would not have known of their presence or absence. Whether the relatives stayed or left during resuscitation they must be allowed time with the body of the deceased to start to come to terms with the death.

Doctors need to be trained to work in public

Peter J F Baskett

Sarah Adams's account of her emotions at witnessing her brother's violent and untimely death will touch all in the medical profession. It makes us reflect on our policy of preventing relatives from watching undignified procedures such as resuscitation.

This was not an isolated incident. As Dr Whitlock points out, several deaths occurred during equestrian events last year and they also occur in other dangerous sports such as motor cycle, motor, and power boat racing, although thankfully less often than previously. The problem arises much more commonly, however, with people who have heart attacks. The relative either attempts resuscitation or watches helplessly as a sole bystander performs chest compressions and mouth to mouth ventilation.

Lay people as well as paramedical and medical

professionals will attempt to exclude relatives from the scene. The action is based on genuine compassion for the feelings of the relative. Those performing resuscitation may also fear that the relative will become overdistressed and interfere or that they will be put off by excessively critical scrutiny.

Increasingly, doctors are expected to perform in front of the public. Mothers watch their children being anaesthetised, fathers are present during childbirth, and there are even reports of relatives observing organ harvesting after death. Doctors attending popular events must be trained and prepared to exercise their skills in front of a grandstand full of onlookers and under the scrutiny of the press and television cameras. Thankfully, the British media are nearly always discreet on such occasions.

We must reconsider our knee jerk reaction that it is psychologically harmful for relatives to watch resuscitation attempts. A degree of emotional scarring will inevitably follow if the resuscitation is unsuccessful, but, as Sarah Adams points out, watching will help some people come to terms with the anguish of bereavement.

Clearly, relatives have only a few seconds in which to decide whether they want to stay during resuscitation. Whatever decision they make it should be immediately respected. Either way they should be comforted and honestly informed of progress at regular intervals. Miss Adams has given us food for thought. The food is certainly not indigestible, and the profession should react with understanding and compassion.

Withholding and withdrawing life sustaining treatment from elderly people: towards formal guidelines

Len Doyal, Daniel Wilsher

Clinicians often decide either to withhold or to withdraw lifesaving treatment in elderly patients. Considerable disagreement exists about the circumstances in which such actions can be defended. Debates about the scarcity of resources in the NHS add urgency to the need to resolve this disagreement. Competent elderly patients have a legal and moral right to decide whether to receive life sustaining treatment. Such treatment should not be withheld or withdrawn on the basis of a patient's age alone. Principles for making decisions about life sustaining treatment in incompetent elderly patients can be defended and should exist as written guidelines.

Clinicians working with elderly patients often face difficult decisions about withholding or withdrawing life sustaining treatment. They must balance the sometimes uncertain benefits of active intervention against the potential burdens. Despite the frequency of such dilemmas little clear guidance exists on the moral and legal status of "non-treatment."

The lack of such guidance is unsatisfactory for several reasons. Firstly, clinicians often disagree about what is morally and legally required of them. Secondly, this disagreement leads to arbitrary differences in the treatment that elderly patients receive; indeed, on occasion, non-treatment on the basis of old age is used unacceptably as a mechanism for rationing scarce resources.^{1,2} Finally, when disagreements arise within clinical teams or with patients or relatives no agreed policy exists to help to resolve these disagreements.

In recent years the extent of the legal duty to provide life sustaining treatment has been substantially

clarified. Allowing elderly patients to die is now without doubt lawful in certain circumstances. Furthermore, developments in moral theory have reinforced the acceptability of such actions. In this paper we build on these results to defend specific principles for non-treatment which can be applied to characteristic dilemmas in geriatric medicine. While many of our arguments are applicable to all adult patients regardless of age, our focus remains firmly on elderly people.

Informed consent and non-treatment

Irrespective of their age all adult patients who are competent to consent to life prolonging treatment are also competent to refuse it. In general, therefore, they have the legal and moral right to know that they are being considered for non-treatment on whatever grounds unless they specifically delegate decision making to their clinician.

