Euthanasia: the institutional response

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For health institutions, euthanasia represents an increasingly complex but increasingly inescapable debate, in which the expectations of health professionals have moved away from the declaratory answer in search of greater sophistication and clarity. The House of Lords' Committee on Medical Ethics drew attention to the unavoidable complexity of future medical decisions at the end of life, the inexorably changing doctor-patient relationship and the demographic shift resulting in greater numbers surviving longer to face chronic, degenerative conditions. The committee proved a watershed in many respects, not least in the moral debate it triggered in the public and among health professionals. Arguably it aired questions which still have not been conclusively answered. Its questioning mirrored the trend observable among the institutions' membership for rigour and detail to justify the positions adopted. It represents one facet of the pressure on health institutions, whose previous mode of dealing with the euthanasia debate was by declaration and some would say by pontification. Their reticence to probe deeper was undoubtedly based partly on the conviction that detailed debate about euthanasia was an anathema within professional groups committed to the traditional life-preserving goal of medicine. Also influential has been the assumption that it would be otiose for professional bodies to issue guidance on matters unambiguously covered by law. Arguably, both of these views should have been challenged if not dispelled by the effort involved in contributing evidence to the House of Lords' Committee. That exercise exposed the need for guidance and the ambiguities at law but it remains to be seen how the debate will be taken forward, or not, by health institutions.

Awareness of evolving practices in The Netherlands and a string of English legal cases, from Bodkin Adams (1957) to Leonard Arthur (1981) and Nigel Cox (1992), have kept euthanasia at the forefront of British medico-legal debate. There have been calls for Parliament or a Royal Commission\(^1\) to review the law and attempts made to introduce Bills\(^2\) to amend it. Euthanasia is guaranteed to provide polemic at medical ethics' conferences and students' debates. Surveys reporting trends in the opinions of the public at large or health professionals in particular constitute a recurring feature in professional journals. Nevertheless there is confusion. Patients' legitimate right to decline life-sustaining treatment is still sometimes conflated with euthanasia, including by some members of Parliament\(^3\). Most discussion about euthanasia, however, defines it as
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A voluntarily and persistently requested active medical intervention whose principal intention is to end life. This is the meaning attached to euthanasia here, although it should also be noted that the potential for progression from voluntary to involuntary and non-voluntary euthanasia forms a persistent undercurrent of much recent debate.

Analysis of the ‘institutional response’ to the debate depends partly on the inclusiveness or exclusiveness of the term ‘institutional’. A variety of official and quasi-official organisations are potentially eligible. My remit is to focus primarily on the regulatory bodies which govern medicine and nursing and the associations which represent health professionals nationally and internationally. To lend context to the substance of their views, however, brief reference is also made to the published comments of some institutions with less singular responsibilities, such as the House of Lords, the Church of England and the Department of Health. In addition, much of the detailed commentary on euthanasia has come from groups which fall outside the common perception of the category of ‘institutions’ but whose publications deserve mention not least because their views are, in some cases, as likely to be influential as those of the professional bodies.

Despite the apparently widespread tide of interest in euthanasia and abundance of material from non-official sources, the response of medical and nursing institutions has seemed, until recently, conspicuous by its absence. Indeed, the statutory body for nurses (the UKCC) has said that ‘the need for debate and serious consideration of these issues has been stifled and obstructed by concealment and a lack of candour’. An exception to the general institutional taciturnity was a report by a British Medical Association (BMA) working party in the late 1980s, which after examining some of the main arguments, supported retention of the criminal penalty for euthanasia. The report attracted criticism at the time for its paternalistic tone and alleged equivocal handling of complex points but it represented an attempt to initiate institutional debate. That apart, the lacuna evident until recently in the publications of British institutions has reflected a similar omission in those of international bodies. The 1994 draft Bioethics Convention of the Council of Europe, for example, while giving considerable attention to most other aspects of medical duties and patient rights—(to the extent of commenting on how discarded human hair and fingernails could be sold without affronting human dignity)—contains no explicit reference to the intentional termination of human life.

