

Medical treatment at the end of life

A POSITION STATEMENT

In 1998 the Royal College of General Practitioners and the Royal College of Physicians* established a joint working group on euthanasia, with the following remit:

- To identify to the Royal College of General Practitioners and the Royal College of Physicians the kinds of conduct which constitute euthanasia and to advise how far they could be justified on moral grounds
- To describe and evaluate the current situation and consider the implications of change
- To advise on the part the health professions should play in public debate and policy making.

These terms of reference focussed on relevant issues concerning euthanasia for both Colleges at the time the working group was established. However, our discussions became increasingly influenced by public and professional concerns about, on the one hand, the unnecessary continuation of treatment and, on the other, a too ready dismissal of possible life saving measures in vulnerable patients. With the agreement of both Colleges the working group resolved that a clarification of definitions, and a considered statement on the wider topic of treatment at the end of life, would be a more useful approach.

The membership of the working group is appended; in addition, some members of the group formed a smaller sub-group with a specific remit – to examine definitions and terms used, and to assess current prevalence.

The working party reviewed existing literature and received comments from a variety of sources. It did not take formal evidence, as it considered that the bulk of public and professional opinion on this subject is available and widely known.

Definitions and terms

We considered current definitions of euthanasia. We recognise that the original meaning of the term, derived from Greek, has been lost. The concept of a good or easy (*eu*) death (*thanatos*) has been replaced by one that describes a deliberate action by one individual, usually, but not necessarily, a doctor, to bring about the death of another.

For the purpose of this statement only, the definition of euthanasia that we adopt is: the active, intentional, ending of the life of a competent patient, by a doctor, at that patient's request.

This also describes 'voluntary euthanasia', a term in wide usage. However, while the definition adopted by the working group is unambiguous, it is clear that a wider range of definitions exists in the minds of both the public and health professionals. New reports tend to produce new definitions. Commentators often stretch the term to include acts they believe to be morally equivalent to euthanasia, even if they are clinically distinct.

We believe that the terms 'non-voluntary', 'passive' and 'involuntary' euthanasia are confusing, and should be abandoned. They are outside the scope of this report. 'Passive euthanasia' has sometimes been used to describe the death of a patient as a consequence of a treatment withheld or withdrawn. An intention to withhold or withdraw burdensome or futile treatment is not an intention to kill, and death by natural causes is not death by the action of a doctor. To describe such actions as euthanasia is therefore misleading.

The issues

Within the current debate on euthanasia, therefore, it is vital that distinctions are drawn between:

- Acts where there is a clear intention to end life
- Acts that are predominantly therapeutic, with a foreseen but unintended consequence that life may be shortened; these therapeutic acts are mistakenly perceived by some to be synonymous with the intentional ending of life.

A major concern for doctors is the foreseen but unintended consequence of treatment given at the end of life to alleviate suffering. This is well

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illustrated in the use of morphine in dying patients. Many other drugs have potentially life-threatening side effects. The principles governing the use of morphine are identical to those justifying any other form of therapy. The risk of serious adverse effects must always be weighed against the potential benefit of good pain relief in each individual, as must the more general assessment of the overall burdens or benefits of treatment. Correctly used, morphine and other opioid analgesics are very safe, and allow doctors to relieve suffering without shortening life. The recent RCP document on the use of opiates in palliative care, referred to later, develops these issues further.

There is increasing debate about clinical decisions involving the withholding or withdrawal of treatment. The BMA's document, 'Withholding and withdrawing life-prolonging medical treatment'¹, sets out a framework for decision-making in circumstances where the provision of life supporting treatment might be withheld or withdrawn on the basis that it is of no continuing benefit to the patient. The guidelines draw on the current state of the law regarding persistent vegetative state, as originally laid down in speeches in the judgement in the case of Tony Bland². These defined artificial nutrition and hydration as part of medical treatment. It is disagreement with this definition, combined with the absolute certainty that the withdrawal of artificial nutrition and hydration will hasten death, that leads some commentators to see the guidelines as promoting euthanasia.

It is clear that the intention behind a therapeutic decision, in contrast to its foreseen outcome, is a central issue for further debate within the profession and within society. In order to be constructive, this debate must be based on agreed and precise terminology, as there is a tendency in discussions about end of life issues generally for the language and terminology to lack precision.

