

Principles in Clinical Ethics

With special reference to Palliative Medicine

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By “clinical ethics”, I refer to the field of activities that investigate what medical staff as professionals should do or how they should behave concerning a certain individual case, especially in the process of decision making. Bioethics might also concern such issues, but not exclusively, since its main concern is general theories and not the solution of individual cases. The field of clinical ethics has been criticised for its

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lack of theories or reasoning, according to which individual cases are considered . Against this criticism, clinical ethicists have cited the complexity of individual cases, saying that the problems they pose are too complex for us to solve by simply applying a set of principles to them. I have been thinking, however, that even though the cases are complex and solutions cannot be attained in either a casuistic way, or by simply applying the principles to them, we can still find a way to analyse or consider each case. Establishing a standard way of analysing and considering individual cases has been one of the main themes of scholars in clinical ethics. I shall presently report my own theory concerning this issue.

We need certain ethical principles for the ethical analysis of individual cases. For even if considered on a “case by case” basis, it is not as if the various cases and their analyses have nothing in common. At least the way in which we analyse and consider each case should be uniform, or else our conclusions and choices would be neither accountable, nor reasonable. This uniformity or reasonability, is acquired by basing our decisions on a set of ethical principles. There can be a viewpoint that refuses to follow such ethical principles and if I put myself in a field of pure philosophy and ethics, I could make a detailed argument to support my view. However, I am now in the field of practical case examination. Here I would only presuppose my viewpoint, and notice that principles are actually relevant and necessary in this field. In this paper, I will first present the set of ethical principles that are applicable to medical activities in general, and then I will show that those principles are valid in palliative medicine as well.

1. PRINCIPLES FOR CLINICAL ETHICS IN GENERAL

I propose the following three ethical principles in medicine:

P1: Intend to promote the well-being of the person(s) you face through medical activities!

P2: Treat the person(s) you face as a human being(s) in medical activities!

P3: Maintain justice and/or equality through and in medical activities!

P1 is a teleological principle, which corresponds with the principle of *beneficence* and it prescribes the point of view from which an activity should be chosen.

P2, on the other hand, is a deontological principle that prescribes how one should engage in one’s activities, with specific reference to the process of decision-making and performing a chosen activity.

P3 is a principle that takes a social point of view. It serves to check the activities of the medical staff not only by taking into account the interests of the persons they face, but also by balancing it with the interests of third parties.

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I shall presently explain in detail what P1 and P2 exactly mean .

1.1 The Bodily Situation and QOL: General Assessment

With regard to P1, the term “a person’s well-being” needs to be clearly defined. When we ask if a person is well or not, the question can be interpreted in two ways: if he lives his life well or if his situation is fine. The

first interpretation refers to the person's attitude towards a particular situation, i.e. what he does or intends to do, or how he lives or intends to live in the given situation. The latter one, on the other hand, refers to his/her given situation or circumstance.

According to both interpretations, we can derive a specialized rule under P1. First, let us examine what rule results from the second interpretation of "a person's well-being".

By "bodily situation", let us refer to the person's given medical situation. This situation is distinguished from other situations that the person might face, e.g. those concerning society, family, etc. "Health" and "disease", for instance, are terms that describe the bodily situation. Mental health also refers to the state of the person and therefore, is also part of the bodily situation.

The person's bodily situation is not evaluated in biomedical terms. Cancer itself, for instance, is neither good nor bad if judged only from the biological point of view. However, it is said to be bad for two reasons: first, it will result in distressing symptoms in the course of time and, second, it will shorten the patient's life. Correspondingly, the bodily situation of a person who has cancer is judged to be bad because of these predicted effects on the person, even if the person is not aware of his/her situation, or is not actually suffering from any distressing symptoms at present. Thus one's bodily situation is medically evaluated by estimating the impact that one's biological condition has on one's life as a human being, and this evaluation is based not only on one's actual present life, but also on one's predicted future life. Thus, we can define

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bodily situation in terms of the course of one's actual life, starting from the moment of evaluation . In order to assess a person's life at a certain moment, we have been using the term "quality of life" (QOL). QOL, however, consists of many aspects, not all of which directly concern the bodily situation. For instance, one's quality of life is also made up of the quality of one's social and economical state, one's relationships with one's family and friends, the comfort of one's house, and other such situations that do not affect one's bodily situation, at least not directly. Therefore the question is, which aspects of one's QOL should we consider while evaluating one's bodily situation? To answer this question, we have to clarify the general concept of QOL.

