

Editorial

PROLONGATION OF LIFE: TO CONTINUE OR TO STOP?

But Death replied: I choose him'. So he went,
And there was silence in the summer night;
Silence and safety; and the veils of sleep.

The Death-Bed by Siegfried Sassoon

In his letter of the 13 November 1789, Benjamin Franklin wrote to Jean Baptist le Roy that 'in this world nothing can be said to be certain, except death and taxes'; more recently Woody Allen, presumably paraphrasing Montaigne, elaborated on this dictum and, perhaps more poignantly and starkly, stated that the three certainties of life are taxes, death and the human fear of both of them. 'What blinds us is our fear of pain and death, our inability to put up with illness and an insane indiscriminate thirst for cures...' Montaigne.¹

Whatever cryobiological interventions are claimed to have been achieved, there can be no doubt that death is inevitable for everyone of us, and immortality is not an achievable goal. The rationalising of this fact in terms of personal beliefs and philosophies, and of the orthodox religions, is perhaps what colours and moulds the thoughts of individuals about this certainty: to some, death is indeed the 'final frontier' that has to be crossed before a journey into uncharted and unfamiliar territories can commence and the belief that perhaps, with the lifting of the mist, a new and different existence will commence in another dimension - 'the undiscover'd country, from whose bourn no traveller returns'. To others, death is the unbroken, precipitous fall from the sheer cliff of life into an abyss of void, nothingness and oblivion. Yet, to many, death is the time of merciful deliverance from disease, sadness, pain and suffering - as Shakespeare expressed it in Macbeth 'after life's fitful fever, he sleeps well'.

Trepidation is to a greater or lesser extent felt by all, when ruminations on our demise are entered into; this is not simply a fear that the final curtain call will be a sudden and unexpected event, a 'thief in the night' occurrence. The mental anguish that is experienced by many relates more to the possibility that 'this awfully big adventure' would turn into a lengthy process, with a lingering on for days, months and years, a protracted event accompanied by a total loss of self-determination, an abject inability to communicate, a period in pain, suffering associated with loss of dignity, incontinence and helplessness. There is fear that the final exit will be transformed into a legacy of anguish, and that an emotionally-fraught burden will be thrust upon our 'loved ones'. These considerations have been fuelled to some extent by the well-publicised and universally appreciated advances in medical knowledge; therapeutics and resuscitative technology have increased the potential for survival of the body in the absence of the spark of immortality that allows that body to function, interact rationally, respond and participate in its environment. The 'persistent vegetative state', the 'locked in syndrome' and 'brain [stem] death' are complex neuropathological concepts that have been aired recurrently both in the forensic context and in the public media.

Thoughts about death have certainly come to exercise more and more of the community at large, and have resulted in the fostering of a culture of legally sanctioned negotiation with medical personnel and relatives in the shape of 'living wills' or - in a more semantically correct phrase - 'advance directives'. These solemn declarations² are meant to provide specific instructions and guidance to what should happen to an individual who, in the event of irreversible disease or senility or brain trauma, is no longer capable of exercising his power of self-determination and direct his own treatment or indicate his non-acquiescence to a continuation of treatment. These directives are aimed to provide by proxy an authority to another person to act on the person's behalf should the signatories be rendered unable to take their own decisions regarding the manner in which they should be looked after when they come close to the end of their lives. These surrogates are entrusted with the task of acting as executors of these wishes and decisions, presumably carefully and thoughtfully formulated at a time when the mind of the signatory was clear and disposing.

It is firmly established in jurisprudence, that any patient of sound mind and legally competent and capax in all other ways, has an unalienable right to refuse treatment, no matter how beneficial and life-prolonging this may appear to those who should know and are advising him, and this right is recognised more clearly in those who are terminally ill.³ As Lord Keith expressed it: '....a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die.'⁴ However, this right is not to be translated or transmuted into a right of the patient to instruct a physician - or someone else for that matter - to materially assist and hasten his demise through the application of active means. This frequent misconception is perhaps where confusion on the ethical, forensic and philosophical planes may have occurred. Compassionate care and relief of suffering should not be escalated to an intentional snuffing of the patient's life with all its moral, ethical and potentially criminal implications.

Aggressive life-expansion at all costs is generally agreed as not to constitute sound and appropriate medical practice: officiously striving to prolong 'life' at all costs and at whatever level of existence, and not knowing when to stop, should be outwith the scope and ethical boundaries of best practice in clinical medicine. A consideration that may weigh heavily on clinical colleagues in other countries is perhaps the potential for forensic litigation: if indeed doctors are observed by the relatives of the ill patient not to have intervened until absolutely nothing else was possible. This is thankfully not an attitude and a frame of thinking that needs exercise us in this country. At all times, prolongation of life should be guided by other principles.

