

Regarding euthanasia

David J Roy, Charles-Henri Rapin and the Board of Directors of the European Association for Palliative Care define the Association's stance on euthanasia

There is currently an extensive debate in Europe concerning the legalisation of euthanasia. Palliative care has also been brought into this discussion because there is confusion in the minds of both the lay public and many professionals about what it is. The Board of Directors of the EAPC has accordingly decided to broach the subject and present a clear and coherent definition.

We should, first of all, look at euthanasia in its familiar context. People used to die at home, with their families, surrounded by objects and memories that represented a life history to them during their last days, hours and moments. Today, people usually die in hospitals and institutions – sterile and strange, and equipped with a complex range of technology capable of supporting and prolonging life, frequently only biological life, when a return to health and vitality is no longer possible. Indeed, life may be prolonged far beyond the time when patients have lost all capacity to be masters of their remaining days.

Consequently, 'dying with dignity' has become a slogan of opposition to useless and degrading prolongation of life when a patient's organs, though still minimally functional, can no longer support or permit the exercise of self-fulfilling personal control over life's events. Dying with dignity, however, means entirely different things to different people. The term is used in support of such ethically disparate approaches to the care of the terminally ill as withholding clinically useless life-prolonging treatment, and adequate control of pain on the one hand, and euthanasia and assisted suicide on the other.

There is much confusion and intense controversy, both in general public discourse and in professional circles, regarding relief from pain and suffering. Arguments abound, confusing language is used, and decisions often show a lack of discernment.

In this context, it is essential to distinguish

between: euthanasia; control of pain and other symptoms; and withholding or discontinuing life-prolonging treatments. One must never confuse these three different types of clinical judgements and activities.

Euthanasia

The term euthanasia should be reserved for the compassion-motivated, deliberate, rapid and painless termination of the life of someone afflicted with an incurable and progressive disease. A suffering and terminally ill person is not allowed to die – his or her life is terminated. If euthanasia is performed at the dying person's request or with that person's consent, euthanasia is voluntary; otherwise it is non-voluntary. The terms 'active' and 'passive' euthanasia are ambiguous and misleading, so should be avoided.

Control of pain and other symptoms

Doctors have a professional and moral mandate to use every reasonable means available to free patients from the pain and other symptoms that cause them to suffer. The relief of pain and

Key points

- 'Dying with dignity' is a term used to support ethically disparate approaches to care of the terminally ill.
- It is essential to distinguish between: euthanasia; control of pain and other symptoms; and withholding or discontinuing life-prolonging treatment.
- A time comes in the course of a disease when it is wrong to continue to prolong life aggressively and when it is right to honour informed patients' refusal of treatments that only prolong suffering.
- Legislation of euthanasia should be opposed is both dangerous and unnecessary.
- We should rigorously promote programmes of education in palliative medicine and care.

other symptoms, such as dyspnoea, has nothing to do with euthanasia. The purpose of such treatment is to free patients from the pain and intense discomfort that dominates consciousness and leaves no psychic space available for the personally important things people want to think about, say and do before they die. The aim of such treatment is to liberate life, not to terminate it.

Withholding/discontinuing life-prolonging treatments

In the course of illness, the time arrives when it is no longer possible to restore health, function or consciousness, and no longer possible to reverse the dying process. The most that even the aggressive use of sophisticated technology can achieve is to prolong that dying process. It is in these situations that we speak correctly of withholding or withdrawing interventions that are not stabilising a person's life, but only prolonging a person's dying. It is in these situations that we speak correctly of allowing a person to die.

Today, people generally acknowledge that medical power to do good has reached its limits when prolonging suffering is all it can achieve. We acknowledge that prolonging life at all costs, especially at the cost of unbearable suffering, is not the right thing to do. That is the point of the evolving ethic of allowing the dying to die, and in doing everything possible and justifiable to help them die in peace and without pain. That is the point of palliative medicine and palliative care.

Allowing a patient to die: basic considerations

A time comes in the course of a disease when it is wrong to continue to prolong life aggressively and when it is right to honour informed patients' refusal of treatments that only prolong suffering. The following basic considerations prepare the way for the decision to allow a patient to die.

Humanity

The concept of humanity is the starting point and the constant reference point for clinical ethics in all its dimensions. It emphasises that each patient is unique and, in critically important respects, different from all other patients. Humanity means seeing and respecting patients as unique human beings, physiologically and psychologically.¹ Such an

approach is essential if we are to maintain the highest clinical ethics.