I would say that a person's QOL is actually estimated according to the measure of his/her freedom or the actual choices that he or she has at the moment of estimation. For instance, pain and other distressing symptoms are bad because they hold the person against his will and restrict his or her chances of doing things freely. Psychological suffering (anxiety, depression, anger, etc.), physical disabilities and other factors that are negatively evaluated in the assessment of QOL are also bad for the same reason. Again, one's social circumstances might either enable one to do things freely or prevent one from doing them and therefore, it is also involved in one's QOL. To sum up, QOL is a measure of the patient's actual freedom at the moment of estimation, and we can define the condition of one's own body and mind that concerns one's freedom as "bodily QOL".

On the basis of the above conception of bodily QOL, we can conclude that one's bodily situation is estimated as the integrated sum of the freedom made possible by the condition of one's body and mind, from the moment of estimation until the time of death. Let " t^l " be the moment of estimation and " t^d " be the time of death. Then, the relationship between the bodily situation and QOL can be expressed as follows:

The value of a person's bodily situation at t^l is the integrated sum of the person's bodily QOL that is and will be actualized in the course of time from t^l on until t^d .

If you prefer a mathematical formulation, let " $B(t)$ " be the estimated value of the bodily situation at a moment " t " and " $Q(t)$ " be the value of the bodily quality of life at " t ". Then,

$$B(t) = \int_{t^l}^{t^d} Q(t)dt$$

Thus the longer the life span and the higher the QOL at every moment, the better his present bodily situation is.

QOL, i.e. the individual's freedom, at a given moment can be estimated publicly and not privately, though it

is mainly estimated on the basis of the patient's self-evaluation. Also the bodily situation at a given moment is estimated in terms of the patient's freedom, though it is valued by means of medical and therefore scientific inspection.

On the basis of this concept of QOL and bodily situation, a rule results from P1:

R1-1: Intend to make the integrated sum of the QOL of the person you face from the present moment until the time of death as much as possible.

Here by "QOL" I primarily mean the bodily QOL, but I would not restrict the term to include only the bodily aspect. Consider the example of a woman who cannot walk by herself, but can move by means of a wheelchair. In this case the weakness in her bodily QOL can be compensated by another aspect of her QOL i.e. her circumstance -- that she can use a wheelchair. Creating such a circumstance is included in medical activities. For instance, a man with advanced cancer in his terminal stage, and in need of treatment for his bodily QOL, has to be separated from his family during the course of treatment. In this case, we should estimate not only the predicted improvement in his bodily QOL but also the change for the worse in his family circumstance. Thus, we should estimate not only one's bodily QOL but also the other aspects of one's QOL that relate to one's bodily situation.

1.2 The Private Attitude Towards Life: Interest Individualized

Besides R1-1, which has resulted from the second interpretation of the "person's well-being", we can arrive at another rule on the basis of its first interpretation, which explains well-being as one's attitude towards the given situation. Here P1, which directs the medical staff to "intend to promote the well-being of a person", cannot explicitly direct them to make the person live well by adopting a certain attitude towards his/her life, for this depends exclusively on the person's own ability to adopt a certain attitude. The principle, however, implicitly directs us to let the person live well, or not to prevent him/her from living well, and this is what "intend to promote one's well being" means in this respect. Thus the second specialised rule under P1 is as follows:

R1-2: Don't prevent the person you face from leading a full life.

Although P1 does not recommend that the medical staff directly help the patient lead a full life, it does recommend promoting the patient's well-being. The patient's well-being is of value insofar as it provides the patient with a chance to lead a full life, and this is what R1-1 explicitly directs the medical staff to do -- improve the person's condition and attend to his/her QOL or freedom from the public point of view.

On the other hand, R1-2 directs by using negative expressions. It does not direct the medical staff positively to help the patient lead a full life, as well as R1-1 doesn't, but negatively not to prevent the patient's activity. This means, they should respect the individual's own preferences and values, which besides the bodily situation and QOL, play an important role in medical decision-making. That is, the patient's overall life-plan and his/her preferences have a casting vote in many cases of decision-making. For instance, QOL consists of several components: physical abilities (i.e., performance status), physical feelings (pain etc.), psychological feelings (anxiety etc.), the capacity to maintain human relationships, and so on. Thus, there can be a case where the patient considers one aspect to be more important than others in order to lead a full life. In such a case, the medics' role is to create circumstances that are conducive to the patient leading a full life. This involves taking care not to prevent him/her from leading a full life.