Nor is evidence of the relatively thin institutional comment on euthanasia restricted to Britain or Europe. The bulletin of the French Medical Association (Ordre des Medecins) published a survey in March 1994, indicating how few articles were available in the medical literature internationally before 1974. It noted an increase in interest resulting in 24 polls of medical practice and opinion in eight countries between 1980
and 1993. None of the quoted articles or surveys conducted in those 13 years, however, appears to emanate from a professional body. They were primarily conducted by medical journals, academic centres or branches of the Voluntary Euthanasia Society.

Even when institutional comments on euthanasia have been available, these have traditionally taken the form of position statements and declarations rather than dialectic or moral discourse. A brief, two-sentence statement categorising euthanasia as unethical was published in 1987 by the World Medical Association (WMA), but provided no supporting reasons for that stance. Similarly, in 1992, the WMA condemned physician-assisted suicide as unethical. In the same year, the Royal College of Nursing published a position statement, declaring ‘the practice of euthanasia is contrary to the public interest and to medical and nursing ethical principles as well as to natural and civil rights’. This may be seen as typifying the traditional declaratory, rather than explanatory, approach of health bodies.

The fact that in Britain there is now a recent collection of institutional views on euthanasia is due primarily to that most venerable and archetypal British institution, the House of Lords. Members of the Lords, sitting as ultimate appellate court in the 1993 Bland case, were obliged to confront a number of philosophical as well as legal concepts, including the distinction between killing and letting die. The case turned on whether withdrawal of nutrition from an incapacitated individual, inevitably resulting in his death, constituted a lawful act. The Lords decided that withdrawal of artificial feeding would be an omission, a failure to act, a ‘letting die’, but would not constitute the offence of homicide. Lord Browne-Wilkinson, however, summed up an apparent anomaly germane to the case:

> How can it be lawful to allow a patient to die slowly, although painlessly over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection?10

Although the Lords agreed that this was indeed the current legal position, the perplexity inherent in Browne-Wilkinson’s question hung in the air to haunt the subsequently established House of Lords’ Select Committee on Medical Ethics.

In the spring of 1993, this committee called for individual and organisational views on care and treatment at the end of life, eliciting among the responses a profusion of comments from bodies representing health professionals. Among those who responded were the statutory body for nurses, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), the Conference of Medical Royal Colleges, the Department of Health, the multi-disciplinary...
National Council for Hospice and Specialist Palliative Care and three professional associations: the British Medical Association (BMA), Royal College of Nursing (RCN) and Association for Palliative Medicine. They were invited to submit commentary on the ethical, legal and clinical implications of patients' refusal of life-prolonging treatment and the possible circumstances in which actions designed to shorten a patient's life might be justified.

Questions circulated in advance by the Lords' committee centred on the principal moral and legal issues which had exercised philosophers and lawyers as well as their lordships in the Bland case. Most of these issues, however, were not matters health bodies had previously explored in print. They included consideration of the sometimes conflicting moral principles of personal autonomy and the sanctity of life, the distinction between withholding medical treatment and a deliberate medical intervention to end life and the different considerations arising for mentally competent and incompetent individuals. The written and oral evidence produced in response and published by the House of Lords in 1994 provides the most comprehensive summary of the current views of the main UK health bodies on euthanasia and related issues.

Nevertheless, given the prominence accorded to the intricacies of the arguments by philosophers, lawyers, patients and journalists, the previous paucity of published advice on euthanasia specifically addressed to those people most frequently asked to administer it, seems surprising. When invited to consider specific questions regarding their policies on euthanasia, health bodies exposed some gaps in what might otherwise have appeared a seamless web of healthcare provision at the end of life. Both of the bodies representing nurses, the UKCC and RCN, took the opportunity of expressing objections to the way in which medical opinion sometimes ignored or subverted the contribution of nurses in end-of-life decisions. Good communication between health professionals themselves and as a component of supportive patient care was seen by all health groups as an important ideal, not always achieved in practice. Most health bodies were opposed to the legalisation of euthanasia. The main endorsement for the idea of new legislation came from the UKCC, which, while not specifically supporting euthanasia, called for sensitive legislation to allow 'professional practitioners the opportunity to identify and serve the best interests of their patients'. In its evidence to the Lords, the UKCC did not specify the type of legislation required or how 'best interests' might be defined but indicated an open attitude on these points. This was also the organisation most critical of the lack of clear guidelines to deal with the complex legal and ethical maze in which health professionals found themselves.

