For Debate . . .

Health Service or Sickness Service?

ELIOT SLATER

British Medical Journal, 1971, 4, 734-736

The annual cost of the health and welfare services is over one and a half thousand million pounds. The lion's share, £800 million or so, goes to the hospital services. As the years go on the proportion of the national income spent on hospital services goes up and up; the proportion made available for general medicine actually declines. Money and facilities are made available much more readily for saving the lives of those who are critically ill than for humdrum medical care.

Detailed studies of mortality rates are available but relatively little is known about morbidity. Such information that we do have is that only a fraction of the people in the community who are suffering from partially or completely incapacitating illnesses are getting any attention at all. Gerald Leach¹ estimated a total of 3,830,000 persons in England and Wales recognized as suffering from the principal incapacitating disorders—hypertension, conspicuous psychiatric morbidity, bronchitis, glaucoma, rheumatoid arthritis, and epilepsy—that is, nearly 4 million recognized sufferers in addition to an estimated 5,440,000 unrecognized.

There is much remediable or preventable disability not receiving attention, as, for instance, in the dental condition of children. Hospital waiting lists for minor but incapacitating conditions such as hernias, varicose veins, gynaecological repairs, and orthopaedic work are long and the queues move slowly. At present over half a million people are waiting for hospital admissions.

Services are not related either to the social magnitude of the problem or to cost-efficiency. Though nearly half of the hospital beds in the country are for psychiatric patients they get only 15% of National Health Service funds and only a tiny fraction of medical research funds. This is not only because psychiatry is less prestigious than general medicine and surgery; a principal reason is that psychiatric disorders rarely cause death in youth or middle life, except for the sprinkling of suicides. Modern medicine fights death rather than mere illness, when illness is the enemy and not death.

Apart from our inadequacies in tackling the easy but not urgent tasks we fail at an earlier stage—in prophylaxis. The crying scandal is, of course, the number of children who every year become addicted to smoking. We show concern about mortality rates but seem hardly bothered at all about the years of morbidity and misery that precede death from lung cancer, respiratory diseases, cardiovascular diseases, and the rest of the sequelae of life-long smoking. The consumption of sweets by children, addiction to alcohol, and death on the road are evils that cannot be laid at the door of our profession but lie rather in universal attitudes and standards. But are we to blame in not trying harder to reform those attitudes? and in not exercising stronger pressure for the nationwide use of screening tests for cancer of the cervix, etc? We try to cure conditions when they

have reached a late stage but show no great enthusiasm in trying to prevent them.

Perinatal Risks

The processes of meiosis and mitosis, of spermatogenesis and oogenesis, and after them of the development of the embryo through all its stages are very delicately controlled. But they are extremely complex and have no margin for error; any error, however minor, has cumulative effects. Nevertheless, the defective embryos are progressively eliminated. Out of every 1,000 conceptuses 120 to 150 die in the first four weeks of life. Probably all of them are seriously abnormal. They cause no more disturbance in the mother than perhaps an unusually heavy menstrual bleeding. Between the end of the first four weeks and the seventh month of pregnancy there will be a further 100 to 150 miscarriages. More than half of these spontaneously aborted fetuses can be seen to be abnormal, even on superficial examination. These are nature's discards.

Of the babies who come to term some 2% are stillborn and a further 4% or so have gross defects. The save-all policy has become the rule in our obstetric and paediatric services, with results which could become grave in terms of human suffering. About three in every 1,000 babies born are affected by spina bifida, in a high proportion of cases to a moderate or severe degree. When I was a student and no treatment was known the usual course was put the little mistake of nature in a cool spot while attention was diverted to the mother. The baby died, the mother wept. But a few months later she would be entering on another pregnancy with every chance of having a normal healthy child.

Then came the time when these damaged babies were given their chance of surviving and got the same support as any other baby. Then the life span was somewhat longer, though only the very mildest cases ever reached adolescence. The most heavily handicapped babies died off rapidly, and four out of five were gone in the first year.

