

Perhaps, as del Pozo points out, we should be inspired to ethically evaluate and debate paid blood donation, if only as part of an attempt to prevent shortages of blood occurring.

Up until the present, ethical discussion has generally been lacking on many issues confronting blood banking and transfusion medicine. This is no less important at a time when the majority of the world is promoting and holding up the non-remunerated donor as the only safe blood donor (7). The article by del Pozo will serve as a point of departure for the many ethical debates that are yet to come, and should come, in this and related areas in transfusion medicine.

References

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Drug trial ethics

SIR
 I would be grateful for the views of your readers about the ethics of

open-continuation studies after the double-blind, placebo-controlled phase of a drug trial. The ethical committee at my hospital take the view that continuation studies are never justified because they give little scientific information and any humanitarian benefit is out-weighted by the danger of giving a drug with unknown efficacy.

I have always taken the view that ethical decisions are rarely absolute but depend on balancing relative values. Even taking a life may be justified if by so doing one saves more lives (when, for example, a terrorist is about to blow up an aircraft). I would suggest that the same principle applies to continuation studies. If the treatment under study is for a self-limited condition like eczema, where there are recognised and effective remedies available, it would seem incontrovertible that a continuation study before analysis of the outcome of the double-blind phase was of doubtful value. If, however, the disease is progressive, ultimately lethal, treatments are more likely to be effective in the early phase, and there are no known effective remedies available, I would suggest that giving all participants of the double-blind phase a chance to try the 'active' medication was essential, and to deny them this opportunity was itself unethical.

Clearly another factor to weigh in the balance is the risk of side-effects, a drug with serious side-effects requiring more evidence of efficacy than one without.

The issue has arisen over a proposal to allow subjects with Alzheimer's disease who have completed a 12-week double-blind phase to go on ondansetron in a dose far below that given for nausea and for which the risk of side-effects must be very small.

One agrees that this phase is essentially for humanitarian reasons although it would allow one to examine the important issue of whether the drug slows the progression of the disease, in which case those on the double-blind active wing would always remain ahead of those starting later, or whether it only causes a functional improvement, the later starters catching up with the others.

The statistical power of a study is increased by delaying the analysis until data collection is complete but the time this takes makes it likely that the first participants in the study would have deteriorated too far to benefit when the final results were through.

My patients and their relatives are alarmed at the prospect that they may be prevented from trying this treatment through an ethical decision which to my biased mind is decidedly unethical.

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In defence of ageism

SIR
 Dr Shaw's article (1) contains flawed arguments and contradictions. One of his principal contentions is that as age is objective it should be used a criterion for rationing as to do so negates the necessity for making subjective value judgements. Dr Shaw writes: 'age is an objective factor in rationing decisions', implying that it is right that it should be. He further writes: 'Health care should be preferentially allocated to younger patients'. However, later in his article Dr Shaw writes, referring to the Bradford Coronary Care Unit Model which he says should be copied, 'The care is targeted on younger patients but none are denied treatment where need arises and benefit is substantial.' This seems to me to show that Dr Shaw does not believe in ageism. If he did, he would not advocate the treatment of *any* elderly patients once they had reached the cut-off age that had been decided on. Surely the whole point of an ageist policy was that after a certain age had been reached the patient would not receive treatment whatever the benefit. (Note that Dr Shaw refers to treatment, as opposed to care, as he makes the point that treatment is given if the ensuing 'benefit would be substantial'. This is an important point because Dr Shaw cannot claim that all he is suggesting is that patients of all ages should be given care, which is different from saying all patients should be given treatment.)

Dr Shaw makes other assertions that should not be accepted on face value. He assumes that the elderly would willingly give up their lives in favour of the young. He gives the example of the grandmother who would want the lifebelt to be thrown to her granddaughter before herself.

Emotional ties may mean that that is the case, *but the crucial test would be to find out the view of the grandmother if she did not know the young woman or girl*. Professor Evans gives evidence of research that shows that elderly people value their lives more highly than both their doctors, and the young, think they do (2).

There are flaws in some of Dr Shaw's other arguments. On page 188 he writes: 'Health care must be distributed in a way that achieves maximum benefit'. This is a surprising statement for a practising physician to make. If doctors decided treatment only on the basis of maximum benefit there would be some very strange decisions made. Those with a poor prognosis, or with an illness that may be expensive to treat would not be treated (as opposed to cared for).

On page 189 Dr Shaw writes: 'Health care is a precious commodity in short supply. It must be used efficiently'. Here he is implying that to treat the elderly would be to use scarce funds inefficiently. However, in 'Age as a criterion for rationing' (3), an article that Dr Shaw quotes from, the author writes: 'Contrary to conventional wisdom, the savings will be small if we eliminate intensive, high-technology care for the aged. ... For substantial savings we must withhold routine medical care from the elderly'. But as we have seen, Dr Shaw is not suggesting that the elderly should be denied routine treatment, or even more expensive treatment such as aortic valve operations if the benefits to the patient would be 'substantial'. If, as it seems, Dr Shaw is only advocating that the elderly should not be given *very expensive high-tech treatment*, then it is not a policy of ageism that Dr Shaw is recommending, it is something very different. Whether anyone, young or old, should be given treatment that uses up large amounts

of finite resources is a different debate and not the point at issue.

We are living in a society with an increasing elderly population. There will undoubtedly be pressures to discriminate against the old in terms of the use of scarce resources. Dr Shaw does not satisfactorily explain why we should discriminate in this way. An ageist policy, far from being fair, would be both very unfair and discriminatory.

References

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Lifestyles and allocation of health care resources

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Calman's overview of the ethics of allocating resources for health care (1) illustrates well the difficulty of overview. One of his central issues is 'the basing of decisions on the outcomes of health care and on their subsequent economic evaluation' but this is incompatible with his description of the General Medical Council's ruling that 'all patients should be treated

equally, regardless of lifestyle'. The second statement muddies the first: is the cost-benefit of liver transplantation to include the transplanting of scarce donor livers into alcoholics who will not give up alcohol?

Most people's sense of justice would argue that unreformed alcoholics should not be given liver transplants, whatever the ethical inequity. Calman rightly stated that those who supported the physicians in the debate about smoking and heart surgery, which includes myself (2), did so because of considerations of outcome. If outcome is measured with no consideration of pre-existing factors, this might be more fair to the smokers, but is less fair to non-smokers because it increases the overall cost and decreases the overall benefit of the procedure.

Lifestyles must be important in the allocation of health care resources whatever consensus bodies - who are more ruled by political expediency than logic - might say. The only question is which lifestyles: 'If we want the right to society's resources we have a duty to respect them and must be prepared sometimes to have resources refused if we ignore those duties' (2).

References

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