Only two exceptions to this legal and moral right exist. The first arises when clinical evidence exists that a discussion of non-treatment may endanger the patient's health. In such a case doctors should seek permission to discuss the patient's care with close relatives. The second exception arises in cases in which treatment would be futile in that it would not achieve its physiological objective. Clinicians are not obliged to offer useless interventions, and these do not need to be discussed with patients.³

Given that consent to non-treatment should normally be sought, we have argued elsewhere that it does not need to be explicit. Elderly patients who are competent

Department of Human Science and Medical Ethics, London and St Bartholomew's Medical Colleges, London E1 2AD
Len Doyal, reader in medical ethics
Daniel Wilsher, King's Fund research fellow in medical ethics

Correspondence to:
Mr Len Doyal.

BMJ 1994;308:1689-92

sometimes state over a sustained period that they "don't want to go on."⁴ In doing so, they are implicitly rejecting all forms of life sustaining treatment. Doctors must ensure that the wishes of such patients are unambiguous.

The stated wish of competent elderly patients to die is of particular concern when they seem to be acting under the influence of close relatives. If a patient's choice is found to have been made under duress then legally and morally it should not be respected⁵; treatment necessary to preserve life should be given while attempts are made to ascertain the patient's true wishes. Of course, such a strategy again presupposes that the patient is competent to make an informed choice. What does this mean in practice?

Competence and non-treatment

Elderly patients must possess each of five basic requirements if they can be said legally or morally to be competent to consent to non-treatment. They must be able to

- Understand a simple explanation of their condition, prognosis, and proposed treatment or non-treatment
- Reason consistently about specific goals linked to their personal beliefs
- Choose to act on the basis of such reasoning
- Communicate the substance of their choice and the reasons for that choice
- Understand the practical consequences of their choice.

An acceptable level of each of these abilities must be present over a sustained period for competence to be established.^{5,6} Standard diagnostic criteria in psychiatry and psychometric tests of competence implicitly refer to the impairment of such abilities.⁷

These general tests of competence, however, should not always be conclusive in the assessment of an elderly patient's ability to decide about life sustaining treatment. The important point is to assess patients' competence to make specific decisions about the prolongation of their life. They may be confused and unable to manage their affairs in general terms but still have the ability competently to say that they would rather die than receive treatment.⁸

In terms of the above criteria for competency, many situations exist in which even a stated positive wish to die will not raise any doubt about a patient's

competence. A good example is the long suffering, elderly arthritic patient who refuses antibiotics for an incidental pneumonia; evidence of disabling depression or lack of comprehension may not be present. Indeed, the choice may reflect not only the known values of the patient but also the values of the whole health care team.

Most patients show their competence *prima facie* by the fact that they discuss non-treatment coherently, which reflects a basic understanding of their clinical circumstances. The presumption should be that elderly patients possess competence unless the contrary is established and the justification recorded in the notes.⁹

Legality of non-treatment for incompetent elderly patients

When a clinician has decided that an elderly patient is incompetent to reject potentially life saving treatment no legal means exists for a relative to make a decision on the patient's behalf. The courts have confirmed that only doctors have the right to make such clinical decisions.¹⁰ In doing so, they have a professional duty to act in the best interests of the patient. Four situations exist in which non-treatment that leads to death is held to be in the best interests of incompetent patients and is legally acceptable.

- Inevitable death in the short term, whatever therapy is provided, as in *Re C* (a minor).¹¹
- Firm diagnosis of persistent vegetative state, as in *Airedale NHS Trust v Bland*.¹²
- Severe brain damage, although the person may not be dying or in severe pain, as in *Re J* (a minor).¹³
- Great pain and suffering, although not necessarily associated with a terminal condition, with the prospect of a demonstrably awful life, as in *Re B* (a minor).¹⁴

Although the cases referred to involved newborn infants or young adult patients, the same legal reasoning applies to elderly patients. Of course, for old people the causes of serious disability are usually chronic diseases that have no counterpart in the young. This does not, however, mean that existing case law is irrelevant. Many elderly patients will, like *Re C*, be lawful candidates for non-treatment—for example, withholding of antibiotics—because they will inevitably die in the short term. Furthermore, as with *Re J*, non-treatment in cases of severe stroke or dementia is arguably lawful on the analogous grounds of serious brain damage.