1.3 Co-operation of Medical Staff, Patient and Family

Two specialised rules result from P2:

R2-1: Share each medical activity with the persons involved in it.

R2-2: Stand by the person you face (share the person's concern).

As regards the rule R2-1, medical activities might appear, at first glance, to be performed only by the medical staff for the patient. But if a person intends to treat another person as a human being, that person cannot perform any acts on the other by himself. Rather, he/she should carry out such acts through a process of truthful communication with the other person in such a way that the other can also commit himself to the

act and participate in it. The patient's family is also involved in the medical activities conducted for the patient. The disease that affects the patient sometimes affects the life of the family. The patient might no longer be able to work and this might cause a financial problem for the family. Further, family members might have to change their schedules depending on the patient's choice of treatment. Thus, in many cases, the family is more or less involved in the medical activities concerning the patient.

According to P1 that prescribes respect for human beings, it is appropriate that the medical staff, the patient, and other persons involved (e.g., the family) co-operate in medical activities, specifically, with respect to shared decision making. Under this rule, the patient's informed consent is necessary in the process of shared decision-making. Informed consent is also needed on the part of the medical staff. In order to choose an appropriate form of treatment, the medical staff need to obtain information about the patient from the patient himself, especially concerning his/her life-plan, preferences and values. Then, they should recognize the patient's request in such information, and consider how to reply to the request; this is what I call "informed consent on the part of the medical staff". Based on the informed consent of both sides, both can subjectively perform the chosen activity. Thus, the medical staff as well as the patient play a role in performing the chosen activity.

Consequently, though R2-1 recommends that the medical staff respect the patient's self-determination, it [4] does not imply that the medical staff should follow it blindly . On the contrary, even the medical staff, as

human beings, should be autonomous and willingly make joint decisions with the patient [5] . Moreover, the patient does not have the right to die, though he has the right to choose his way of living. Nor does he have the right to refuse all treatment, though he is allowed to refuse a particular treatment and to request another in its place according to his view of life. Generally speaking, I agree that "it is the patient's

body, and in turn the patient's life, that bears the principal effects of any treatment instituted [6] ". It does not [7] follow, however, that the patient has the right to decide *by himself* how to treat his body or life , but he/she needs to negotiate with the people involved and reach an agreement concerning it.

1.4 Standing by the Person you Face --- Share the Person's Concern

The rule R2-2, i.e. standing by the patient in suffering also follows from the fact that to treat someone as a human being means to maintain truthful communication with that person, which is what R2-2 prescribes. In such communication, participants can have two different positions: facing each other and facing in the same direction. When the participants face each other, they exchange words and interact with each other. When the participants face the same direction, they share the same view, feelings, ideas, intentions, etc. One position alternates with the other during communication.

A patient in suffering is in great need of such communication. He needs someone who is face to face with him, takes care of him, and shares his suffering and awareness of death. The medical staff are therefore expected to stand by the patient as humane participants in such communication.

2. APPLICATION OF THE PRINCIPLES TO PALLIATIVE MEDICINE

Below, I shall show that the set of principles proposed in the preceding section is also valid in palliative [8] medicine and is applicable in the process of exercising clinical ethics concerning cases in palliative care .

2.1 The Definition of Palliative Care

The dictionary defines the term "palliative" as "a drug or medical treatment which relieves suffering without [9] treating the cause of the suffering ". In terms of the theories described above, we can translate the phrase,

“which relieves suffering”, into “which makes the present QOL of a patient higher”, and “without treating the cause of the suffering”, into “without trying to cure” or “without trying to eliminate the disease that renders the patient’s QOL lower and/or his/her lifespan shorter”. Consequently, palliative therapy can be distinguished from curative therapy in that it is concerned with the present life, while the latter is mainly concerned with the future life.

Surgery, for instance, generally makes the patient’s present QOL lower (sometimes considerably) for a while. Nevertheless, it is recommended when, by repairing or removing the part of the body which is causing the problem, the patient’s future QOL will presumably be much better and his/her lifespan will be prolonged. The patient is willing to sacrifice a better present for the sake of a better future. The saying, “Good medicine tastes bitter”, recommends such a sacrifice in its literal meaning. In contrast, palliative therapy attends to the patient’s present QOL and is aimed at a better present.

