Rasaiah might like to look at the paper by Evans and colleagues[1] on the elderly and resource use. They report a dramatic increase in hospital use among the elderly. In discussing the implications of this Evans and colleagues make the point that "the extension of the reach of technology and the changing attitudes of providers can easily lead to serious confusion between 'doing the best possible' for a patient and 'doing everything possible'."

I hope that Rasaiah accepts the importance of this point. Care that has limited or no benefit is not good care. I know Rasaiah and the hospice movement are aware of this. Alas, not all care for the elderly is provided by the hospice movement.

I am surprised that Rasaiah appears to be unaware of the issue of child poverty and the significant impact of early childhood on subsequent development and adult health. I suggest that he read *Within Our Reach: Breaking the Cycle of Disadvantage*.[2] There are interventions that work for children being brought up in poor circumstances. Special preschool support in early life for women from a poor social environment has led to a reduction in the rate of teenage pregnancy by more than 40%; this is an outcome of benefit to all of society.

In a country that has limited resources and is in serious economic difficulty we have to select priorities. I stand by my response to Dr. Wilson: "Those caring for all of us as we approach the end of life have a difficult and important task to avoid directing excess resources to the end of life rather than the beginning of life and child development." I did not say "wasting dollars on dying seniors." My goal is the appropriate use and allocation of resources.

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2. Schorr LB, Schorr D: *Within Our Reach: Breaking the Cycle of Disadvantage*, Doubleday, New York, 1988

Jehovah's Witnesses and the transfusion debate: "We are not asking for the right to die"

In this article (*Can Med Assoc J* 1991; 144: 770-776) Bill Trent notes that Mr. Justice Sydney Robins wrote in his decision: "The principles of self-determination and individual autonomy compel the conclusion that the patient may reject blood transfusions even if harmful consequences may result." Autonomy, so highly valued in modern society, implies that we take into account freedom from coercion. According to Haworth[1] a truly autonomous person has the ability to evaluate opinions and options and to choose what is best for him or her. When patients are not free (e.g., prison inmates and mentally ill patients committed to a psychiatric facility) the courts and civil libertarians have clearly indicated that treatment choices must be free of coercion or threat.

Was Georgette Malette really making a free decision when she signed the card that prohibited blood transfusions? We know that Jehovah's Witnesses who do not abide by the teachings are "disfellowshipped" — that is, treated as pariahs by friends and even close relatives. The Jehovah's Witnesses ensure that those who stray are guaranteed hell on earth. Therefore, in signing the card the patient did not make a free and autonomous decision. But as it turned out Georgette Malette now enjoys the best possible outcome: she survived because of the skilful work of the physicians and surgeons who treated her, she is not rejected by her coreligionists, and she has a monetary award.

As for the case of the 12-year-old child who was allowed to die, in my view the court was guilty of criminal neglect in judging that a person of this age can make an autonomous decision.

I cannot understand how Mr. Justice David Marshall can say: "Twenty years ago patients really thought they had to do what their doctors told them to do but the law of consent has turned that right upside down, so that now physicians can't do anything to them without their consent." When I was in medical school, 35 years ago, we were taught clearly that we cannot do anything to patients without their implied or explicit consent. Patients could always accept or reject what their physicians recommended, and physicians had no coercive methods for ensuring compliance.

It is ironic that when physicians had the least to offer in the way of treatment patients understood the nature of the fiduciary patient-physician relationship, whereas today, when treatments are so often effective, patients put themselves in a competitive or adversarial relationship with physicians.

Marshall is right on one point: "People don't have faith in anybody." Are they any the better for it?

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Reference

1. Haworth L: *Autonomy, an Essay in Philosophical Psychology and Ethics*, Yale U Pr, New Haven, Conn, 1986

To drag an honest physician through the courts under the circumstances described in this arti-