undertakes bolder and yet bolder proceedings; a complete hysterectomy is probably carried out or some short-circuiting device, or the colon is fixed, or even partially removed, but still the patient is not cured of the pains, whilst the state of the nervous system has steadily worsened.'

Both physicians also recognized the difficulties encountered by their own specialty. Allbutt[2] commented: 'The physician has been at least as much to blame, in that he has contemptuously thrown aside many cases of genuine malady and of genuine suffering as hysteria. Even hysteria is a complaint to be treated and relieved, but the central blunder has been the stupid confusion between the hysteric and the neurotic subject.' Hutchison[5] opined:

> 'Meanwhile, and between the more dramatic entries and exits of the surgeon, the physician has not been idle. The patient has been thoroughly "investigated" - possibly at a "team-work" clinic; she has certainly been provided with an X-ray picture-book of her entire alimentary canal...
>
> In a word, she has run the whole gamut of "modern" therapy, has submitted to every "stunt" and conformed to every fad - but is none the better. And just as she can only escape the attentions of the surgeon when - as Sir Clifford Allbutt said of the gynaecologist - he is "grouse-shooting or salmon-catching or leading the fashion in the Upper Engadine", so she is only at peace from the physician when the latter is recruiting his exhausted energies by a short holiday at an inexpensive seaside resort.'

As regards management of patients with intractable abdominal pain, Hutchison[5] was quite clear: 'In the treatment of the chronic abdomen the most important thing is to catch the patient early. If she has once set her feet on the slippery slope which leads to succesive operations she is undone.' His candour prompted him to say, however: 'I confess, therefore, to some feeling of despair as regards the treatment of the more advanced cases of the chronic abdomen, and on the whole I am inclined to think that the less one has to do with them the better both for one's peace of mind and one's professional reputation'.

Many doctors would doubtless echo these sentiments and, feeling frustrated at their inability to treat such patients effectively, refer them on to another specialist, particularly the psychiatrist, thus further reinforcing the patients' neuroses. The clinician may contain the situation, however, by seeing such patients every few months or so and by listening sympathetically as they describe their symptoms. The adage to be adopted is 'first do no harm' and it should be considered a bonus if the patient's pain actually improves. Such a policy may help patients to come to terms with their affliction and enhance their ability to cope.

Drugs which may be effective include analgesics, anxiolytics, antidepressives, antispasmodics, fibre-containing preparations and hypnotics. A recent report[6] on the efficacy of hypnotherapy over a three month follow-up period in the treatment of patients with severe refractory irritable bowel syndrome offers a ray of hope to patient and doctor alike. The results of long-term follow up and of similar studies in other centres are eagerly awaited.

In his 'Gulstonian lectures on the neuroses of the viscera', Allbutt hoped to stimulate greater interest in the 'brooding and silent life of the organs of vegetative existence'[2]. Quite clearly, this hope has been realized. However, despite extensive research during the past hundred years, we are still a long way from understanding the nature of, or from being able to effectively treat many who suffer from, 'pains and storms of the abdominal regions'[2].

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Motor neuron disease and ethics: a neurologist's point of view

> 'I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous'. *(Hippocratic Oath)*

In a recent discussion paper, J S Carey[1] has argued that explicit ethical judgments are as important a criterion as clinical judgment when considering the treatment of patients with motor neuron disease (MND). His arguments are not convincing, nor does he state how they relate specifically to MND as distinct from other chronic fatal diseases.

There is, firstly, a semantic problem. The meaning of the term 'treatment' is not explicitly given. It is stated and assumed that a 'course of treatment involves both clinical expertise and a well developed ethical position'. Thus it is not surprising that explicit ethical judgments are found to be required. The statement is as general as the following ones: 'a stable marriage involves a well developed ethical position' or 'being a good citizen involves a well developed ethical position' or 'dealing with terrorism involves a well developed ethical position'. It could be argued that most human actions 'involve' a well developed ethical position. The point here is what 'involvement' means and how 'fundamental importance' is defined in relation to this 'involvement'. Involvement, understood as a specific normative-prescriptive set of principles to use with *all* patients, is not acceptable to the physician and is far less important than clinical judgment regarding the treatment of patients. Treatment here is understood as medical treatment of the disease in an individual patient, either symptomatic or aetiological.

