MISCELLANEA MEDICA

ADVANCE STATEMENTS ABOUT MEDICAL TREATMENT

In April 1995 the British Medical Association published a Code of Practice, *Advance Statements About Medical Treatment*. This was in response to requests for advice from health professionals consulted by patients with, or wishing to make, advance statements about their future medical care. This Code of Practice has been endorsed by the Conference of Royal Colleges and the Royal College of Nursing.

The Code provides advice to health professionals on a range of advance statements. It is concerned not only with clear instructions refusing some or all medical procedures (advance *directives*), but also with statements which reflect an individual's aspirations and preferences, statements of general belief and aspects of life which an individual values, and with statements which name another person who should be consulted, on the individual's behalf, about medical decisions.

The BMA believes that people should have the opportunity to plan for their future care if they so wish. Whilst making decisions in advance may help to ensure that the care they receive is what they would want in the circumstances, there are disadvantages. The way healthy people feel about illness before they have experienced it may be quite different to how they feel when it happens. It is also possible that a badly worded statement may be implemented in circumstances the patient had not foreseen. Health professionals should ensure that patients are aware of the advantages and disadvantages before they decide to make an advance statement.

The legal position

There is currently no legislation covering advance statements but it is now clear, in common law, that competent, informed adults have a legal right to refuse medical procedures in advance and that an unambiguous and informed advance directive (refusal) can be as valid as a contemporaneous decision. Thus, where the refusal addresses the situation which has actually occurred, health professionals may be legally bound to comply with the terms of the advance directive. If doubt exists about what the individual intends, the law supports a presumption in favour of providing clinically appropriate treatment. However, health professionals may be legally liable if they disregard the terms of an advance directive, where this is known to them, is clear and unambiguous and is applicable to the circumstances. Health professionals who follow the terms of a clear advance directive, and exercise due care and attention, would be most unlikely to face prosecution.

Advance statements expressing preferences about treatment decisions or requesting certain treatments are not legally binding. In England and Wales, views expressed by a third party about medical care are also not binding on health professionals. The BMA believes however, that wherever possible, such statements should be taken into account in deciding on the patient's best interests. In all circumstances, a contemporaneous decision by a competent individual overrides previously expressed statements by that person.

Scope of advance statements

Individuals cannot authorise or refuse in advance procedures which they could not authorise or refuse contemporaneously. They cannot authorise unlawful

procedures, such as euthanasia, nor can they insist upon futile or inappropriate treatment. Although not stated in the law, the BMA believes that people should not be able to refuse, in advance, the provision of 'basic care'. This includes the administration of medication or the performance of any procedure which is solely or primarily designed to provide comfort to the patient or alleviate that person's pain, symptoms or distress. Women of childbearing age should consider the fact that an advance statement might be implemented at a time when they are pregnant and should be advised to consider inserting a waiver to cover pregnancy. In the case of young people under the age of majority, advance statements should be taken into account and accomodated if possible but can be overruled by a court or person with parental responsibility.

Provision of information

In order to make informed choices about advance statements patients have a legitimate expectation of being provided with information in an accessible form. Thus health professionals should ensure that the foreseeable options and implications are adequately explained, admit to uncertainty when this is the case, and make reasonable efforts to discover if there is more specialised information available to pass on to the patient. In response to a request for assistance with advance statements, health professionals should ask whether the patient is mentally competent, whether the patient has sufficient knowledge of the medical condition and possible treatment options if there is a known illness, and whether the patient is being coerced into making decisions by other people.

Format of statements

Oral statements are likely to be legally valid if supported by appropriate evidence but there are clear advantages to recording general views and specific refusals in writing. Advance statements are an aid to, rather than a substitute for, open dialogue between patients and health professionals. There are no specific legal requirements concerning the format of advance statements but it is recommended, as a minimum that the following information is included: full name, address, name and address of general practitioner, whether advice was sought from health professionals, a clear statement of wishes or the name, address and telephone number of a person to be consulted, signature and the date the document was written and reviewed. It is recommended that the statement is reviewed on a regular basis and at least every five years. The only minimum requirements for legal validity are that the patient is competent at the time of making the statement, is aware of the implications of the decision and that the circumstances match those in the statement.

Advance Statements About Medical Treatment is available from BMJ Publishing Group, PO Box 295, London WC1H 9TE (tel: 0171 383 6185) and costs £4.95 for BMA members and £5.95 for non-members.

Advance Statements About Future Medical Treatment. A Guide for Patients can be purchased from the Patient's Association, 8 Guilford Street, London WC1N 1DT (tel: 0171 242 346).

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FAMILIAL ASSOCIATIONS OF ATOPIC DISEASES AND THE PREVALENCE OF A CANDIDATE GENE FOR ATOPY IN GRAMPIAN

Atopy is an important risk factor for asthma, hay fever and eczema. The genetic basis of atopy has recently been the subject of much interest and a mutation in the FcεRIβ gene on chromosome 11q has been shown to be associated with atopy in some families, although its significance in the wider population has not been clearly established (Shirakawa T, *et al.*, *Nature Genetics* 1994; **7:** 125–30). We set out to investigate the familial associations of atopic diseases and the prevalence of this mutation in the Grampian population.

