Another GMC consultation: doctors 'assisting' suicide

Upholds law and ethics, but needs input from the consulting room

Review by **Andrew Fergusson**
Chairman, Advisory Group, Care Not Killing Alliance

The General Medical Council has launched a consultation ending 4 May, on 'Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide'.[1] The definitive version will primarily be for the GMC's own purposes, to decide whether to proceed against doctors whose fitness to practise is apparently questioned.

Why the need? In July 2009, the Law Lords (now Supreme Court) ruled on the case brought by multiple sclerosis sufferer Debbie Purdy. She wanted assurances that if her husband assisted her suicide, he would know what criteria the Director of Public Prosecutions would use in deciding whether to prosecute. Ordered to publish criteria, the DPP's final guidance included among the 16 public interest factors listed in favour of prosecution: 'The suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional… and the victim was in his or her care'.[2] Subsequently, the Medical Defence Union[3] and the Medical Protection Society[4] issued advice that doctors should not involve themselves at all, and the Royal College of Nursing guidance[5] is cautionary.

Health professionals are at risk both of criminal prosecution and of action by their regulator. The GMC's guidance, which will affect all registered doctors, is brief and commendably clear. It sets out the current law, and makes no ethical comment, but the detail is incredibly significant as it is against those final words that the GMC will judge any doctor's conduct.

Like the DPP, the GMC effectively lists 'more likely to prosecute' and 'less likely' factors. These are ethically conservative and show common sense, though questions remain. Most likely to affect doctors is: 'She wants records and a medical report for Dignitas – what am I allowed to do?' While 'providing access to a patient's records in compliance with a valid subject access request under the Data Protection Act 1998' (22b) is listed as less likely, 'assessing a person's physical health or mental capacity and/or writing reports knowing, or having reason to suspect, that the assessments and/or reports would be used to enable the person to obtain encouragement or assistance in committing suicide' (19c) is rated more likely.

This example suggests a potential minefield in practice. Individual doctors should respond to uphold law and ethics, and to comment on details in this consultation from the perspective of their consulting rooms.

references

1. Assisted Suicide Consultation *GMC bit.ly/yLqmOo*
2. DPP publishes assisted suicide policy *CPS* 25 February 2012 *bit.ly/ys9yko*
3. MDU's concerns over CPS's new assisted suicide policy MDU 25 February 2012 *bit.ly/ADQ66J*
4. Press Release *MPS* 25 February 2012 *bit.ly/wJejSL*
5. When someone asks for your assistance to die *RCN* 2 November 2011 *bit.ly/wleeOz*

Changing views about sexual orientation

'A more fluid approach'

Review by **Peter Saunders**
CMF Chief Executive

Many people believe that homosexual and heterosexual are distinct biological categories like race – unchangeable, biologically fixed and genetically determined. It is on the basis of this view that the gay rights lobby and sections of the media argue that 'homophobia' is a form of discrimination akin to racism.

But this view is being increasingly challenged, not least by gay rights activists themselves. In a recent Huffington Post article that has generated a huge amount of attention, 'Future Sex: Beyond Gay and Straight',[1] Peter Tatchell affirms both the spectrum and also the fluidity of sexual attraction.

Regarding bisexuality he says: '*We already know, thanks to a host of sex surveys, that bisexuality is a fact of life and that even in narrow-minded, homophobic cultures, many people have a sexuality that is, to varying degrees, capable of both heterosexual and homosexual attraction.*'

Then he challenges the traditional view that gay and straight are distinct categories: '*Research by Dr Alfred Kinsey in the USA during the 1940s was the first major statistical evidence that gay and straight are not watertight, irreconcilable and mutually exclusive sexual orientations. He found that human sexuality is, in fact, a continuum of desires and behaviours, ranging from exclusive heterosexuality to exclusive homosexuality. A substantial proportion of the population shares an amalgam of same-sex and opposite-sex feelings - even if they do not act on them.*'

Tatchell, however, grossly inflates the true incidence of exclusive homosexuality. The best evidence[2,3,4] suggests that only a very small percentage of men (1-2%) and women (0.5-1.5%) experience exclusive same-sex attraction throughout their life course. But bisexuality appears to be more prevalent than exclusive homosexuality.

What is the relative ratio of bisexuality to exclusive homosexuality? For each man who is 'completely homosexual' (Kinsey score 6) there are three with varying shades of bisexuality; but for women the ratio is 1:16.[5]

Sexual attractions are therefore best understood as lying on a spectrum rather than in terms of a simple dichotomous binary categorisation, and mixed patterns of sexual desire, including attraction to both sexes at the same time, appear to be more common than exclusive same sex attraction, especially among women.

But the concept of a spectrum of sexuality–known for decades, but often ignored–also calls into question simplistic analogies between sexual orientation and race. Conflating sexual orientation and race is not really comparing like with like. It is what is called a 'category error'.

references

1. *Huffington Post*; 10 January 2012 *huff.to/xJjxBm*
2. Dickson N, *et al*. Same-Sex Attraction in a Birth Cohort: Prevalence and Persistence in Early Adulthood. *Soc-Sci and Med* 2003; 56 (8):1607-15.
3. Savin-Williams RC, and Ream GL. Prevalence and Stability of Sexual Orientation Components During Adolescence and Young Adulthood. *Arch Sex Behav* 2007;36:385-94.
4. Laumann EO, *et al*. *The Social Organization of Sexuality: Sexual Practices in the United States*. Chicago: University of Chicago Press, 1994.
5. Bailey JM, *et al*. Genetic and environmental influences on sexual orientation and its correlates in an Australian twin sample. *J Pers Soc Psychol* 2000;78(3):524-36. *1.usa.gov/zDLKj8*