Nowadays paediatric surgery proceeds stage by stage to ward off all the dangers. There is operation after operation, always new adjustments having to be made as the child grows. Attention is needed because the child is spastic and paralysed and incontinent. There has to be special education to help him to adjust to the combination of defects, among which there is often superadded mental subnormality.

It appears that the proportion of spina bifida babies now having an immediate operation is rising. So too no doubt are the numbers of severely handicapped survivors; and so too the medical, educational, social, and family burdens. In the first five years of life most survivors spend an average of two years in hospital, mainly in spells of one to two weeks. Admissions are numbered in dozens, and the child is hardly out of hospital before the time is nearing for him to go back again. Special schooling can usually enable these children to walk and to get their incontinence under a socially acceptable degree of control. But if Britain were to provide special schools for every spina bifida child who is now being salvaged Leach¹ estimated that it

would have to build one with 50 places, and staff it with about 10 skilled people, each and every month for the next 15 years.

These children are now beginning to come into puberty and adolescence, when their sufferings will really begin. Only the most miserably impaired social life will be open to them; they will be equipped with normal sex drive but no normal sex function; all around them they will see the normal, the vigorous, and the healthy. Will they really be grateful to the fates, the all too human fates, but for whose intervention they would have died before their miseries began?

Perhaps the whole procedure is mistaken. If this is one of the necessary consequences of the sanctity-of-life ethic perhaps our formulation of the principle should be revised. The spina bifida baby is a mistake of nature not equipped to survive. Who suffers if he dies at birth? Certainly not the child, though if he is forced to survive he faces years of suffering. Do the parents suffer if he dies? Yes, in the disappointment of not having a baby when they had hoped for a normal little boy or girl; but in a few months they can try again. If the child survives, however, they have years of servitude, of tortured love, trying to make up to him for all his disadvantages. And society, the community? The death costs nothing; the life costs not only money but the pre-emption of precious medical, nursing, social, and educational resources.

It is sometimes said that the handicapped child has the same right as the normal child to a normal family life. But the mentally subnormal and the severely handicapped child cannot have a normal family life. The abnormal child causes emotional reactions in his parents and sibs that distort normal relationships, and these families suffer severely (see, for instance, *Families at Breaking Point*²). The true ethic is, I believe, that normal parents have a right to a normal child. It is their first duty to preserve the normality of their home, the welfare of their marriage, their mutual relationship, and their family life. They should think it wrong to inflict an abnormal sib on their other normal children, who cannot defend themselves against this trauma. Sometimes parents do reject the abnormal baby when he is born, but if so it is in the face of strong emotional pressures from everyone—doctors, nurses, and neighbours. Yet common sense and humanity are on the side of rejection. The spina bifida baby, the mongol, the phenylketonuric are not babies so much as attempts at babyhood that misfired. If as a community we impose on our medical services the duty of keeping them alive, then through these and other State services we should bear the whole burden. It is one for specialists. We should not shuffle it off on to untrained women and men of only average ability and stability, who by their relationship with the abnormal infant are put under particular strain.

Life-saving or Death Prevention?

It is the very best hospital facilities, equipment, and medical and nursing personnel that we have devoted to such basically insoluble problems. Improvement in the routine services of the N.H.S. is low priority, but we can look forward to the expansion of the accident and emergency services, intensive treatment centres, haemodialysis units, organ-transplant facilities, etc. They are very expensive, claim very high prestige, and are the pride of their mother-hospitals. The work is demanding, is a high challenge to everyone engaged in it, and provides a basis for advancing knowledge. But from the point of view of cost-effectiveness it is uneconomic. In deploying the limited resources available in these fields for preference we are tackling the most difficult rather than the most rewarding problems. We are countering mortality at the expense of promoting morbidity.

Some gravely damaged patients who without expert help would have died right away do die a few years later. In the interval, as a general rule, the killing disease has been kept at bay but not cured. The years intervening between rescue and eventual death are spent in continuous dependence, not fully well and often with serious physical and psychiatric symptoms.