All health institutions accepted competent patients' rights to decline life-prolonging treatment as a facet of respect for autonomy. Most also
saw a valid moral distinction between a medical decision to withhold futile treatment (‘letting die’), professional actions which shorten life as an incidental consequence of ensuring patient comfort (the principle of ‘double effect’) and the intentional terminating of a patient’s life. Only the latter was regarded as ‘euthanasia’. The other options were generally classified as acceptable facets of good professional practice. The UKCC, however, considered the act and omissions distinction rather discredited and expressed reservations, which many of its members were said to share, about the validity of the principle of ‘double effect’. The distinction between ‘killing or letting die’, which the medical bodies generally supported was considered to be frankly hypocritical by the UKCC which was undoubtedly the most outspoken body in challenging the otherwise broadly accepted views of professional bodies.

Some support for the UKCC view was forthcoming from the English and Welsh Anglican and Catholic Bishops who issued a joint statement. While recognising that medical treatment could be morally withdrawn or withheld if treatment was disproportionate in terms of its painfulness, intrusiveness, risk or costliness in relation to the expected therapeutic benefit, the Bishops nevertheless envisaged cases where ‘withholding treatment might be morally equivalent to murder’. They opposed the legalisation of euthanasia but rejected the notion of conflict between the concepts of sanctity of life and personal autonomy since, they said, there can be no obligation to keep seriously ill patients alive at all costs. The Board of Responsibility of the Church of Scotland also published a booklet on euthanasia in 1995 which saw no theological difficulty in allowing patients to die naturally and depicted good terminal care as the best solution to requests for euthanasia, which it unreservedly opposed. The Churches, like most of the health professionals, also considered that personal autonomy could not constitute an absolute right but should be considered in relation to other moral values. In their emphasis on the sanctity of life as a God-given gift and the view ‘that the Christian recognises no right to dispose of his own life’, the Churches diverged from the health professional organisations.

The secular nature of the responses from health professional organisations is worthy of note. It may be contrasted with the approach taken by the BMA’s report of 1988 which devoted a chapter to religious and humanist perspectives while acknowledging that ‘the religious conviction which underlay the concept of sanctity of life is no longer a universally accepted basis for medical practice’. In response to the Lords’ committee in 1993, however, several health bodies in answering the question on the concept of sanctity of life drew specific attention to non-religious values attached to the phrase and emphasised the pluralistic and multi-cultural background within which terminal care is currently provided.
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Interestingly, the Lords’ committee’s own response to the moral questions raised echoed a prominent line of argument adopted by many of the health bodies in that it was essentially pragmatic. The committee did not accept the possibility of setting secure limits on the practice of voluntary euthanasia if the law were to be changed and considered it impossible to frame adequate safeguards against non-voluntary euthanasia or other abuses creeping in. While acknowledging ‘that there are individual cases in which euthanasia may be seen by some to be appropriate’, the committee insisted that ‘individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions’.

This did little to alleviate the profound dilemmas experienced by some health professionals since it simply appeared to distil a mass of wide-ranging opinions into what was arguably a self-evident conclusion: i.e. that euthanasia may appear appropriate in some cases but is illegal. Guidance on how to handle the cases where euthanasia might apparently be ‘appropriate’ has not been forthcoming. Furthermore, from the evidence provided to the Lords by the palliative care bodies, one is left with the abiding sense that health professionals, working intimately with the dying, feel frustrated that the wrong questions are sometimes being asked by theoreticians with little experience of the realities and complexities which occur in terminal care.