Social care funding

Archbishop adds to pressure on government

Review by **Helen Barratt**
Speciality registrar in public health

The Archbishop of York, Dr John Sentamu, has called on the Prime Minister to address the current 'crisis' in the elderly care system. The Archbishop said it is 'widely acknowledged' that the existing funding arrangements are 'unfit for purpose' as pressure grows on the government to reform the social care system. [1]

Social care includes the support services that help frail and disabled people remain independent, active and safe. Such services are funded in a separate and more localised way than the NHS. Whilst the NHS was established as a centrally directed service, largely free at the point of use, personal social services remain the responsibility of local councils and subject to means-testing. [2]

Despite an ageing population, there has been little increase in gross spending on social care for older people in recent years. Consequently, councils are having to restrict help to smaller numbers of older people with the most intensive needs. Individuals with assets totalling more than £23,250 are liable for their full care costs: a quarter of those aged 65 today can expect to spend over £50,000 on care in their lifetime. [3]

Following the General Election in May 2010, the coalition government acknowledged the urgency of reforming the social care system to ease the cost burden many individuals face. [4]

A commission, chaired by the economist Andrew Dilnot, reported in July 2011. In his report to the government, Dilnot recommended that individuals should not have to pay more than the first £35,000 of their care costs. Additionally, individuals with assets, including their homes, totalling less than £100,000 should not have to pay for care. [5] The cost of the Dilnot proposals is estimated to be around £1.7 billion.

The Commons' Health Select Committee has recently called for the government to implement the findings of the Dilnot Commission, noting that older people are being let down by a social care system in which they are 'passed like a parcel' between services. The government has however yet to accept the recommendations, and Health Secretary, Andrew Lansley has referred to them as merely 'a basis for engagement.' [6]

However, in his open letter to the Prime Minister, Dr Sentamu described the Dilnot report as 'a call to action which our country cannot, must not ignore'. Quoting Proverbs, the Archbishop called for a new social covenant that 'assures the weak and vulnerable of proper protection,' stressing the valuable contribution that older people make to a society which increasingly considers them 'an irrelevant burden'. [1] The government has pledged to set out its approach to reform in a White Paper to be published 'in spring 2012'. [7]

references

1. Archbishop Calls for Urgent Action on Funding of Care for Older People: A New Social Covenant *Archbishop of York* 11 December 2011 *bit.ly/vjiQuN*
2. Social care funding and the NHS An impending crisis? *The Kings Fund* 17 March 2011 *bit.ly/hW2J4X*
3. Technical Briefing Note *Dilnot Commission* September 2011 *bit.ly/xnyhLI*
4. *The Coalition: Our Programme for Government* 31 October 2010 *bit.ly/fK5vov*
5. *BBC* 10 July 2011 *bbc.in/pyXOuC*
6. *Guardian* 4 July 2011 *bit.ly/jU8WJu*
7. *DH* 18 October 2011 *bit.ly/ylnOyC*

Four steps forward, five steps back

Continuing challenges in global health

Review by **Steve Fouch**
CMF Head of Allied Professions Ministries

The last year has seen some significant changes relating to global major health problems. We saw that maternal mortality in the developing world was less than had been previously reported, [1] there were improvements in child health [2] and the global community came together over strategies to invest in treatment and prevention of non-communicable diseases (NCDs) [3] and neglected tropical diseases (NTDs). [4]

But we have also seen a crisis of confidence in the Global Fund to fight TB, HIV and malaria, partly over corruption allegations (mostly untrue) [5] but largely due to the Eurozone crisis. [6] Most major donors used the allegations as an excuse to renege on funding pledges as they struggled with mounting sovereign debt crises.

During the year Bill Gates has poured more money than most governments into tackling global health issues, and the UK government has kept its status as the second largest bilateral donor to health development. However it is sobering to reflect that the annual funding to eliminate NTDs and NCDs and the three major infectious killers (TB, malaria and HIV) come to little over 1% of the money the UK alone put into bailing out the banks. And this as we languish under a national debt of £1 trillion, fuelled by self-interest and cheap credit. [7]

More recently we learnt that the global malaria situation may be far worse than we thought, [8] that cancer is a bigger killer in the developing world than AIDS [9] and the crisis in midwifery recruitment globally may set back the modest gains in reducing maternal and infant mortality of the last decade. [10]

We know *how* to tackle these health problems, and many (including our own government, to their credit) are putting in the money and resources to make this happen, but in the face of a worsening global economy, many are pulling out of funding initiatives that could save lives for a fraction of what is being spent to bailout the failing economies of Europe.

God's judgement of Sodom was simply that, 'She and her daughters were arrogant, overfed and unconcerned; they did not help the poor and needy. They were haughty and did detestable things before me. Therefore I did away with them as you have seen.' [11] Let's be careful the West does not fall into the same judgement.

references

1. *Lancet* 2010;376:1389-1390. (23 October.)
2. Levels and trends in child mortality, *UNICEF 2011 uni.cf/za1PK3*
3. United Nations high-level meeting on non-communicable disease prevention and control reports and papers *bit.ly/wihpaO*
4. *www.unitingtocombatntds.org*
5. *AIDSpan Global Fund Observer*, Issue 139 27 January 2011 *bit.ly/xnWk3E*
6. *Bloomberg Business Week*, 18 January, 2012 *buswk.co/AOWplk*
7. *Christian Medical Comment*, 5 February 2012 *bit.ly/zVLsZV*
8. *Lancet*, 2012;379:413-431, (4 February)
9. *Huffington Post* 4 Feb 2012, *huff.to/xVlauc*
10. *CMF Blog* 2 April 2011 *cmf.li/wSyi6U*
11. Ezekiel 16:49, 50