It always has to be ensured by the doctor that whatever else is done, the discomfort and pain that is being inflicted on the patient is indeed a debit that is feasible and appropriate for that particular individual to have to endure. Palliation should ensure that such factors as the stage of the disease, the frailty of the particular patient, the realistic potential for some recovery and the patient's age are carefully weighed against the short-term and long-term outcome of the intervention being proposed and, if possible, the patient himself should be a party to all the decisions taken on his behalf. Addressing the needs of the dying should be strategically planned as a multi-professional task⁵ and not allowed to be an unstructured reflex response conditioned by the development of new symptoms and the emergence of uncontrolled further spread of the disease process. Generally speaking, oncologists are much more conversant with the requirements of those close to death and of their

relatives than other doctors.⁶ The hospice movement is intended to embrace all who are dying, and not simply cancer patients, and greater use should be made of this unmeasurably valuable resource. A need for more universal education of physicians of all grades presents itself.⁷

To allow a person to die may be significantly much kinder than to continue to treat or to investigate. Symptoms of pain, depression and anxiety have to be relieved at all costs and whatever the dire side-effects of such treatment. Physical and emotional distress and suffering should be combated aggressively, and with any and every weapon of the therapeutic armamentarium, until they are vanquished, whatever that entails, even if the eventual victory is of Pyrrhic quality. Ambivalence of purpose need not be a consideration; the aim is simply and plainly to rid the patient of the suffering, discomfort, anguish and pain. A universal agreement on such a principle is subscribed to by all known religions, and thus no ethical boundaries or serious dilemmas have to be faced. The law does not censure this attitude, but is likely to condone and encourage the action of the physicians acting in this capacity, and is likely to censure those who prefer to withhold such therapy on the grounds that pain control may alter the level of consciousness and the alertness of the patient, or perhaps that the continued functioning of the lower cerebral centres may be depressed.

In this context there should also be careful consideration of the need for rigorously continuing with routine nursing, investigative and therapeutic procedures; these may be upsetting to the patient and would therefore have to be curtailed in the interest of allowing the patient to rest. Thus, why should a patient be bled every day for routine biochemical and haematological investigations? Why should aggressive chest physiotherapy inexorably proceed literally till the very last breath? Is it right that a patient should be subjected to recurrent radiological investigations so as to monitor disease response or to localise the pneumonic consolidation, with all the prodding, turning, movement and transporting that these may of necessity entail?

The quality of the life that remains should be carefully titrated against the quantity of life that can be on offer. The current advances in medicine may have resulted in our losing sight of the 'letting die' principle. Petronius Arbiter,⁸ writing in the first century A D, in defining the tasks of a clinician, suggests that a doctor can do nothing more than be a consolation for the spirit - *medicus enim nihil aliud est quam animi consolatio*. Montaigne also remarks: 'living is slavery if the freedom to die is wanting'.¹ Doctors have a responsibility and a duty of care to ease this 'passing on', and to ensure that it is as smooth and unperturbed as it could possibly be made to be.

A somewhat more difficult decision relates to the manner in which the actual withdrawal of treatment already being administered to the dying patient should be withdrawn in a compassionate and strategic manner, so as to ensure that the distress and potential discomfort to the patient is kept to a minimum.⁹ In a study of the attitudes of clinicians to such therapy withdrawal from agonal patients carried out in a number of different institutes, it was shown that in about 60 per cent of the cases, the withdrawal of therapy followed an order with vasopressors being stopped initially, then antibiotics, followed by enteral feeding, dialysis and finally the ventilators were disconnected. This reflects the ascending order of seriousness in which these various interventions are considered medically - and by nursing staff - and the difficulties that the compassionate withdrawal of these various treatment modalities will impose on the carers to ensure that after their removal, the patient can be made comfortable.

When 'staging port of life has been reached', the judicious use of medication in

sufficiently effective doses and a phased withdrawal of therapy are elements of the contractual duty of care which doctors owe to their patients. and which they should be adequately trained to deal with in the course of their careers.

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CURRENT MEDICINE, PROCEEDINGS AND CONTINUING MEDICAL EDUCATION

Over the last few years the Royal College of Physicians of Edinburgh has published irregularly a book entitled *Current Medicine*, whose aim was to update Fellows and Collegiate Members of recent advances in topical clinical issues. The next issue was to be published this year and in line with the newly established College policy regarding publications it has been decided that *Current Medicine* will replace one issue of *Proceedings*. Thereafter *Current Medicine* will be discontinued and *Proceedings* will publish papers which would have appeared in *Current Medicine*, as part of a new Continuing Medical Education section. The CME editor on the Editorial Board of *Proceedings* is Dr I J T Davies.