Autonomy

Saving lives has always been and always will be a central goal of clinical practice. However, a physician's commitment to this goal must be tempered and balanced by an equally strong professional commitment to patients' life plans and respect for their independence and dignity. This respect is essential if voluntary patient consent is a justification for a physician's intervention into the body and life of a human being. If confusion, the brainwashing influence of other people and pathological depression can be excluded, then the will of the patient, and not health or survival alone, should govern decisions about initiating or discontinuing life-prolonging treatment.² Physicians are wrong to believe that they are obliged to insist on such treatment against the informed, free and stable refusal of a patient.

Proportionality

Patients may be allowed to die when the only treatments that could prolong life cause suffering that exceeds the joys and opportunities for personal fulfilment that extended life may offer. The proportionality principle, succinctly stated, affirms that life-prolonging treatments are contraindicated when they cause more suffering than benefit.

Futility

There is general agreement today that patients are not obliged to undergo treatments that are futile, and physicians are not obliged to begin or continue such treatments.^{3,4} However, there is confusion and controversy about the meaning of futility.^{5,6} The futility of an intervention should be judged in terms of the clinical goals for each individual patient. The central question is: Will the intervention benefit the patient as a whole?

It is essential to identify two components in the concept of futility: physiological effect and patient benefit. Some treatments are futile because they cannot produce a desired physiological effect for a given patient or category of patients. For example, the probability of chemotherapeutically halting a metastatic process may, on the basis of clinical trial results or accumulated clinical experience, be nil, or so low as to constitute the rare and uncontrollable exception. In these

circumstances, chemotherapy would be futile, as, even more obviously, would be resuscitation in the event of cardiac arrest in the terminal phase of the disease.

Treatments that can produce a physiological effect (eg antibiotic treatment of pneumonia) may be futile because they cannot reverse a deeper and more catastrophic underlying condition, such as persistent vegetative state, and therefore offer the patient little or no benefit.

Consideration of each individual patient in his or her body and biography – the total patient – is the key to proper use of futility as a criterion for allowing a patient to die.

Should euthanasia be legalised?

We should, firmly and without qualification, oppose the legalisation of euthanasia as both unnecessary and dangerous. We should vigorously promote programmes of education in palliative medicine and palliative care rather than jumping on the bandwagon of hysterical pleas for the decriminalisation of euthanasia.

Euthanasia is not necessary

The binary logic of the alternative, dying with pain or euthanasia, may have held true in earlier periods, before the development of modern methods of palliative medicine and palliative care. It does not hold true today, anywhere in the world. The civilised solution rests with a rapid implementation of programmes of palliative medicine and palliative care, not with resignation to pressures for euthanasia.

Euthanasia, even when motivated by compassion, is not a socially acceptable substitute for the establishment of effective programmes of palliative medicine and palliative care.

The challenge of civilisation to our societies at the end of this decade is to transform our care of the suffering and the dying, not to legalise an act that would all too easily substitute for the palliative competence, compassion and community that human beings need during the most difficult moments of their lives.

Legalisation of euthanasia would be dangerous

The lobby to legalise euthanasia presupposes a world of ideal hospitals, doctors, nurses and families. But we do not live in an ideal world and, for this reason, arguments supporting the

legalisation of euthanasia rest on five flawed premises:

- Euthanasia, once legalised and socially acceptable, would remain voluntary and vulnerable and burdensome patients would not be subtly manipulated and pressured to request termination of their lives
- We would continue to resist the extension of euthanasia to those who are irreversibly unable to request or consent to termination of their lives
- The legalisation of euthanasia would protect doctors against lawsuits and would minimise the chances of doctors being brought to trial
- With euthanasia legalised, we would remain a caring society ready, in times of budgetary constraints, to invest money and resources to develop humanitarian programmes of palliative medicine and palliative care
- We could never, as have civilised societies before us, slip into the intolerable abuses of legalised euthanasia.^{7,8}

These illusions, upon which arguments rest in favour of legalising euthanasia, need to be identified and exposed. Some believe that it is not proven and utterly unlikely that legalisation of euthanasia would provoke a slide towards intolerable abuse. Admittedly, that slide is not certain and there is no proof that it would occur. But it is prudent to ask whether we should try this social experiment once again in this century and see what will happen.

In 1920, Karl Binding, a doctor of jurisprudence and philosophy, and Alfred Hoche, a doctor of medicine, published a book in Germany on euthanasia.⁹ They did not intend the Nazi euthanasia programmes that were a central focus at the Nuremberg trials. Nor, perhaps, could these two eminent men have foreseen the second-order links between their 'benevolent' ideas on euthanasia and an emerging Nazi ideology. But those links were eventually forged, and evidence at the Nuremberg trials established the influence they had on those who designed and implemented the Nazi programmes.¹⁰

The signs in our society of overt discrimination, latent racism, and utilitarian insensitivity to the vulnerable are too prominent for us to be naive about proposals to decriminalise euthanasia. We should maintain an uncompromising stand against a law that would permit the administration of death.

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