

## **WMA DECLARATION OF VENICE ON TERMINAL ILLNESS**

Adopted by the 35<sup>th</sup> World Medical Assembly, Venice, Italy, October 1983  
and revised by the 57<sup>th</sup> WMA General Assembly, Pilanesberg, South Africa, October 2006

### **PREFACE**

1. When addressing the ethical issues associated with end-of-life care, questions regarding euthanasia and physician-assisted suicide inevitably arise. The World Medical Association condemns as unethical both euthanasia and physician-assisted suicide. It should be understood that WMA policy on these issues is fully applicable in the context of this Statement on Terminal Illness.

### **PREAMBLE**

1. When a patient's medical diagnosis precludes the hope of health being restored or maintained, and the death of the patient is inevitable, the physician and the patient are often faced with a complex set of decisions regarding medical interventions. Advances in medical science have improved the ability of physicians to address many issues associated with end-of-life care. However, it is an area of medicine that historically has not received the attention it deserves. While the priority of research to cure disease should not be compromised, more attention must be paid to developing palliative treatments and improving the ability of physicians to assess and address the medical and psychological components of symptoms in terminal illness. The dying phase must be recognized and respected as an important part of a person's life. As public pressure increases in many countries to consider physician assisted suicide and euthanasia as acceptable options to end suffering in terminal patients, the ethical imperative to improve palliative treatment in the terminal phase of life comes into sharp focus.
2. The World Medical Association recognizes that attitudes and beliefs toward death and dying vary widely from culture to culture and among different religions. In addition, many palliative and life-sustaining measures require technologies and/or financial resources that are simply not available in many places. The approach to medical care of the terminally ill will be influenced significantly by these factors, and thus attempting to develop detailed guidelines on terminal care that can be universally applied is neither practical nor wise. Therefore, the World Medical Association articulates the following core principles to assist physicians and National Medical Associations with decision-making related to terminal care.

## PRINCIPLES

1. The duty of physicians is to heal, where possible, to relieve suffering and to protect the best interests of their patients. There shall be no exception to this principle even in the case of incurable disease.
2. In the care of terminal patients, the primary responsibilities of the physician are to assist the patient in maintaining an optimal quality of life through controlling symptoms and addressing psychosocial needs, and to enable the patient to die with dignity and in comfort. Physicians should inform patients of the availability, benefits and other potential effects of palliative care.
3. The patient's right to autonomy in decision-making must be respected with regard to decisions in the terminal phase of life. This includes the right to refuse treatment and to request palliative measures to relieve suffering but which may have the additional effect of accelerating the dying process. However, physicians are ethically prohibited from actively assisting patients in suicide. This includes administering any treatments whose palliative benefits, in the opinion of the physician, do not justify the additional effects.
4. The physician must not employ any means that would provide no benefit for the patient.
5. Physicians should recognise the right of patients to develop written advance directives that describe their wishes regarding care in the event that they are unable to communicate and that designate a substitute decision-maker to make decisions that are not expressed in the advance directive. In particular, physicians should discuss the patient's wishes regarding the approach to life-sustaining interventions as well as palliative measures that might have the additional effect of accelerating death. Whenever possible, the patient's substitute decision-maker should be included in these conversations.
6. Physicians should endeavour to understand and address the psychosocial needs of their patients, especially as they relate to patients' physical symptoms. Physicians should try to ensure that psychological and spiritual resources are available to patients and their families to help them deal with the anxiety, fear and grief associated with terminal illness.
7. The clinical management of pain in terminal patients is of paramount importance in terms of alleviating suffering. Physicians and National Medical Associations should promote the dissemination and sharing of information regarding pain management to ensure that all physicians involved in terminal care have access to best practice guidelines and the most current treatments and methods available. Physicians should be able to pursue clinically appropriate aggressive pain management without undue fear of regulatory or legal repercussions.
8. National Medical Associations should encourage governments and research institutions to invest additional resources in developing treatments to improve end-of-life care. Medical school curricula should include the teaching of palliative medical care. Where it does not exist, the establishment of palliative medicine as a medical specialty should be considered.

9. National Medical Associations should advocate for the development of networks among institutions and organizations involved in palliative care in order to foster communication and collaboration.
10. Physicians may, when the patient cannot reverse the final process of cessation of vital functions, apply such artificial means as are necessary to keep organs active for transplantation provided that they act in accordance with the ethical guidelines established in the World Medical Association Declaration of Sydney on the Determination of Death and the Recovery of Organs.

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