic medication in patients who have been treated for many years? Surely no one who had witnessed the infected ulcers and sores and recurrent urinary

infections in patients with uncontrolled diabetes would wish to inflict that kind of suffering? I wonder what treatment he would suggest for an acute intestinal obstruction in patients with senile dementia. Would Dr Robertson have us forget the surgical emergency and let the patient die in that unpleasant way?

Finally, dementia is not a homogeneous diagnosis. Dementia covers a wide range of conditions of differing severities with an infinite variety of symptoms of brain disease. Patients can be gravely behaviourally disturbed with a relatively mild degree of frontal lobe disease without any memory difficulty whatsoever. On the other hand, a patient may have gross impairment of memory and inability to plan for the next minute and yet have a well preserved personality and be socially appropriate and well liked. I do not believe that it is possible to decide in advance at what point to implement the non-interventionist policy that Dr Robertson advocates, nor do I believe that even having given prior written authority the patient will be happy to go along with his policy in the face of a serious illness. Patients with dementia make their wishes known only too clearly. One of the unsolved problems of community care programmes is that patients will not readily accept domiciliary services such as home helps and meals on wheels because they lack insight into their condition. They do not perceive themselves to be demented, feel just as fit and well as they always did, and cannot understand why their relatives and neighbours are in such a flap about them. Dr Robertson is suggesting that a patient with impaired judgment, who has no insight into his mental state, will be denied appropriate treatment for a physical ailment because of a statement made in earlier life.

Dr Robertson's solution is a nonsense. He is suggesting an impractical and inhumane solution to a problem that can be tackled effectively in other ways, by continuing research into the causes of dementia and by providing of appropriate care to sufferers and their relatives.

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SIR,—Once again, the New Year starts with proposals to unburden medicine of the task of caring for those who, through no fault of their own, have grown old. Dr Kellert's proposals to substitute money for care¹ were less unorthodox than the latest proposal by Dr George S Robertson for euthanasia as a solution to the loss of dignity in old people. His concept of dignity fails to realise that dignity is as much a function of the environment as of the patient. To take the example of urinary incontinence, this is a problem on understaffed geriatric and psychogeriatric wards but decreases considerably with improved staffing. In the patient's home, too, medical, nursing, and social help can often reduce incontinence and the burden of care. Thus the degree of dignity depends not only on the patient but also on the resources available for care.

There is a danger of the moral and ethical issue of euthanasia being clouded by the fact that euthanasia is certainly cheaper than good quality community or hospital care. A compassionate, scientific approach can alleviate

many of the problems that lead to loss of dignity in old people. In contrast to this, those who advocate euthanasia seem to suggest we should literally bury our problems. Besides which, when we in our turn have grown old and demented with subsequent loss of language function yet are still able to enjoy life, how do we tell Dr Robertson "I changed my mind"?

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¹ Kellert JM. A new approach to the elderly. *Br Med J* 1982;285:1588-9.

SIR,—I think that Dr George S Robertson dealt with a difficult subject extremely well.

While at one extreme there are the libertarians advocating freedom of choice in dying for all and at the other those following the "where there's life there's hope" principle, I think the majority of doctors and the general public adopt an eclectic position. I have almost without exception never found myself, after proper discussion, in conflict with relatives over the treatment of a dementing or terminally ill patient.

It would be wrong to use some arbitrary definition of social functioning to decide when to terminate life, as would be the temptation in the case of dementia, and I feel that we assume an even more God-like role in helping extinguish a life than in trying to prolong it. Surely we cannot compare the positive suffering of the patient with cancer with the "painless extinguishing of the emotions" experienced by a person with dementia. Dementia cannot as yet be considered to have met the exhaustive rigours of public debate that terminal illness has.

The subject seems destined to be dragged through the law courts, and perhaps this is as good a way as any of bringing it to public attention. Meanwhile doctors will have to rely on common sense and on their professional relationship with patients and their relatives.

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SIR,—Dr George S Robertson does little to clarify the ethical dilemmas presented by an old person with brain failure. He demands challenge, however, when he states that a doctor's two functions of curing disease and relieving suffering are incompatible in old age. He further says that if you believe in the sanctity of life you continue maximum efforts to maintain life at all costs.

The principle of the sanctity of life dictates the ethics of many doctors, and demands a respect of the whole person. Those who have such respect are left free to cure where a cure is available, to relieve suffering when it arises, and to help the patient and his relatives to come to terms with the inevitability of death; in no way does it demand the maintenance of life at all costs, as this too can be a violation of the person.

Many of the so called dilemmas concerning the elderly do not arise if one is motivated by respect. Respect demands dignity to be pursued as a prime aim in advanced incurable illness. It must be clear, however, that even to contemplate a decision to kill or not to kill