Hence we can revise the definition of palliative care as follows:

Palliative care is a medical activity which is aimed at making the integrated sum of the patient’s QOL from the present till the time of death as much as possible, by improving the QOL at every moment, and not by prolonging his/her lifespan.

2.2 Reasoning for Choosing Palliative Medicine

As mentioned above, with respect to surgery, the patient prefers a better future over a better present, because the integrated sum of his QOL from the present until the time of death in the event of receiving surgery is estimated to be higher than in the event of not receiving it. This reasoning based on R1-1 is appropriately applied to the choice of medical treatments for a patient in his terminal stage, when we emphasize palliative rather than curative therapy. By comparing various kinds of therapies and treatments, we choose the one that will result in the best integrated sum of the patient’s QOL from the present moment till his death. In most terminal care cases, palliative therapy will achieve the best results. In some cases, curative therapy combined with palliative therapy will further increase the integral sum of the patient’s QOL.

Even when we discontinue curative therapy and restrict our activities to palliative therapy, we do not intend to shorten the patient’s life, but rather to raise the integrated sum of the patient’s QOL. In some cases, despite the prediction of a shorter life, we may discontinue curative therapy because the integrated sum of QOL will be higher than in the event of our continuing it. In other cases, we may foresee both a prolongation of the patient’s life as well as an improvement in his QOL by discontinuing curative therapy. Of course, there are cases, in which we cannot publicly conclude which of the two kinds of therapy results in the better integrated sum of QOL. For such cases we can refer to R1-2, and observe the patient’s choice based on his/her life-plan.

Thus, the choice of palliative therapy as the primary form of therapy is based on P1 (R1-1 and R1-2) and

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there is no intention of either hastening or postponing death, even though we might foresee it to be hastened or postponed. For patients in their terminal stage, the present life rather than the future is the most important. Hence the improvement of the patient’s present QOL proportionally corresponds to the increase in the integrated sum of his QOL. Consequently, palliative therapy becomes the primary form of therapy according to P1.

In addition, the process of making a decision concerning the choice of palliative care should also be in accordance with P2. That is, the medical staff, the patient and his/her family should jointly make the decision (R2-1) and the medical staff should stand by the patient and the family (R2-2). This attitude is especially important because the patient and the family have to choose their way, facing severe suffering and death.

2.3 Relief from Pain and other Distressing Elements

Palliative care aims to relieve the patient of forces that take away his/her freedom, and hence physical pain and other distressing symptoms, including psychological ones, should first be alleviated by medical

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treatment .

Psychological, social and spiritual suffering should also be dealt with, as they are some of the forces that take away the patient's freedom and directly impair the corresponding aspects of QOL. They are generally affected by the patient's recognition of his present situation. For instance, physical pain might make someone anxious, but anxiety, which is a kind of psychological suffering, does not result directly from the pain itself, but from the obscure recognition that he/she has pain and therefore something wrong must have happened in his/her body and something worse might be happen in the future. Similarly, information regarding the patient's condition sometimes results in psychological and/or spiritual suffering for the patient. Besides, the disease might affect the patient's social status and deprive him/her of the chance of social activity.

The reverse is also true. These aspects of suffering sometimes affect physical pain and lower the physical aspect of QOL. Pain is caused not only by the physical aspect of a patient's condition, but also by others. Therefore, it is called "total pain".

To relieve the patient of psychological, social and spiritual suffering, the medical staff should approach the patient's mind. Though some drugs might be helpful, the most basic approach is communication with the patient (R2-2). Psychological suffering is deeply connected with the patient's recognition of his situation, and hence he should be offered adequate information about his situation (R2-1). Even when the patient's situation is beyond hope, it is presumably better for the him/her to know about it than to be anxious without knowing. In such a case the most important form of care is for the medical staff to stand by the patient and to prevent him from despairing of his situation (R2-2).

2.4 Leading a Full Life During the Last Days

In order to keep the patient's QOL as high as possible during his/her terminal stage, palliative medicine is chosen in the hope that he/she will be able to lead a full life during his last days. A few brief comments will clarify the relationship between maintaining a high QOL and leading a full life.

First, the medical staff are sometimes expected not only to provide the patient with the chance to lead a full life, but also to directly help him/her do so. Although the activities which are directly involved in the patient's leading a full life are generally not recommended by P1, they are often in accordance with P1 in terminal care cases. The patient in his/her terminal stage usually cannot maintain contact with many people and the medical staff are among the few who can help him/her. Thus, if the medical staff do not directly help the patient in leading a full life, they must be considered as preventing the patient from doing so (R1-2) and not standing by him/her (R2-2). In such a situation, activities that help the patient lead a full life are appropriately performed by the medical staff according to R1-2 and R2-2.

