Author's reply

EDITOR—Leung's comment is useful, and anyone treating this age group will find Jones's book helpful.¹ To summarise Jones, a child under 16 can consent to treatment (be "Gillick competent," a fact reiterated in *Re R*).² However, "no minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and *a fortiori* a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor" (Lord Donaldson in *Re W*).³

The approach that a clinician should adopt when assessing whether a child is Gillick competent was identified in the following passage from Lord Donaldson's judgment in *Re R*: "What is really being looked at is an assessment of mental and emotional age, as contrasted with chronological age.... What is involved is not merely an ability to understand the nature of the proposed treatment... but a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects, and equally important, the anticipated consequences of failure to treat." Such competence "is a developmental concept and will not be lost or acquired on a day-to-day or week-to-week basis. In the case of mental disability, that disability must also be taken into account, particularly when it is fluctuating in its effect."

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- 1 Jones RM. *Mental Health Act manual*, 5th ed. London: Sweet and Maxwell, 1996:340-2.
- 2 *Re R* (a minor) (wardship: medical treatment) (1992) 3 WLR 592.
- 3 *Re W* (a minor) (medical treatment: court jurisdiction) (1992) 4 All ER 627.

All women with abnormal genital tract bleeding should have gynaecological examination

EDITOR—Everett is concerned that "many thousands of women who miscarry may be excluded from important health planning processes," and he attempts to quantify and monitor miscarriage rates.¹ He may be setting a wrong precedent by relying on ultrasonography and ignoring the value of a gynaecological examination.

All women with abnormal genital tract bleeding should have a gynaecological examination; this includes women who are pregnant. The possibility of a local cause for such bleeding should be excluded by a speculum examination aided by a good light source. Furthermore, digital examination distinguishes the different forms of miscarriages (spontaneous abortions) into threatened abortion, incomplete abortion, and

inevitable abortion based on the dilatation (or not) of the cervix.²

Recently, three pregnant women in my unit underwent radical hysterectomy because of cervical cancer discovered in pregnancy. In two cases the presenting symptom was abnormal bleeding in pregnancy; one patient was under 20 weeks' gestation. Ultrasonography was of little help in the patients' management and possibly hindered early treatment because it generated a false sense of security by showing "placenta in the fundus" and "viable fetus seen."

Furthermore, a history of a recent smear test might misguide clinical judgment, as cervical carcinoma has been diagnosed in women who are compliant attenders of cervical screening programmes (interval cancer)³; the result of a smear test may be negative despite the presence of invasive cervical cancer.⁴ However, those women at greatest risk of cervical cancer are the ones most likely to fail to accept an invitation for screening.⁵

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- 1 Everett C. Incidence and outcome of bleeding before the 20th week of pregnancy: prospective study from general practice. *BMJ* 1997;315:32-4. (5 July.)
- 2 Chamberlain G. Vaginal bleeding in early pregnancy—I. *BMJ* 1991;302:1141-3.
- 3 Mitchell H, Medley G, Giles G. Cervical cancers diagnosed after negative results on cervical cytology: perspective in the 1980s. *BMJ* 1990;300:1622-6.
- 4 Berkeley AS, Livolsi VA, Schwartz PK. Advanced squamous cell carcinoma of the cervix with normal Papanicolaou tests. *Lancet* 1980;ii:375-6.
- 5 Williams C. Ovarian and cervical cancer. *BMJ* 1992; 304:1501-4.

Physician assisted suicide, euthanasia, and withdrawal of treatment

Full debate is needed in Britain...

EDITOR—In view of the recent conclusion by the BMA that the practice of euthanasia should not be sanctioned¹ and the admission by some doctors of their own practice,² it is important that the central issues of the debate over euthanasia and assisted suicide are fully clarified.

The legal framework, although extremely important in regulating practice, is unlikely to be able to resolve the individual moral dilemma presented to a practitioner who is contemplating euthanasia or assisted suicide for a patient.³ It is important to differentiate legal from moral frameworks in this respect. Legal frameworks are designed to enforce a baseline of reasonable behaviour in society. If individuals behave in an illegal way then they can expect to receive punishment for their actions. Moral frameworks, in contrast, are meant to achieve more than this. They are concerned not only with minimal standards of behaviour but also with ideals. In short, moral frameworks can inform how we ought to behave as well as how we must behave if we are not to be punished. Clearly, in some cases of euthana-

sia and assisted suicide, practitioners believe that they ought to help suffering patients but are not legally permitted to do so.

The two main moral arguments used to condemn euthanasia and assisted suicide are the "doctrine of double effect" and the "slippery slope" argument.⁴ The doctrine of double effect essentially differentiates between the morality of the action of a doctor who intends rather than foresees a patient's death. For example, pain relief for a terminally ill patient is seen as morally acceptable, whereas an injection of potassium cyanide is not.⁵ In normal medical practice, however, the distinction between intending and foreseeing death is far from clear. There are occasions when doctors give patients pain relief knowing that their actions will dramatically shorten the patients' lives. In short, how much morphine must a doctor give a patient before the action becomes morally indefensible?

The other argument against euthanasia and assisted suicide is that if it were to be legalised, patients would be open to abuse and doctor-patient trust would substantially decrease. In view of the recent admissions by doctors that they have practised euthanasia, we must now question whether a regulated framework would protect patients more than the current official and legal ban, which is not adhered to. A full debate on the moral issues of euthanasia and assisted suicide is now needed between the public and professionals.

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- 1 Beecham L. BMA opposes legalisation of euthanasia. *BMJ* 1997;315:80. (12 July.)
- 2 Dyer C. Two doctors confess to helping patients to die. *BMJ* 1997;315:206. (26 July.)
- 3 Churchill LR, King NMP. Physician assisted suicide, euthanasia, or withdrawal of treatment. *BMJ* 1997;315:137-8. (19 July.)
- 4 Jeffrey D. Active euthanasia: time for a decision. *Br J Gen Pract* 1994;44:136-8.
- 5 Campbell R, Collinson D. *Ending lives*. Oxford: Blackwell, 1988:153-4.

... and Argentina

EDITOR—Further to the editorial by Churchill and King on physician assisted suicide, euthanasia, and the withdrawal of treatment, we wish to report data on physician assisted death in Argentina.¹ We assessed doctors' attitudes about decisions not to treat, physician assisted suicide, and the ending of life without an explicit request from the patient. We interviewed young Argentinean doctors who attended the sixth national congress of medicine organised by the Argentinean Society of Medicine in November 1996 in Argentina. To be eligible, doctors had to be ≤ 34 years old and to have practised medicine for ≤ 10 years.

Of the 407 doctors who participated in the survey, 287 supported the withdrawal of life sustaining interventions; of these, 145 had already withdrawn such interventions. A quarter (97) of the doctors supported physician assisted suicide. Almost two thirds of the respondents (257) supported active euthanasia in terminally ill patients unable