The key institutions for health professionals are the regulatory bodies: the General Medical Council (GMC) for doctors and the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) for nurses. The GMC was placed under a statutory obligation by the Medical Act, 1978 to give ethical advice and set standards and the role of both bodies includes the training and disciplining of their members. The only specific comments on euthanasia from the GMC were published in November 1992, when it was required to examine the actions of Dr Nigel Cox who had been found guilty of the attempted murder of a patient by administration of a lethal substance. In its statement, the GMC did not attempt to probe the moral arguments but simply reminded doctors of their duty to obey the law. The Conference of Medical Royal Colleges and Faculties have also steered clear of the issue. Hippocratic values and the clear legal prohibition of euthanasia have been seen as obviating the need for guidance or prolonged institutional debate. It is interesting to note, however, that although the traditional wording of the Hippocratic oath clearly prohibits the administration of ‘deadly medicine’, when the WMA came to restate the oath in modern terms in the Declaration of Geneva, it referred only to a general respect for human life and ‘laws of humanity’. The Geneva Declaration contains no specific mention of euthanasia.

Nevertheless, it appears that doctors are not only asked to limit or withhold treatment but also to practice euthanasia. Rising figures have
been documented in surveys and medical willingness to discuss them appears also be increasing. It has been claimed, for example, that as many as one doctor in two in some parts of western Europe is likely to face a request for euthanasia at some point. Excluding The Netherlands, where different legal provisions apply, Belgian GPs may be among the most frequently approached European professional group. In Britain too, if the perennial and complex ‘end of life’ queries to the BMA are representative of the uncertainty of health professionals, there is a need for professional guidance which goes beyond declarations or statements of illegality. Most particularly, doctors appear to echo some of the UKCC statements in their concern about how boundaries are to be drawn between acceptable measures which accelerate dying; non-treatment or non-resuscitation which may have the same effect; and intentional termination of life. Additional misgivings often arise about philosophical arguments differentiating treatment of autonomous individuals and non-autonomous beings, such as handicapped neonates or people who are permanently unconscious. Health professionals frequently appear to want guidelines which incorporate elements of intuitive correctness as well as logical consistency and intellectual rigour. Whether health institutions are able to satisfy these demands in the future remains to be seen.

The BMA responded to the changing needs in 1993 by publishing discursive commentary and advice on ‘care for the dying’ and ‘cessation of treatment, non-resuscitation, aiding suicide and euthanasia’. In this publication, it maintained its anti-permissive stance on euthanasia, this policy having been established and repeatedly confirmed in open debate at its membership conferences. The justifications for the policy were discussed, including the premise later endorsed by the Lords’ committee that the risks of tolerating euthanasia in even a few individual cases might outweigh the benefits by having a negative impact on the whole fabric of society and potentially introducing additional pressures on the elderly and sick to avoid being a public or family burden.

As noted previously, many of the detailed contributions to the euthanasia debate have been provided by groups other than professional institutions. The Linacre Centre, for example, established in the late 1970s to promote study of health care ethics within the Catholic moral tradition, published a study of euthanasia in 1982 which discussed five areas of care where questions of medical termination of life arise. It concluded that involuntary euthanasia was systematically practised on viable handicapped neonates (principally by omission of life-saving procedures) and active euthanasia was practised but seldom prosecuted in cases of terminally ill patients. The report found no evidence of either euthanasia or medical attitudes favouring it in relation to handicapped adults, the elderly and people in intensive care units, but noted that both...
under-treatment and overtreatment were equally common in geriatric wards. It argued against euthanasia on the grounds of the enduring value of human life but recognised some circumstances in which the curtailment of burdensome treatment would be morally justifiable.

