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Editorial

'On dying and on dying well'

Some doctors counsel reticence in discussing medico-moral questions and oppose the involvement in such discussions of those who are not medically qualified. They argue that these matters should be discussed by consultants with consultants and *in camera*.

Those who doubted that there was a current and pressing need for an authoritative statement on the care of the dying patient and the moral responsibility of the medical profession in this matter must have been surprised by the widespread and detailed reports in the national press of the Archbishop of Canterbury's recent lecture to the Royal Society of Medicine. (Extracts will appear in the next number of this Journal.)

There can be no question but that the case of Karen Quinlan and the events preceding the death of General Franco have led to a general belief that there is a moral obligation, accepted by some doctors, to sustain life at all costs, using whatever means are available to them. Frequent arguments have been heard that legislation is necessary to give patients 'the right to die' – such as Lady Wootton's Incurable Patients Bill and the recently enacted 'right-to-die' law of the State of California. Furthermore, the word *euthanasia* continues to do duty for such a variety of meanings, from outright killing to allowing nature to take its course (with or without the assistance of the medical practitioner), that its very use serves to obscure rather than to clarify the issues.

There is nothing new in this discussion. To some doctors its repetition may even be tedious, but this reaction in itself illustrates the communication gap between the professions and the public. When we consider the advances in medical technology, the expectations that patients now have of their doctors, and the general atmosphere of moral uncertainty in which doctors prescribe similar treatments whilst asserting or denying that they constitute euthanasia, there is sufficient reason for restatement. Moreover, when some doctors and nurses believe that the Church, and especially the Roman Catholic Church, teaches that a doctor's responsibility to maintain life is unlimited, and when official teaching is to the contrary, then it is not inappropriate for a churchman to intervene. Worse still, in its report of the Quinlan case the *Osservatore Romano* appeared to endorse the decision of a US court that it was a doctor's responsibility to maintain life at all costs, thus supporting the medical advice offered to the Quinlan family. By so doing it was departing from the theological tradition elaborated by a Pope and subsequently endorsed by an Archbishop of Canterbury, that there was no obligation on the doctor to resort to 'extraordinary' means to maintain life artificially – 'prolongation of dying' as it was characterized by the *Lancet*. We welcome, therefore, as timely, the careful restatement by Dr Coggan of a general consensus which already exists between the churches, the English common law and medical tradition, as regards the moral obligations of doctors in terminal illness.

One of the declared aims of this Journal is to influence the quality of both professional and public discussion of the consequences of medical practice, whilst remaining independent and non-partisan. It follows that we welcome not only the fact that the Royal Society of Medicine should invite Dr Coggan to give the 1976 Edwin Stevens lecture, but also that he should have taken the opportunity to deny that the Christian tradition required life to be maintained at all costs. We also welcome the Primate's endorsement of the Papal allocution on 'Ordinary and extraordinary means', as demonstrating that there ought to be no disagreement between doctors and nurses of differing allegiance in this matter, and his demonstration of the large area of agreement between what is taught by the moral theologians and the English common law doctrine of necessity. Together with the much quoted aphorism of not striving officiously to keep alive, there is a clear consensus between three disciplines.

There was, however, an element in the lecture which was noted by many commentators. Having excluded legislation at the point of clinical judgment in preference for the experience and wisdom of the individual doctor, even when faced with hard cases, Dr Coggan has been reported as calling for consideration of the country's economy to be included in deciding appropriate treatment. If he was saying that governmental decisions about the provision of facilities in the National Health Service may have moral consequences, then we would agree: but such considerations do not influence the way in which the individual doctor uses the resources available

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to him at a particular time and place. It would be a pity if the belief that the Primate was introducing a novel element in medical responsibility, by urging doctors to decline to use expensive equipment already available, were to cloud the clarity with which he restated a moral consensus that already exists. When the Primate of England is able to demonstrate that there is in fact an identity of opinion between the church, the law and medicine, he speaks with an authority that a purely ecclesiastical statement could not be expected to carry in contemporary society. His wise words can only enhance the care of the dying.

'Physician, heal thyself'

Doctors tend to be elusive of doctors, in addition to being extraordinarily bad patients. There have been relatively few studies, however, on the response of doctors, as a group, to emotional stress but the high incidence of drug addiction and of suicide among doctors seems undisputed. It would appear that drug and alcohol addiction in doctors starts at medical school or in early professional life and a feature of these doctors is reluctance to have treatment, neglecting their emotional problems as they do their physical disabilities. All workers in this field seem to agree on the peculiar difficulties of the therapeutic situation and there has been much discussion and speculation on the nature of the special stresses to which the doctor is subject. Some writers have drawn attention to the relationship between high suicide rates and high incidence of drug and alcohol addiction amongst medical practitioners. There is, therefore, a suspicion that many doctors with a neurotic illness do not reach the psychiatrist, probably because doctors manage to recognize their own neurotic symptoms and may be reluctant, or embarrassed, to seek assistance for symptoms which they feel they should be able to control for themselves. The increasing complexity of medicine, associated with a diminishing public image and failing self respect, are factors that have been identified leading to breakdown, while many doctors seeking psychiatric help comment on being overloaded with work and responsibilities.

On the evidence of existing published work, there is obviously a reluctance at present for the doctor to seek early advice in psychoneurotic illness which is perhaps the most relevant from the point of competence to practise since physical disability is much less easy to conceal. The early age of breakdown within the medical profession suggests that more effective psychiatric screening of medical students should be introduced, together with emphasis during the medical curriculum of the hazards to which the medical profession is peculiarly exposed. If we are to reduce the impact of stress, those responsible for teaching must provide an insight into these dangers so that the young doctor can take his own remedial action, either through seeking professional help or, on occasion, by political action. Without a positive programme on the part of the profession to provide these insights and supporting services, the restrained recommendations of the Alment Committee[1] will do little to safeguard the public from the doctor experiencing early breakdown. The desire of the Committee to advocate a counselling rather than an authoritative approach is commendable but one would have wished for rather more practical suggestions regarding the ways in which the profession can be more self-supportive to those in need of help. The available evidence suggests that in the critical area of psychoneurotic illness, the proper protection of the public will inevitably impose a greater restriction on the individual freedom of doctors. The Alment Committee, like the Merrison Committee before it, recognizes this dilemma and its stimulus to public debate is likely to be more effective than the strength of its proposals.

Reference

[1]Separating the sheep from the goats (1976). *British Medical Journal*, **2**, 1218.

Where are the promised secure units for the mentally ill?

Neither Lord Butler, nor the other members of his committee on mentally abnormal offenders, nor indeed anyone else is likely to be satisfied by the rate at which regional secure units, whether interim or permanent, are being provided. More than two and a half years have passed since the Butler Committee, impressed by the urgent need for such units, took the unusual step of making an interim report.[1] The urgency derived, the report said, not only from the extreme pressure on places in the (then) three special hospitals in England and Wales and the consequent shocking overcrowding, particularly in Broadmoor, but also from the spread of an open-door policy in ordinary psychiatric hospitals. Such an unrestrictive policy makes any but the special hospitals reluctant and eventually unable to provide care and treatment in conditions of modest security and creates a 'yawning gap'.

For several reasons, it is rather difficult to make out what is happening in the provision of either interim or permanent units. Plans, diverse in pattern, are in the hands of regional authorities. These are subject to discussion by area health authorities, by individual hospitals and, no doubt, by many other people and groups. In some regions, eg, Mersey, a firm plan for a permanent unit has been decided[2]; in others, plans have been 'approved in principle' by the Department of Health and

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