Information about the occurrence of atopic disease was obtained, using a questionnaire, from 425 children, and their parents, attending clinics in the accident and emergency department of the Royal Aberdeen Children's Hospital. The children provided mouthwash samples for DNA extraction. Among atopic children 57 per cent had a parental history of atopic diseases and there were highly significant associations between parental atopic disease and atopic disease in their children. The risk of asthma, hay fever and eczema in children increased with the number of atopic parents, suggesting polygenic inheritance. Logistic regression analysis showed a genetic influence on symptom specificity, distinct from general atopic predisposition, with the risk of a child having a particular condition greatest if there was a parental history of the same condition. This effect was predominantly maternal. Notably, only maternal asthma (OR 3·48, 95 per cent CI 1·71–7·10) and not paternal asthma (OR 0·40, 95 per cent CI 0·11–1·37), significantly increased the risk of childhood asthma. Increasing number of siblings had a protective effect on all three atopic diseases but this reached statistical significance only for hay fever in girls (OR 0·61, 95 per cent CI 0·38–0·99). Using a modification of the polymerase chain reaction (the ARMS test) to detect the presence of the FcεRIβ mutation in the DNA extracted from the mouthwashes, the genotype was determined for 332 samples; 331 children were homozygous normal and one child was heterozygous for the mutant allele. Therefore, the prevalence of the mutation was 0·30 per cent, suggesting that, although familial influences on atopic diseases are important, this mutation in the FcεRIβ gene is not important in the aetiology of atopy in Grampian.

CATHERINE M. McDOUGALL

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COLLEGE LITERATURE

The Medical Consultation by David Short, (Mark Allen, Dinton 1995 pp XIII+129 £14.95). In a foreword Lord McColl writes 'this book is important not only for consultants in all specialities, but also for those on the promotion ladder, and especially for those involved in training the doctors of the future'. New technologies, both in treatment and diagnosis, have made the consultation more, not less, important. For although they provide immense benefits for patients collectively, each carries a risk of some adverse effect and, in some cases, great cost. Among other things the consultation does, it enables a physician to decide whether for an individual patient the probable benefit of an investigation or a therapy outweighs the risks and to explain these to the patient. Doctor Short's book is a delight for it is not only full of wisdom but has some good stories.

R.P.

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A History of the Western General Hospital, Edinburgh by Martin Eastwood and Anne Jenkinson (Edinburgh, John Donald, 1995 £15.00 pp 252). The story begins in 1868 with the foundation by the municipality of an additional poor law hospital, the Craigleith Hospital. It continued in this role until 1947 but was renamed the Western General Hospital in 1932. In the First World War it was a military hospital and in the Second part of it was used as a teaching hospital by the Polish medical school. In 1947 largely due to the imagination of Stanley Davidson, professor of medicine at the university, it became a university teaching hospital but in contrast to the Edinburgh Royal Infirmary, a number of specialised units were developed. He recruited, among others, Wilfrid Card (gastroenterology), Dick Turner (cardiology), John Strong (metabolic diseases) and Ted French (general medicine). Each of these four played a major role in establishing the hospital as a centre of excellence. Perhaps significantly they all were recruited from London. The newly organised hospital owed much to the medical superintendent, Sandy Donald, and to the matron, Estelle Adamson, who came from the Nightingale School at St Thomas Hospital. In 1995 the hospital had over 35 special departments and the book gives an account of how each developed and of their present work. The book contains much factual information about past and present times and describes the birth and growth of a great hospital.

R.P.

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WELSBY'S WISDOM NO. 3

'AIDS speak'. The advent of AIDS has modified the English language. From it new words have emerged; there have been articles on 'Condomania' which presumably results from excessive condoning of condoming. Verbs, adverbs or adjectives have lost their distinctive identity and have been transmogrified. We learn that safe sex constitutes both an erotic and an ethic. Attitudes are concretised or pathologised. Never in the history of philology have so many new words been created as by the addition of 'ings' to AIDS-related nouns. We now have 'scapegoating' and 'faghagging', the latter being a word invented to describe the tendency of certain militant women to aggressively defend, almost proselytise, on behalf of, male homosexuals who are perfectly capable of espousing their own views. 'Outing' is the persecution by homosexuals who have come out of homosexuals who wish to keep their homosexual private life private; refusal to join the cause by 'decloseting' themselves is seen as a weakness, not a human right.

New words may prove useful, but how should they be launched into the language? There may be a need for another new word—AIDS 'bandwagoning'. In 1986 the number of lectures given by people who were regarded, by those who attended, as experts on AIDS in a period of one month was greater than the number of AIDS patients in the United Kingdom. This could be described as 'bandwagoning'. Financial AIDS 'bandwagoning' literally capitalises on AIDS as a new disease which is receiving new money. Anyone who requires funds for any project related, no matter how distantly to sex, philosophy or religion now attempts to associate their cause with AIDS and the available new money.

Well established words with long, interesting and possibly relevant track records tend to be neglected. No bandwagoning AIDS moral crusader has yet suggested mass infibulation as a prophylactic measure.

P. D. WELSBY