Life on the kidney dialysis machine is so stressful that some patients withdraw from treatment knowing that is death, others commit suicide, others have severe depressions or even schizophreniform psychoses; very many, of course, can stand these stresses and lead worthwhile lives for the interim available. Patients with kidney transplants are much better placed; but they face their own dangers—of organ rejection, of uncontrollable infection, of such rare events as carcinoma in situ. The half-life of the transplant kidney-recipient after initial success is about five years.

So saving a life is a very relative term. We behave as if we thought it was absolute, that death could be staved off indefinitely. We have become unrealistic in our attitudes to death and have encouraged death phobia in ourselves and in our patients. Death, of course, is nothing; it is the prolongation of dying that is to be shunned, not death but the illnesses and injuries that destroy the value of life. We must distinguish between terminal illnesses and death; death is the end of terminal illness. For the dying man death is a boon. If illness is distressing and incurable that boon should not be withheld. But all too often we do withhold it.

Accepted Tradition

When I was newly qualified there was not much one could do to ward off death in the dying man. It was held humane to let him die. More than that, it was thought truly ethical to hasten his end. This was stated very clearly by Lord Dawson of Penn when speaking on the Voluntary Euthanasia Bill in the House of Lords on 1 December 1936.³ He said that there had been a big change in medical practice over the past 50 years. It had been "an accepted tradition that it was the duty of the medical man to continue the struggle for life right up to the end." That had changed and been replaced by the feeling that "one should make the act of dying more gentle and more peaceful even if it does involve curtailment of the length of life." But: "When the gap between life burdened by incurable disease and death becomes wider, then greater difficulty presents itself, and greater variety in practice holds amongst individual doctors and patients. None the less there is in the aggregate an unexpressed growth of feeling that the shortening of the gap should not be denied when the real need is there. This is due, not to a diminution of courage, but rather to a truer conception of what life means and what the end of its usefulness deserves."

What Dawson was talking about—the deliberate, fully intentional shortening of the gap—was, of course, a kind of euthanasia. The movement he detected among his medical colleagues in that direction has ebbed back again since his day to the point from which he had seen it start 50 years before. The Representative Body of the B.M.A. in 1969 resolved that "This Meeting in affirming the fundamental objects of the medical profession as the relief of suffering and the preservation of life, strongly endorses the Council's view on the condemnation of euthanasia . . ." This is, I submit, an unfortunate directive. It contains a self-contradictory element, since the preservation of life often means the prolongation of suffering. But the whole approach is wrong. We are talking about our objects when we should be thinking about our duties.

We must remember that we are the servants of our patients and not their masters. We must abandon our claim for limitless control over the patient's body (subject only to an explicit veto) in the pursuance of what we think is right on his behalf. It is only by his permission that we touch his body at all. In caring for him we are acting as his agent. We must put him in the position to be the master of his destiny and provide him with the information he needs to know what is available and to decide what he wants. Part of the trouble is that for the sake of a simplistic ethical rule, such as the sanctity of life, we assume that all patients are the same, that they all want to live for an indefinite term longer, and if they don't it is because their minds are disordered. Patients differ as much as their circumstances

differ. In making a single rule valid in all conditions we deny the patient's individuality, even his humanity.

Let me submit for consideration a different ethic. The doctor's first duty, subject to the patient's consent, is to do all he can to maintain health and vigour; to restore health when it has been impaired; to repair incapacities when they are sustained. Second to this comes the duty to relieve or if not relieve then alleviate suffering. If we bear these principles in mind the preservation of life will look after itself in all cases in which it is desirable and desired. Per se it is no part of the doctor's ordinary duties.