Second, in order for patient to lead a full life, it is important to respect his/her preferences and values. For instance, when we must prioritize one aspect of QOL over others, we should do it according to the patient's life-plan, preferences etc. (R1-2).

Third, the purpose of improving QOL is to help the patient lead a full life, but the reverse is also true -- the fullness of life itself improves QOL. A full life at least improves the psychological aspect of QOL and psychological relief might have a positive influence on physical pain. Thus, leading a full life is also indirectly relevant to R1-1.

Fourth, the person's spiritual well-being is more important for leading a full life than other aspects. Even if the physical, psychological and social aspects of one's QOL are good, one is not capable of leading a full life if one's spiritual QOL is low. By contrast, even if the former are not very good, one can live a full life if the latter is high. The spiritual aspect concerns how one recognizes one's own life from a global point of view, and this directly concerns one's attitude towards one's own life in the world.

2.5 Death with Dignity

The set of principles and the rules under them are also appropriate to the problem of how to treat the dying.

Palliative medicine based on these principles will result in the patient's death with dignity.

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With respect to active and passive euthanasia, or killing and allowing someone to die, neither is justified by R1-1. If a medical treatment can be described as "killing someone" or "allowing someone to die", its intended purpose cannot be to raise the integrated sum of QOL. On the other hand, if the physician chooses a form of treatment intending to gain the best integrated sum of QOL, while foreseeing the patient's earlier death, then, such a treatment can be justified according to R1-1.

A similar line of reasoning is valid for the problem of withholding and withdrawing life-sustaining treatment. For instance, the condition of foregoing nutrition and hydration, set forth by Lynn and Childress, is in accordance with P1. They say that it is justifiable "only when the procedure and resulting improvement in nutrition and hydration do not offer the patient a net benefit over what he or she would otherwise have

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faced".

Some argue, however, that the prohibition of active voluntary euthanasia results in a failure to respect the

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self-determination of patients who want their lives directly ended. In response to this, I would say that both P1 and P2 are principles governing life and not death. Death is only the end of life and therefore has no positive content. We cannot compare the integrated sum of QOL of a patient in his terminal stage who directly ends his life with that of a patient who continues to live. We can make comparisons only between different ways of life, and not between life and death. Similarly, as mentioned before, a human being does not have the right to die or to end his life, although he has the right to choose how to live. Again, if the medical staff were to agree with a patient in a condition, which he/she thinks is not worth living in, by the agreement they would be telling other people in a similar condition who are willing to live, "your life is not worth living". Consequently, the medical staff should not give in to a patient who wants his life directly ended, but rather should try to persuade the patient not to end his/her life (P2) and to improve his/her circumstances so that he/she could change his/her mind. To sum up, although palliative medicine intends to relieve the patient of suffering, in no way does it offer any relief from life itself.

Problems however, do remain. One problem concerns the course of action to be followed in a case where the palliative treatment will drastically shorten the patient's life as a side effect, to the extent that a third party is unable to distinguish it from active euthanasia. My response to this is as follows: On the one hand, the agent him/herself can distinguish between the two. On the other hand, if a treatment can be publicly shown to be the one intending the best integrated sum of QOL, and not death, it would be publicly judged to be a sound palliative treatment, even if the medics actually intended the patient's death. However, if it cannot be done, without being accompanied by the intention of the patient's death, we have to judge it as active euthanasia. Secondly, one could argue that my argument might be valid in the case of the patient whose suffering can be publicly estimated to be bearable, but not when everyone agrees that the suffering must be unbearable and worse than death, and there remains no way to alleviate the patient's unbearable suffering, other than ending his/her life. I agree that the patient could ethically be allowed to end his/her life in such situation. This, however, should be done either by withdrawing life-sustaining treatment, or by treatment used for palliation, and not by positive killing. In the posited case both would immediately result in death and the latter is the case examined as the first problem in the preceding paragraph. If withdrawing life-sustaining treatment results in an improvement of QOL, it can be considered as being for the sake of QOL. If it does not, it should be considered as an activity intending the patient's immediate death, and is certainly euthanasia. Thus at the moment I cannot entirely reject euthanasia. The limit, however, of allowable euthanasia is not appropriately explained by simply distinguishing between its active and passive forms. I will argue about this in detail elsewhere.