Two central concepts and assumptions in Carey's analysis are *prudence* and *hope*. Some of the diffi-

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culties of the ethical analysis become apparent to the physician here. Prudence is the key concept for managing these patients, along with clinical judgment. Insofar as prudence is the correct knowledge about things to be done, it hardly differs from medical expertise in this context. But, we are told, prudence is also an attitude and an intellectual virtue which allows us 'to recognize what is good and what is evil'. It is clear that having defined the right 'attitude' to respond to the challenge of MND as both knowledge *and* a moral virtue, we can only conclude that ethical judgments are of fundamental importance. But the physician will not accept this definition of prudence as an established truth. Prudence as a moral virtue stems from a particular philosophical stance as exemplified by Aristotle[2–4] and Aquinas[5]. Other philosophers take a different view. For Kant, for example, prudence does not belong to morality; it is a pragmatic imperative which commands us to act not absolutely, but as a means to another purpose[6–8]. What the physician is being asked, then, is to accept that, when dealing with his patients, he must either add to or replace his clinical judgment with a particular attitude defined from a particular ethical (and hence metaphysical) standpoint. This standpoint may not be either his own or that of the patient.

Hope is another key concept. Carey tells us that hope is a way to address the transcendent dimensions of humanity, that Gabriel Marcel is 'quite correct' in stating that any physical theory of hope is absurd, but he gives no evidence for or reasons why Marcel is correct. We are further told that we should accept the belief that hope 'is not to dictate the flesh and other physical matter'. The meaning of hope then is charged with a metaphysical-religious tone and, again, it is not surprising that if treatment is to consider hope (understood in this way), then ethical judgments are to become of fundamental importance.

The criticisms levelled at placebo treatment as a 'deception' and at the resignation proposed by neurological colleagues stem partly from this use of the term 'hope', that is with a meaning that has little to do with medical reality. The *Concise Oxford Dictionary* (1976) defines hope as expectation and desire combined, which is much closer to what patients and physicians mean by it. Over the past two years I have seen 48 patients with MND. In not a single case has any patient been heard to use the term 'hope' as a way to 'address the transcendent dimensions of humanity'. Their question, 'Doctor is there any hope?', has a concrete meaning, i.e. is there hope of a cure? Cure for patients means restoring their physical well-being and halting the progression of the disease. It is a fact that often patients who are not given a placebo by the doctor will obtain it from other sources. It is not unusual for them to visit healers, herbalists and others, and dutifully to try whatever is offered as a way of keeping their hope for a cure. Many patients with other chronic neurological diseases, such as multiple sclerosis, do exactly the same.

There is then the ideological or religious hope from which Carey draws arguments to criticize placebo treatment and the concrete hope for health on which the latter is based. Experience shows that dealing purely with the first, that is assuming that it fulfils also the concrete hope for health, is often unsuccessful. The physician deals with hope for health. Priests of whatever denomination and spiritual advisors of whatever ideology may deal with religious and metaphysical hope, provided (1) it corresponds to the patient's own background, be it Christian, Muslim, Buddhist, phenomenological, materialist, existentialist, etc, and (2) is not *paternalistically* imposed from any specific standpoint. I agree, then, with Carey's assertion that a physician must especially refrain from engaging in transcendental meditation. Paraphrasing him, it could be added that those involved in ethics should especially refrain from engaging in factual medical statements at the expense of ethical theory.

The symptomatic treatment, which Carey calls the 'rational treatment plan', is well known and used by those who deal with these patients regularly. The assessment of its value and indications as well as the need for a placebo, in addition to 'spiritual counselling', are a matter for medical expertise – for prudence devoid of absolute moral connotations. The decision to prolong life at a particular point when the disease is advanced may not need an explicit ethical position either, but rather a proper previous assessment of the individual case including, if appropriate, a discussion with the patient and/or relations of this eventuality.

My conclusion, then, is that clinical judgment is indeed paramount in the treatment of MND, first because the diagnosis depends upon clinical knowledge; secondly, because symptomatic treatment depends upon clinical knowledge; thirdly, because a decision on whether or not to support prolongation of life depends upon an informed assessment of chances of medium-term survival; and fourthly, because the decision on how much to tell a patient, and when, rests not on abstract ethical principles which vary according to the philosophical stance from which they are proposed, but on a very concrete assessment of the individual patient, including his medical background, his hopes, his beliefs, his personality and his fortitude. No previous assumptions of what is good and what is evil are acceptable, but only what benefits the individual patient. No general ethical stance will ever cover what he needs. Finally, when eventually the means of stopping the progression of the disease are discovered, the question about 'telling the truth' may well become obsolete.

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