Following the BMA's 1988 report, the Institute of Medical Ethics established a working party to consider the ethics of prolonging life and assisting death. It provided a counter-point to the BMA's views in its report\(^2\) of 1990, suggesting that 'assisted death' should be acceptable in certain clinical situations. It concluded that 'a patient's sustained wish to die is a sufficient reason for a doctor to allow him to do so' and that 'a doctor acting in good conscience is ethically justified in assisting death if the need to relieve intense and unceasing pain or distress caused by an incurable illness greatly outweighs the benefit to the patient of further prolonging his life'. The report's thoughtful evaluation of the primary ethical principles and its wide dissemination in the Lancet undoubtedly contributed to the trend towards increasing sophistication in the institutional debate.

Academic and inter-disciplinary publications have also doubtless influenced British opinion and practice. A notable example is the Appleton Consensus\(^2\) of the late 1980s, which established widely accepted 'guidelines for decisions to forgo life-prolonging medical treatment'. The consensus document, produced by an international, multi-disciplinary group, set standards for many aspects of decision making but left open the desirability or otherwise of 'statutory legalisation of the intentional termination of life by doctors'. While rejecting active euthanasia of permanently incapacitated people, it stated that requests from competent but incurably ill patients for medical assistance in dying 'may be morally justifiable and should be given serious consideration'.

Finally, the contributions of patient representative groups cannot be overlooked. The Voluntary Euthanasia Societies in particular have published prolifically their predominantly rights-based and utilitarian arguments. Their surveys and widely disseminated newsletters appear to attract a growing membership and exercise an influence on public opinion.

References

1 See for example, Smith R. Euthanasia: time for a royal commission BMJ 1992; 305: 728–9. In the Lords' hearing of the Bland case, both Lord Browne-Wilkinson and Lord Mustill identified a need for Parliamentary review
2 See for example the Voluntary Euthanasia Bill introduced by P Khabra, MP on 10 June 1993
3 See for example, early day motion by David Alton MP on Withdrawal of Treatment, 10 February 1994 and Parliamentary debate on Euthanasia, 19 April 1995, Hansard p 150-170
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4 Written evidence from the United Kingdom Central Council for Nursing, Midwifery and Health Visitors to the House of Lords Select Committee on Medical Ethics, vol II, p 142, para 31
5 BMA report on Euthanasia, 1988. The report was updated by the BMA in its 1993 publication Medical Ethics Today
6 Draft Convention for the protection of human rights and dignity of the human being with regard to the application of biology and medicine: Bioethics Convention and explanatory report. Council of Europe, July 1994
8 World Medical Association Declaration on Euthanasia, adopted by the 39th WMA meeting in Madrid, October 1987, published in the WMA Handbook of Declarations, October 1994
9 Royal College of Nursing Council paper, March 1992
11 Select Committee on Medical Ethics, vol II written evidence. London: HMSO, 1994
12 Evidence to the House of Lords Select Committee on Medical Ethics, vol II, pp 75, 155
13 Joint press statement and submission from the Church of England House of Bishops and the Roman Catholic Bishops' Conference of England and England, 8 July 1993
16 BMA report on euthanasia, p 41, para 148
17 Report of the Select Committee on Medical Ethics vol I. House of Lords, p 48, para 237
18 Brief oral comments were, however, made by Sir Douglas Black to the House of Lords on behalf of the Conference or Royal Colleges and their Faculties, 4 May 1993, published in vol II of the House of Lords' report
21 A 1984 survey conducted by Le Journal du Médecin indicated 69% of Belgian GPs reported receiving requests for euthanasia although it must be noted that the sample population was small (100 doctors) and self-selecting. Vankeerberghen JP. Resultats du referendum du Journal du Medecin. J Med 1984; 234: 2
22 These topics form chapters 5 and 6 of the BMA's publication, Medical Ethics Today, 1993
25 The Appleton Consensus was drawn up by a multi-national group meeting in Appleton, Wisconsin in the late 1980s. Their consensus document was first published in the journals of three Scandinavian Medical Associations in 1989 and in Britain by the Journal of Medical Ethics in 1989 and 1992, (supplement to vol 18)