If we take the patient's personal needs and wishes as our prime directives we must allow for self-destruction. This is not to decry all the work that is done by suicide prevention services; many suicidal attempts, sometimes called "parasuicides," are cries for help, cries that should be heeded. But about one attempt in seven is fully intended. This is so for the lonely people with multiple physical illnesses or handicaps, who make up the bulk of successful suicides among the elderly. Since the Suicide Act of 1961 killing oneself is not unlawful, and these people are doing only what is within their rights. Barraclough⁴ studied 30 suicides by people over the age of 65; in five of them there was a terminal malignancy or other condition likely to be fatal in two years. Would we really wish that those five had been found in time and rescued to live a little longer with their terminal disease? It is to be hoped that very soon now doctors will come to respect the wishes of the man who has given thought to his duties and obligations and has deliberately decided to end his life on grounds that are obviously valid, at

least for him. We must hope for more than this. There are so many ways of killing oneself disgracefully, as by throwing oneself under a train, or messily or uncomfortably or at great inconvenience. Some day, perhaps, when there is more respect for suicide as a way of death, kindly and comfortable means will be made available.

Conclusion

It is very natural that doctors should feel profound repugnance when the suggestion arises, as they see it, that they should act as "executioners." Yet considerations of humanity no less than common sense lead one to the view that when the process of dying is intolerably long drawn out its abbreviation is a service to the individual patient which only his doctor can perform. This places us all before a very painful dilemma. We shall be able to find our way past it only by the kind of discussion which involves new thinking and much heart-searching. *Non est vivere, sed valere, vita.*

References

- ¹ Leach, G., *The Biocrats*. London, Cape, 1970.
- ² National Society for Autistic Children, *Families at Breaking Point*. London, N.S.A.C., 1971.
- ³ Dawson of Penn, Lord, *House of Lords, Parliamentary Debates*, vol. 103, p. 480. London, H.M.S.O., 1936.
- ⁴ Barraclough, B. M., in *Recent Developments in Psychogeriatrics*, ed. D. W. K. Kay and A. Walk. Ashford, Kent, Headley, 1971.

Scientific Basis of Clinical Practice

Drugs Acting on the Heart

IAN R. GRAY

British Medical Journal, 1971, 4, 736-738

The function of the heart is to maintain a flow of blood through the systemic and pulmonary circulations commensurate with the needs of the tissues, and the return of blood by the venous systems. For the heart to perform perfectly in all circumstances its rhythm and neurological control must be normal, and the conduction of the impulse through the heart muscle intact. The force and amplitude of myocardial contraction must be able to increase appropriately in response to a pressure or volume load, and flow of blood through the coronary vessels must be unimpeded. Symptoms of heart disease occur only when one or more of these vital mechanisms is disturbed: rhythm, conduction, myocardial function, or coronary flow. The drugs which act on the heart may conveniently be considered in relation to these four mechanisms.

Disturbances of Rhythm

The drugs which are used in the management of supra-ventricular and ventricular dysrhythmias fall into three groups—digitalis; quinidine and quinidine-like drugs; and beta-adrenergic blocking drugs.

DIGITALIS

The effect of digitalis on heart-rate and rhythm depends mainly on its action in slowing atrioventricular conduction and prolonging the refractory period of the conducting tissues. It also slows the heart rate through vagal stimulation, but this is probably of little clinical importance. The dysrhythmia most responsive to digitalis is atrial fibrillation, where its effect on atrioventricular conduction slows a rapid ventricular rate. Digitalis is also highly effective in atrial flutter by increasing the degree of atrioventricular block. It is surprising how effective digitalis can be in paroxysmal atrial tachycardia. Some recent studies on the mechanism of this dysrhythmia indicate that an abnormal feedback of the electrochemical impulse from ventricle to atrium may be responsible for this dysrhythmia, and possibly digitalis is effective by interfering with this mechanism.

While digitalis is one of the most valuable and potent drugs used in cardiology, its dangers must not be disregarded. Overdosage with digitals may lead to almost any disturbance of rhythm and conduction—from ventricular extrasystoles, the commonest, to atrial tachycardia with atrioventricular block, said to be the most dangerous. The role of potassium depletion in heightening the vulnerability of the heart to digitalis toxicity is now widely recognized, and every care is necessary when potent diuretics are being used along with digitalis. It is sometimes difficult to judge whether a disturbance of rhythm is due to digitalis intoxication, and whether digitalis should be used in its management. The

Coventry and Warwickshire Hospital, Coventry

IAN R. GRAY, M.D., F.R.C.P., Consultant Cardiologist