In addition, we commend the emphasis on team-based decision making, and the need for developing consensus between the healthcare team, the patient, and the patient's family. These principles apply in all areas of end of life care. We also stress the importance of respecting both the autonomous wishes of the patient, including those expressed through competent advanced statements, and the status in common law of advance refusals of treatment. It is also fundamental to good practice that doctors recognise their continuing responsibility, in such areas as palliation and basic nursing care, following a decision to withhold or withdraw. Effective palliative care following the withdrawal of artificial nutrition and hydration will eliminate any distress in patients during the terminal phase of their illness. In particular, it is important to emphasise that the withdrawal of nutrition and hydration from patients will not cause additional suffering if proper attention is paid to palliation.

We recognise that the debate around euthanasia is shaped by two major, and increasingly articulated, factors:

- that patients' wishes regarding their treatment at the end of life will be respected.
- the increasing potential for the maintenance of life in

circumstances where previously death would have naturally supervened.

We believe that these factors are creating significant changes in attitudes within society. However, it is also important to stress that recognising a patient's autonomy is not synonymous with agreeing to undertake an action that is illegal. The consequence of such a change in practice would fundamentally alter the role of the physician. In addition, we believe that a wider provision of good palliative care would satisfy many patients' expectations that compassionate care, and good pain relief, will be available at the appropriate time in their illness. We are concerned that by continuing to argue for the option of euthanasia we may, as a society, give insufficient priority to the development of effective and accessible palliative care.

While there is a widespread belief that voluntary euthanasia occurs in the UK, its prevalence is a matter of conjecture. The procedure's illegality makes reliable information impossible to obtain. In addition to the problems of definition, surveys of opinion, both of health professionals and patient groups, tend to be difficult to analyse due to the ambiguous nature of the questions used. Many claim to show both widespread and increasing support for the legalisation of euthanasia. The fact that the questions emphasise patient choice in situations of intolerable pain and incurable, progressive disease may lead to such a result. In addition, the lack of uniformity of polling questions, and of those to whom the questions are addressed, leads to considerable difficulty in comparison.

While acknowledging the strength of public concern and debate, we have not been convinced that there is a strong and informed support for active euthanasia as we define it here. We believe that the way in which many surveys are presented tend to obscure the fact that the primary concerns of patients centre on two aspects of care. The first is that doctors will not unnecessarily prolong life when it is clear that there is no benefit in continuing treatment. The second is that palliative care will be both available and effective in relieving pain and distress.

Our main conclusion is that, with the best clinical practice in place, situations where any arguments for euthanasia as we describe them here could possibly be justified are rare indeed. On balance there is, therefore, no current reason for abandoning the profession's established view that acts motivated by a clear intention to end a patient's life cannot be justified on ethical grounds. In all cases, the intention behind any treatment decision must be to act in the best interests of the patient. We believe that the existing ethical and legal framework, in which appropriate treatment decisions can be made in the interests of patients, even where the foreseeable consequence of such actions may be the earlier death of the patient, should continue to be accepted. In opposing active euthanasia, we support the current legal position that a doctor ought not to carry out any act that has as its primary intention the death of a patient.

Palliative care

The working group considered carefully the issue of pain relief in terminal care. It recognised that confusion in the minds of doctors and changing attitudes within society regarding the intention behind the provision of palliation has led to some shortcomings in care. It also recognised that clearer guidelines on the use of opioids in palliation would be valuable, as these would assure doctors that their clinical decisions represent good practice. The Royal College of Physicians has therefore prepared advice *separately* on this issue.³

Conclusions

1. We do not support legislative change to legalise acts where there is a clear intention to end the life of a patient.
2. Similarly, we do not support any change in the law on assisting suicide, but accept that there is a wider professional and lay view on this topic that requires continuing review.
3. Both our Colleges have endorsed, and support, the fundamental principles that underlie the document 'Withholding and withdrawing life-prolonging medical treatment' (BMA, 1999).
These include:
 - a careful clinical assessment of the benefits of treatment, made over a period of time that is sufficient to reach a reliable prognosis, and
 - a clear distinction between foreseeing that the outcome of a clinical decision may be the early death of a patient, and intending to produce such an outcome.
4. We believe that the existing ethical and legal framework, in which appropriate treatment decisions can be made in the

interests of patients, even where the foreseeable consequence of such actions may be the earlier death of the patient, should continue to be accepted.

References

- 1 British Medical Association. *Withholding and withdrawing life-prolonging medical treatment: guidance for decision making*. London: BMJ Books, 1999.
- 2 Airedale NHS Trust vs Bland. House of Lords judgement, 1993.
- 3 Royal College of Physicians. Principles of pain control in palliative care for adults. *J R Coll Physicians Lond* 2000;**34**:350–352. (Also available as a laminated guide for use on the wards).

Members of the working group

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