EDITORIALS

Euthanasia in the Netherlands

An escalating downward slide

In 1989, euthanasia was decriminalised in the Netherlands and in 2000 it was legalised. The headline in the *British Medical Journal's* news pages (*BMJ* 2000; 321:1433, 9 December) proclaims 'Netherlands gives more protection to doctors in euthanasia cases'. One is tempted to wonder about protection for patients.

Euthanasia has been increasingly accepted in the Netherlands since 1973, when a doctor put an end to her mother's life and received a seven day suspended sentence. It comes as no surprise, then, to anyone who has followed the story, that tolerance of the practice has brought it now to the status of law. Its progression has proved to have a momentum of its own.

Some of the milestones along that road should be noted. In 1982, a State Committee set the criteria under which euthanasia could be practised and in September 1993, Dutch Paediatricians drew up guidelines for euthanasia in children. The new law requires that 'parental consent will now be required before incurably sick minors aged 12-16 can request euthanasia'.

In December 1993 the standard questionnaire for doctors was amended to include a section related to 'Active Termination of Life without Express Request'. The non-prosecution of doctors in the Netherlands applying euthanasia under the specific regulations, led to an increase in its use, in many cases without reference to the regulations. It is estimated that the lives of some 950 to 1000 people are ended every year in the Netherlands without any request for euthanasia. In June 1994 the psychiatrist Boudewijn Chabot was found guilty of unlawful killing of a depressed patient who was not suffering from terminal illness but in his case no criminal sanction was applied.

Despite the assurances of 'doctors acting within strict criteria', some of the figures coming out of the Netherlands suggest that, in fact, anything goes. One paper refers to the 'dark numbers', unreported cases, which may be variably estimated between 30% and 70%, neither figure having any possibility of confirmation. Even the lower figure is very disturbing.

Christian ethical thinking has always given importance to the intrinsic value and equal worth of every human life, regardless of age, health, or any other extrinsic factor. Caring for the sick and disabled is a high social priority which characterises a compassionate society. This has been and remains the basis for much of our law and social policy.

It is also the basis for safe and responsible medical practice and any erosion of such a core value weakens the foundations, not only of medical practice, but of society itself. The Netherlands may see itself as leading the way in this field, but we need to ask very clearly, 'where they are going?', before we even consider following that lead.

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The MMR dilemma

Be informed, inform others and act on the evidence

Vaccination programmes pose a dilemma; individuals face remote but sometimes catastrophic risks to ensure that the community presents no risk to them of the disease. If individuals fail to take that risk however, both they and the community will suffer. We cannot isolate ourselves from the community of which we are part. As similar pertussis 'scares' in the 1970's showed, everyone suffers if we try.

In MMR vaccination a very effective multiple vaccine protects against measles, mumps and rubella. The risks of non-vaccination are incomparably greater than those of vaccination as large long term studies in other countries and increasing experience in the UK fully confirm. High take up levels are necessary to achieve the benefits of the programme. One largely discredited article has claimed that the triple vaccine is associated with a greater risk of autism and possibly Crohn's disease. The media raise doubts; vaccination rates fall; and the risk of a measles epidemic is real. Parents are frightened and seek single injections instead.

The injection of foreign protein can never be a risk free procedure. In infrequent cases, local and/or systemic complications of varying severity occur. Single injections multiply that admittedly low risk. We may concede much to modern autonomy but doctors are not morally or legally required to act against their better judgement when choosing vaccines however 'paternalistic' their actions are judged by others to be. Doctors must use their own rigorous standards in reaching this 'better judgement' and not simply adopt the opinions of others. Wakefield and Montgomery (*Adverse Drug React Toxicol Review* 2000; 19:265-283) imply that the 'Establishment' has failed to undertake all necessary research and ignored some that has been done. We need to satisfy ourselves that this is not true and to warn parents of the real dangers and choices. The public is well aware that 'Establishment' views have been wrong in the past and is unlikely to be convinced by slick advertising campaigns. Whilst the media like to present contrasting views as equally valid, doctors must be clear that, in this case, one view is overwhelming and the other tenuous.

Doctors who have read professional reviews and who are prepared to expose their own close relatives to vaccination can be reasonably satisfied that their own 'better judgement' is indeed ethical. We need to be honest about vaccination risks confirmed by reliable evidence and to change our practice if new findings justify it. We must ensure that all those who actually give the vaccine know and observe any contraindications however rare. Audit procedures will need to be in place. If parents reject our advice that is their legal right but our moral responsibility remains to ensure that such a decision is as 'informed' as possible.

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Research Fraud

The search for truth must be the prime motivation

Research is essential to advance medical knowledge and ultimately improve patient care. All doctors in training should be taught research techniques, have an opportunity to spend time in research under supervision and be able to interpret published data. Fraud impedes the advancement of both medicine and patient care (*BMJ* 2000; 321:1429).

Recent cases have come before the General Medical Council. It is planned to set up a national panel to address this issue but some perceive the advisory nature of the panel as a weakness. The Committee on Publications Ethics (COPE) set up three years ago, has already had over 100 cases submitted to it (*BMJ* 2000; 321:1487).