Finally, these cases also reaffirm that no legal distinction exists between withholding and withdrawing treatment. Both are lawful in appropriate circumstances—for example, clinicians treating very ill elderly patients are sometimes reluctant to begin a treatment for fear of having to withdraw it at a later stage. Yet the likely outcome can often only be determined after time limited treatment. Treatment should therefore be started when necessary to obtain an accurate prognosis.¹⁵ Withdrawing treatment later if it proves futile remains a lawful option; after the decision in *Bland*¹² this can be argued to apply even to the medical provision of nutrition and hydration.

Non-treatment for cerebrovascular accidents: moral justifications

Cerebrovascular accidents, one of the main causes of brain damage in elderly people, often raise issues of non-treatment. Most clinicians reject the moral doctrine of the absolute sanctity of human life. Lifesaving treatment often is not begun or is withdrawn in various related clinical circumstances. Yet this practice must mean that the moral right of patients in

Competent elderly patients have the right to decide their own medical destinies

these cases to lifesaving treatment is called into question. How might this be justified?

The possession of human rights depends on the potential ability to act on them. The right to freedom of movement, for example, would make little sense without the capacity in principle to choose where to move to. Generally, to exercise their rights patients must have some potential ability to formulate aims and beliefs and to choose to act accordingly. They must also have self awareness—that is, some appreciation of the fact that it is they who are choosing.¹⁶ Without such potential, patients cannot be regarded as “persons” with any associated rights, including the right to lifesaving treatment.^{16 17}

Furthermore, how such individuals can be regarded as having any objective human interests is hard to see. Humans do not just have abstract interests but rather have interests in pursuing life plans: we do things for reasons.¹⁸ Patients who can no longer actually or potentially act with self awareness can have no human interests in anything. The legal and moral duty of health care workers is to protect these patients from whatever discomfort they might experience but not to save or prolong their lives.

Given these arguments, two situations exist in which patients who have had a cerebrovascular accident should not have their lives unnecessarily prolonged. The first is when they are diagnosed as inevitably close to death. The second is when patients are not terminally ill but have such a large amount of neurological damage that the capacity for intentional action will be either non-existent or so rudimentary as to be morally unimportant. Yet because of the uncertainty that often surrounds the prognosis of patients who have had a cerebrovascular accident, clinicians must take adequate steps to ensure that recovery would be highly improbable.¹⁵ For this reason, many clinicians delay decisions about non-treatment until the health care team agree about the futility of further intervention.

Non-treatment for severe dementia: further moral arguments

Dementia is a common cause of impaired cognitive and motor function in elderly people. We have seen that non-treatment is lawful when serious brain damage has occurred.¹³ Severe dementia is arguably in this category. Does a coherent moral, rather than legal, justification exist, however, for non-treatment in such cases?

Of all the effects of dementia extreme memory loss has the most drastic consequences for personality. An individual's ability to remember past experiences is crucial to his or her personal identity.^{18 19} The fact that a patient with severe dementia has a body and brain is not enough to establish that the patient is the same person as they were before. Personality and individual identity consist of something more than simple physical survival.

What makes people the same persons that they were as children is that they perceive a narrative chain linking their many memories, goals, and beliefs. If, however, a complete break occurs in this chain, where no connections exist, their personal identity is destroyed. Despite the fact that their bodies are the same these patients are not the same persons that they were.^{19 20} Indeed, without the long term and short term memory to develop new connections they are not persons at all. Even when such patients seem to be doing things intentionally they are primarily reacting to external stimuli.

Of course, in practice things are rarely this clear because progressive dementia presents such a varied clinical picture. Even minimal levels of personal identity, however, clearly do not exist in some elderly

Justifiable conditions for non-treatment of incompetent patients

- Imminent and irreversible closeness to death
- Extensive neurological damage leading to the permanent destruction of both self awareness and intentional action
- Little self awareness accompanied by such severe motor disability that sustained independent and intentional action becomes impossible
- Destruction of both long and short term memory to such a degree that the person who used to exist no longer does and no other person can evolve instead
- Severely limited understanding by the patient of distressing and marginally effective lifesaving treatment that leads to a demonstrably awful life

patients—for example, in many with advanced Alzheimer's disease. When such patients reach the stage at which they no longer have any consistent sense of their past, present, or future, their “biographical” life has ended.²¹ In such circumstances clinicians do not have a moral obligation to attempt to prolong lives that have little more than a physical dimension.

