Not the last word on euthanasia

Some doctors in Britain have been accused of prolonging patients' lives unnecessarily, while others have faced the charge that they have terminated life inappropriately or illegally.¹ Societies such as our own with few common attitudes or traditional responses to death are showing more interest in active intervention when dying is prolonged or painful. This increased interest is often presumed to be based on a "humanistic" perspective, and yet a current survey in Camberwell among bereaved relatives seems to be showing lack of "spiritual" care at the time of the patient's death to be a common concern. Against this background the annual representative meeting of the BMA called in 1986 for a reconsideration of its policy on euthanasia, and the working party established published its report last week.² The recommendations of the report are published on p 1376, and an account of the council debate on the report appears on p 1408.

In 16 months the working party has done well to reach a consensus statement of such detail. The report distinguishes between "an active intervention by a doctor to terminate life, and a decision not to prolong life." While underlining the importance of being able to decide not to treat, the report firmly indicates that active intervention should remain illegal and should not be imposed on doctors whatever patients may choose. Particular emphasis is laid on improving communication with the dying, but active intervention is seen as incompatible with good terminal care, which works to affirm the worth of the life remaining to the patient as well as to relieve suffering. The deliberate taking of life should remain a criminal act, and a doctor who did intervene on the dictate of his conscience should be prepared to face close examination of his actions in law.

The consensus of the report is welcome but has been achieved at a cost. Referencing is disappointing (one publication of ours is misquoted and not referenced at all³), and a list has not been included of those who gave evidence and how the evidence was gathered. These are minor quibbles, however, beside the more disturbing feature of the report, which is that it reads as if it has been written by people who had already made up their minds before gathering evidence. This may well be unfair to the process but is unfortunate when the report was needed not simply to guide doctors but also to inform and reassure an anxious public. Although most doctors would not argue with its conclusions, many will be dissatisfied with the reasoning that leads to them. Emotive subjects like euthanasia require more objective handling than is seen here. The time honoured ordering of examination and diagnosis before prescription still has its place.

Doctors are given a framework by society within which they must work, but when alone with patients they are often privy to ideas and concerns that are publicly unacceptable but which need to be shared. Whether the patient feels able to discuss these depends partly on a relationship of trust but also on how the patient thinks the ideas will be received. As with information about incontinence or suicidal thoughts, the prevalence of desires for an active termination of life will never clearly emerge unless it is sought. The report rightly points out that the moral worth of an argument cannot be judged by the numbers of those who subscribe to it, and so questionnaires may have a limited value. But that argument can work both ways: if doctors were to be out of step with the population (no evidence is offered in the report either way) they could not plead their own majority opinion as having

any more weight than their arguments warranted. The minority in both cases must have a fair hearing.

The commitment of doctors to respect for life is not in doubt, but the nub of the problem appears to lie in who should make decisions about dying. Ideally modern health care is seen as a shared process, a partnership between the professional, who is the expert on medical matters, and the patient, who is the expert on what he or she wants.^{4,5} The complexity of the decisions to be taken in the personal sphere may greatly outweigh that in the professional, and the approach of death would seem to be a time when the wishes of the patient should be paramount. Most patients reconcile themselves to the timetable imposed by nature, as modified by medical treatment; but when someone has decided that he or she wishes to die we are not entitled to jump to the conclusion, as does the report, that such "expressed wishes . . . make doctors wonder about the patient's competence as a decision maker." This may need to be established, but equally there are indications here for further exploration of the problems or the solutions proposed and for an attempt at seeing things from the patient's point of view.⁶ Loss of control or dignity may be a worse option than death. There may be opportunities for personal growth and progress even in the last moments of life, but if the patients do not see them—despite time or careful counselling—this choice is theirs.

It is at this point that both theory and clinical practice become confused. Any policy which challenges the law and appears to offer more active medical intervention may seem like the thin end of a wedge, awkward in practice and nasty in a time of restricted resources. Decisions not to treat may seem attractively different from any quietus, yet the neat distinctions between acts and omissions on which this depends disappear embarrassingly under close and careful scrutiny.⁷ Intentions are as important in morality as in law, and both the principle of double effect and the distinction between ordinary and extraordinary means deserved a mention in this report—even if they prove currently inadequate for our purposes.⁸ Ultimately both future policy and individual decision must rest on a careful balancing of principles where respect for life is weighed with autonomy in a just system that maximises individual welfare but avoids personal and societal harm. The results should be tested against difficult examples.⁹

A change in the law on euthanasia would not do much to help, until or unless we can all be much clearer about what we do and why. This comprehensive report is not the first word and will not be the last.

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2 Working party to review the British Medical Association's guidance on euthanasia. *The euthanasia report*. London: BMA, 1988.

3 Higgs R. Cutting the thread and pulling the wool: a request for euthanasia in general practice. *J Med Ethics* 1983;9:219-26.

4 Kennedy I. A survey of the year 1: the doctor-patient relationship. In: Byrne P, ed. *Rights and wrongs in medicine*. London: King Edward's Hospital Fund for London, 1986.

5 Tuckett D, Boulton M, Olson C, Williams A. *Meetings between experts: an approach to sharing ideas in medical consultations*. London: Tavistock, 1985.

6 Campbell A, Higgs R. *In that case*. London: Darton, Longman and Todd, 1982.

7 Rachels J. Active and passive euthanasia. *N Engl J Med* 1975;292:78-80.

8 Gillon R. *Philosophical medical ethics*. Chichester: Wiley, 1985:133-47.

9 Higgs R, Livesley B, Rennie J, and relatives. Earning his heroin but seeking release while the surgeon advises amputation. *J Med Ethics* 1987;13:43-8.