Why do individuals falsify data or even communicate results ambiguously to disguise weakness in the research? There is enormous pressure to publish to gain career advancement, greater personal or institutional prestige, or just further funding. In the United States, 20% of applicants for gastroenterology fellowships and 7% of those for emergency medicine residency programmes are said to have misrepresented publications (*Ann Int Med*1993; 123:38-41, *Ann Emerg* 1996; 27:327-330). Those who have been involved in research, whether Christian or not, will know the temptation, so 'casting stones' is not appropriate. 'If we say we have no sin we deceive ourselves…' (John 8:7, 1 John 1:8).

As Christians, we must stand for integrity in every aspect of medicine not just in research. Those in positions of influence in institutions, training and research must set an example but also be supportive. The creation of a 'cut throat' atmosphere in which failure is unacceptable, sets a bad example. Good role models introduce their trainees to the concept of a search for Truth rather than a Nobel Prize. They encourage the concept of research that is valuable whether the results are positive or negative. A manufactured, dramatic finding may bring temporary success but if the foundations of the research are not honest, like any house built on sand - it will eventually fall (Matthew 7:24-27). Ultimately only research conducted with scrupulous integrity is worthwhile.

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The National Clinical Assessment Authority

Should not influence Christians' enthusiasm

'….a rapid response unit for investigating doubts about doctors performance' was *The Times*' description of the new 'National Clinical Assessment Authority'(NCAA)(15 Feburary, p8). John Denham, Health Minister, described it as a 'new approach to the problem of poorly performing doctors'.[1] Formed as part of the implementation of 'Supporting doctors, protecting patients' (*Dept of Health*, November 1999) the NCAA is a new Special Health Authority. Its purpose is to 'operate a new performance assessment and support service to which a doctor can be rapidly referred, where the concern about their practice will be promptly assessed, and an appropriate solution devised'.[2]

How do we respond to news of the new Authority? Enthusiasm? Resignation? Anger? *The Times*' front page headline for the same day as the above was 'Doctors in crisis as complaints soar' and there can be little doubt that the confidence and morale of British doctors has been battered by a series of damning inquiry reports (Bristol and Alder Hey) and an increasingly hostile media interest in highlighting medical errors. The previous week's *Sunday Times* majored on the 'Arrogance' (11 February, p1) of the NHS and of doctors in particular. But it is despair rather than arrogance that pervades many of our colleagues at present.

For many doctors medicine has been the most important thing in their life and seeing it tarnished and brought into disrepute has overwhelmed them. As Christian doctors we know that we work for the glory of God (1 Corinthians 10:31), but our work, even medicine, should never become our God (Exodus 20:3-4). It will be important in the months ahead that Christian doctors are not overwhelmed by cynicism and despair but continue to show an enthusiasm for their work, an enthusiasm which, as Paul writes, is driven by serving the Lord Jesus, not by the fear of the NCAA! (Colossians 3:22-24)

If the NCAA can reassure the public and press that doctors are serious about wanting to ensure a good standard of service for all patients then it will have a valuable role to play.

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1 Assuring the Quality of Medical Practice, January 2001, p2 www.doh.gov.uk/assuringquality
2 Ibid: 6

Anal Sex

We need to be honest about the health risks

On 30 November 2000 the Government voted to lower the age for consent for anal sex from 18 to 16, by invoking the Parliament Act to overrule the House of Lords and pass the 'Sexual Offences (Amendment) Bill'. Less than a month later, research released at a British Psychological Society conference suggested that many homosexuals are tired of constant warnings about their sex lives and feel empowered by rebelling against them (*The Times*, 20 December 2000). An earlier survey of 10,000 UK homosexuals showed that 45% had had unprotected anal sex; two thirds of these did not know the HIV status of their partners. This February it was announced that new HIV infections had hit a record UK high in the year 2000 (*BMJ* 2001; 322:260).

The health risks of anal sex are well documented but poorly publicised. The delicate columnar epithelium of the rectum makes it highly susceptible to syphilis, gonorrhoea, HIV and other viral infections predisposing to anal cancer. Anal squamous epithelial lesions are now found in 36% of HIV positive gay men (*Sex Trans Dis* 1997; 24:14). Furthermore breakage and slippage rates for condom use in anal sex are 32% and 21% (respectively six and three times higher than for vaginal sex)(*AIDS* 1998; 12(5): 495-503).

But whilst doctors would consider it negligent not to warn their patients of the health dangers of smoking, excessive alcohol, poor diet and lack of exercise; most are reluctant to highlight the dangers of anal sex. Nor does the health of its homosexual citizens appear to be a leading priority for government.

The Bible is clear that homosexual acts are wrong and their associated high health risks should come as no surprise. No one is saying that as Christian doctors we should judge our homosexual patients or deny them good medical care. But, as well as being vehicles of God's mercy and compassion, Christian witness also involves being informed in an atmosphere of ignorance and misinformation and speaking the truth about risks to health. Even at the cost of incurring the wrath of the politically incorrect. If we remain silent, we share the blame.

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