Moderate dementia: life sustaining treatment for all?

Moderate dementia does not in itself denote incompetence to make decisions about non-treatment—for example, short term memory loss is not sufficient to establish a patient's incompetence for this purpose. Suppose that such patients repeatedly refuse treatment, forgetting the next day that they have done so; provided that the choice seems to be based on underlying aims and beliefs that they are still able to communicate over time, their wishes should be respected.²²

Even when patients with moderate dementia are not competent to reject treatment they are still persons capable of initiating intentional action. They continue therefore to have the same right to lifesaving treatment as any healthy individual. As always, decisions about non-treatment must be made on the basis of an assessment of their best interests. The most important criteria are their degrees of incompetence and life expectancy. Consider, for example, a patient with increasing dementia and cancer whose competence is too compromised to understand the purpose of burdensome treatments such as chemotherapy that might only prolong life for a relatively short time.²³ Intervention in such a case would only cause dramatic distress and suffering without, on balance, appreciably enhancing whatever remaining capacity the patient has for intentional social participation.

We are not suggesting that elderly patients conforming to any of the above criteria should be given no treatment; they should receive the medical, surgical, and nursing care that is necessary for them to be comfortable even if this care might incidentally lengthen life.²⁴ What should not occur is lifesaving treatment that will significantly diminish the patients' remaining quality of life while doing nothing to check the progress of their mental deterioration.

Conclusion

We have argued that competent elderly patients have a legal and moral right to determine their own medical destiny with regard to life sustaining treatment. Clinicians must act to enable incompetent patients to flourish as persons to the degree to which they are capable. The only moral justification for denying treatment to such patients is that they no longer have

this capacity. Withholding treatment from an elderly person of whatever age simply because he or she is old is both morally and legally impermissible.²⁵

We have outlined five situations in which non-treatment is justified for incompetent elderly patients (box). All of our arguments assume that explicit moral and legal principles are appropriate for informing clinical decision making in relation to non-treatment. Clinicians already make such decisions according to a range of personal beliefs. A policy with written guidelines would be a way of exposing to public discussion the explicit or implicit rules that guide clinicians.²⁶ We believe that the arguments developed in this paper provide a coherent foundation for such a policy, which is likely to find broad acceptance in hospital wards and the courts and among most of the public.²⁷

We thank P Mills, C Oppenheimer, C Reisner, and especially G Sayer.

- 1 Do doctors short-change old people? *Lancet* 1993;342:1-2.
- 2 Royal College of Physicians. *Ensuring equity and quality of care for elderly people*. London: RCP, 1994.
- 3 Williams F. Medical futility in context. *Br J Hosp Med* 1993;50:50-3.
- 4 Doyal L, Wilsher D. Cardiopulmonary nonresuscitation: proposals for formal guidelines. *BMJ* 1993;306:1593-6.

- 5 *Re T* [1992] 3 WLR 782, 798 CA.
- 6 Doyal L, Gough I. *A theory of human need*. London: Macmillan, 1991.
- 7 Fraser M. *Dementia: its nature and management*. Chichester: Wiley, 1987.
- 8 Age Concern Institute of Gerontology, Centre of Medical Law and Ethics. *The living will: consent to treatment at the end of life*. London: Edward Arnold, 1988.
- 9 *Re C* [1993]. *Butterworths Medico-Legal Reports* 1994;15:77-83.
- 10 *F v West Berkshire HA* [1989] 2 All ER 545, HL.
- 11 *Re C* [1989] 2 All ER 782, CA.
- 12 *Airedale NHS Trust v Bland* [1993] 1 All ER 821, HL.
- 13 *Re J* [1990] All ER 930, CA.
- 14 *Re B* [1981] 1 WLR 1421, CA.
- 15 Asplund K, Britton M. Ethics of life support in patients with severe stroke. *Stroke* 1989;20:1107-12.
- 16 Harris J. *The value of life*. London: Routledge Keegan and Paul, 1985.
- 17 Doyal L, Wilsher D. Withholding and withdrawing lifesustaining treatment in neonatal medicine: towards formal guidelines. *Arch Dis Child* 1994;70:66-70.
- 18 Dworkin R. *Life's dominion*. London: Harper Collins, 1993.
- 19 Parfit D. *Reasons and persons*. Oxford: Clarendon Press, 1984.
- 20 Buchanan AE, Brock DW. *Deciding for others: the ethics of surrogate decision making*. Cambridge: Cambridge University Press, 1989.
- 21 Rachels J. *The end of life: euthanasia and morality*. Oxford: Oxford University Press, 1986.
- 22 Wicclair M. *Ethics and the elderly*. New York: Oxford University Press, 1993.
- 23 *Superintendent of Belchertown State School v Saikewicz* 373 Mass. 728, 370 N.E.2d 417 (1977).
- 24 Volicic L, Rheume Y, Brown J, Fabiszewski K, Brady R. Hospice approach to the treatment of patients with advanced dementia of the Alzheimer type. *JAMA* 1986;256:2210-3.
- 25 Grimley Evans J. Caring is caring. *Age Ageing* 1989;18:217-8.
- 26 Doyal L. Medical ethics and moral indeterminacy. *Journal of Law and Society* 1990;17(1):1-16.
- 27 Select Committee on Medical Ethics. *Report*. London: HMSO, 1994. (House of Lords, session 1993-4.)

