

Medical management of terminal illness

A statement of the Committee on Ethical Issues in Medicine of the Royal College of Physicians

The central function of the Royal College of Physicians and other Medical Royal Colleges and their faculties is to maintain and enhance standards of practice in the interests of patients. Recommendations tend to be on general matters of principle, and not on the conduct of individual physicians; the Colleges have no investigative machinery, and in matters of discipline they have no sanction other than removal of diplomas, in which they generally follow the lead of the statutory authority, the General Medical Council.

The Royal College of Physicians speaks with some authority on the pragmatic and ethical aspects of the practice of physicians. But it has no similar authority in defining what is *legal*; what is *acceptable to society*; and what is *morally right*. Also, there would on these matters be wide divergencies of opinion among Members and Fellows of the College.

In the context of terminal illness, doctors have a number of duties which may at times be in conflict. These include the preservation of life; the relief of suffering; obedience to the law as it stands; and a general conformity to accepted ethical standards. Perhaps none of these duties is absolute, in the sense that it overrides all other considerations, including other duties with which it may conflict. Some formulations of the Judaeo-Christian tradition come close to making 'sanctity of life' an absolute obligation; but in general these allow, though in no way commend, the right of a state to inflict capital punishment, or to make war—and it is relevant to later discussion to note that in war doctors are not normally combatants, and that they should not participate in the infliction of capital punishment [1].

Doctors as a rule do not spend their days contemplating whether they are breaking the law or even offending against the ethical canons of society. They work within a professional code of conduct in which the preservation of life is an assumed rather than a stated objective. But when all the evidence suggests that life is nearing its close, and especially when there is great physical or mental suffering, a real dilemma arises relating to the conflict between prolonging life, perhaps with a very remote hope of a turn in events towards recovery, and giving analgesic or sedative

medicines in amounts which, while relieving distress, may also shorten what remains of life.

For a doctor in this situation it is a real help to know the patient's own wishes, preferably those declared beforehand while still in health rather than those expressed in the anxiety of mortal illness, and perhaps influenced by the various solitudes of relatives. It is, however, possible for attitudes to change with time, or for the circumstances of the illness itself to cast doubt on previous declarations—so the doctor (who, like the patient, has some right to autonomy) should not be mandated to a specific policy. Also, the doctor is expected to act within the prevailing legal and societal framework.

There is considerable evidence that the attitude of society is moving away from trust in professional people, including doctors, towards greater emphasis on individual autonomy. (To give a related example, suicide is no longer a crime, even if furthering it remains so.) The sharpness of doctrinal condemnation of measures which may shorten life is partially blunted by the distinction between 'ordinary and extraordinary means', and the concept of 'double effect' [2]. While the law in this country condemns and penalises any act whose sole and deliberate intent is to shorten life, in its practice it does not prosecute the withholding of life-prolonging measures which are 'futile' in the clinical context, including the withdrawal of sustenance from a patient in a well certified 'persistent vegetative state'. Many ethicists do not accept a distinction between 'active' and 'passive' euthanasia; but many doctors would be glad to be less than logical, in the company of theologians and lawyers.

While active euthanasia remains illegal in the Netherlands, it is widely condoned and practised; the ethical aspects have been discussed by Habgood from a religious perspective [3]. The general question whether in this country there should be any weakening of the constraints on the purposed shortening of life is one primarily for discussion within society, followed by legal determination, though doctors are interested in it as citizens, no doubt with divergent views. But in their medical role, doctors must be concerned about their participation in active euthanasia. They should have the right to act in accordance with their own conscience, but with due awareness of how the law stands at present. The widespread practice of euthanasia would have an adverse effect on the public perception of doctors and of their role within society.

Prepared by:
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References

- 1 Report of a working party of the British Medical Association. *Medicine betrayed: the participation of doctors in human rights abuse*. London: BMA, 1992.
- 2 Gillon R. *Philosophical medical ethics*. Chichester: John Wiley & Sons, 1986.
- 3 Habgood J. The end of life in medical practice. *J R Coll Physicians Lond* 1993;27:133-4.

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