CONCLUSION

The set of principles and rules mentioned above not only provide an ethical check on medical activities, but

also function as guidelines. The set is relevant to clinical ethics as well. I will show elsewhere the standardized way of analysing and considering individual cases on the basis of these principles, which I have already reported in my papers written in Japanese.

They are also useful for the theoretical understanding of palliative medicine as well as of medical activities in general, and hence can be the basis for analysing and considering individual cases.

Having concentrated on the ethics between the medical staff and the patient, the present paper may be said to be lacking in the concept of justice from the social point of view, another concept about which I hope to argue elsewhere.

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Jos, V.M. Welie, *In the Face of Suffering: The Philosophical-Anthropological Foundations of Clinical Ethics*, Creighton U.P., 1998, pp.1-5.

[2]

For other theories on the subject, see the following: Beauchamp, T.L., "Ethical Theory and Bioethics", in Beauchamp, T.L. and Walters, L., eds., *Contemporary Issues in Bioethics*, 3rd edition, Calif. Wadsworth Publishing Company, 1989, Chap.1. Veatch, R.M., "An Ethical Framework for Hospital Ethics Committees", in Beauchamp and Walters, eds., *op. cit.*, 1989, p. 298-304. Engelhardt, H. and Tristram, Jr., *The Foundations of Bioethics*, New York, Oxford University Press.1986. Childress, J.F., "The Normative Principles of Medical Ethics", in Veatch, R.M., ed., *Medical Ethics*, Boston, Jones and Bartlett Publishers, 1989, Chap.2.

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For another approach to the concept of health and disease, see the following article: Caplan, A.L., "The Concepts of Health and Disease", in Veatch, ed., *op. cit.*, 1989, Chap. 3.

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The patient is expected to justify his decision publicly, or his decision should be publicly justifiable with reference to his life-plan, his basic values, etc., even when he is incompetent. Of course the medical staff are responsible for discovering the patient's reasoning and respecting his will. Nevertheless, the patient's will might not be followed in every case. For instance, the patient has no right to commit suicide and others should not consent to this (at least in most cases), for the patient's decision will not be justifiable.

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Also see the following articles: Brody, H., "The Physician/Patient Relationship", in Veatch, ed., *op. cit.*, 1989, Chap. 4. Cassell, E.J., *The Healer's Art: A New Approach to the Doctor-Patient Relationship*, Cambridge, Mass., MIT Press, 1976. Veatch, R.M., *The Patient as Partner: A Theory of Human-Experimentation Ethics*, Bloomington and Indianapolis, Indiana University Press, 1987.

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Brock, Dan W., "Death and Dying", in Veatch, R.M., ed., *op. cit.*, 1989, chap.12, p.336.

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This view might not entirely agree with theories of respect for the patient's self-determination or autonomy (e. g., Engelhardt (1986), Veatch (1987), Brock (1989), et al.). The view may reflect attitudes in Japan and might not be universally accepted by people in the U.S. or the western world. The view is presumably a basic belief itself and therefore cannot be justified using more basic principles. Nevertheless, it is also presumable that the other view which admits that the right to decide how to live one's own life is a basic belief as well.

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Cf. Brescia, F.J., "Palliative Care -- An Overview: Thoughts of a Deathwatcher", *Cancer Therapy & Host*, 1-1, 1989, p. 31-40.

[9]

Cobuild English Language Dictionary

⁹ WHO, *Cancer pain relief and palliative care* (WHO Technical Report Series 804), 1990.

¹⁰ The following book shows a clear means of assessing decision making.

Pereira, J. & Bruera, E., *The Edmonton Aid to Palliative Care*, Edmonton AB, 1997, Chap. 1.

¹¹ Rachels, J., "Active and Passive Euthanasia", *N Eng J Med*, 292, 1975, p. 78-80. Cf. Bok, S., "Death and Dying: Euthanasia and Sustaining Life – Ethical Views", In Reich Warren T., ed., *Encyclopedia of Bioethics*, Vol. 1, New York, Macmillan and Free Press, 1978, p. 268-278. Brescia, F.J. "Killing the Known Dying: Notes of a Death Watcher", *Journal of Pain and Symptom Management*. 6-5, 1991, p. 337-339.

¹² Lynn, J. and Childress, J., "Must Patient Always Be Given Food and Water?", *Hastings Cent Rep.*, 13, 1983, p. 17-21.

¹³ Brock, Dan W., 1989, pp. 347-349.