Style Matters

Advertising in medical journals and the use of supplements

International Committee of Medical Journal Editors

The following statements were agreed by the International Committee of Medical Journal Editors (the Vancouver Group) at its meeting this month in Oslo

Advertising

Most medical journals carry advertising, which generates income for their publishers, but advertising must not be allowed to influence editorial decisions. Editors must have full responsibility for advertising policy. Readers should be able to distinguish readily between advertising and editorial material. Juxtaposition of editorial and advertising material on the same products or subject should be avoided, and advertising should not be sold on the condition that it will appear in the same issue as a particular article.

A journal should not be dominated by advertising, but editors should be careful about publishing advertisements from only one or two advertisers as readers may perceive that the editor has been influenced by these advertisers.

Journals should not carry advertisements for products that have proved to be seriously harmful to health—for example, tobacco. Editors should ensure that existing standards for advertisements are enforced or develop their own standards. Finally, editors should consider for publication all criticisms of advertisements.

Supplements

Supplements are collections of papers that deal with related issues or topics, are published as a separate issue of the journal or as a second part of a regular issue, and are usually funded by sources other than the journal publisher. Supplements can serve useful purposes: education, exchange of research infor-

mation, ease of access to focused content, and improved cooperation between academic and corporate entities. Because of the funding sources the content of supplements can reflect biases in choice of topics and viewpoints. Editors should therefore consider the following principles:

- (1) The journal editor must take full responsibility for policies, practices, and content of supplements. The journal editor must approve the appointment of any supplement editor and retain the authority to reject papers.
- (2) The sources of funding for the research, meeting, and publication should be clearly stated and prominently located in the supplement, preferably on each page. Whenever possible, funding should come from more than one sponsor.
- (3) Advertising in supplements should follow the same policies as the rest of the journal.
- (4) Editors should enable readers to distinguish readily between ordinary editorial pages and supplement pages.
- (5) Editing by the funding organisation should not be permitted.
- (6) Journal editors and supplement editors should not accept personal favours or excessive compensation from sponsors of supplements.
- (7) Secondary publication in supplements should be clearly identified by citing the original paper. Redundant publication should be avoided.

Members of the committee were: Edward J Huth, Kathy Case (*Annals of Internal Medicine*), Richard Smith (*BMJ*), Bruce Squires (*Canadian Medical Association Journal*), Richard Glass (*JAMA*), Robin Fox (*Lancet*), Magne Nylenna (*Tidsskrift for den Norske Lægeforening*), John Overbeke (*Nederlands Tijdschrift voor Geneeskunde*), Robert D Utiger (*New England Journal of Medicine*), Richard G Robinson (*New Zealand Medical Journal*), Daniel J Ncayiyana (*South African Medical Journal*), Einar Krag (*Ugeskrift for Læger*), Patricia Woolf (Princeton University)

Correspondence to:
Ms Kathy Case, *Annals of Internal Medicine*, American College of Physicians, Sixth Street at Race, Philadelphia, PA 19606-1572, USA.

BMJ 1993;308:1692