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From the USA

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Reading this position paper reminded me of George Bernard Shaw's quip about England and America: 'two countries separated by the same language.' While I easily appreciate most of the argument, some parts seem quite 'foreign,' while major elements are lacking that I would expect in a review on euthanasia and physician-assisted suicide from North America. I wish the intended audience was defined. The absence of references to articles and monographs that have accompanied the heated public and professional debates on these issues in the USA suggests strict reliance on a European viewpoint.

The section on 'Medicalized killing' was most anomalous. Here, the paper only refers to withholding and withdrawing 'futile treatment.' The concept of futility, while popular in the recent past, has largely been abandoned as a useful construct.[1] More importantly, we recognize the right of patients to refuse any treatment, regardless of whether it can be construed as futile. Withholding or withdrawing a potentially life-sustaining treatment at the wish of the patient is carefully distinguished from euthanasia or assisted suicide.[2]

Likewise, 'sedation for intractable distress in the dying patient'[3] – a much more precise term than 'terminal sedation' and less prone to misunderstanding – is generally (but not universally) accepted here as distinct from euthanasia or assisted suicide. However, no discussion of acceptable medical procedures that might hasten or cause death should omit the important and often unappreciated rule of double effect.[4,5] The document does elsewhere resort to distinguishing between intended and unintended effects of treatment, a difference that, I would argue, is often hazy[6] but is essential in applying the principal of double effect. A great deal of palliative care that might be viewed as hastening death is commonly justified by this rule, while overt 'terminal sedation' is a rather rare practice. Some commentators also recognize 'voluntarily stopping eating and drinking'[7,8] as an acceptable method for allowing dying patients to hasten death. Importantly, such methods that hasten death are only ethically acceptable in patients near death; broader application of euthanasia, suicide, and related approaches to 'self-determined' death are rarely endorsed.

The definitions of euthanasia and physician-assisted suicide also look foreign insofar as they seem to imply that only physicians can carry out euthanasia and that euthanasia and assisted suicide are solely accomplished with drugs. Other persons may carry out or assist in these acts, and other methods may be used. I do not believe the combination of barbiturates and neuromuscular blockers are 'usually' chosen for euthanasia in this country.

The debate in the USA has been extremely heated, and many writers readily vilify the Dutch and advocates of legalization as somehow inhumane and ignorant of palliative care, while dismissing so much of the data that helps frame the issues in more objective terms.[9] The document at hand seems to fall into some of these traps. For instance, it refers to legalized euthanasia or physician-assisted suicide 'under certain circumstances' without describing, for instance, the careful safeguards built into the Oregon Death with Dignity Act. I find the statement that palliative care '. . . seeks to strengthen and restore autonomy, and not to destroy it' biased and inflammatory, while the listing of only potential ills from legalized euthanasia (paragraph 4.7) suggests a one-sided view. I would have liked to see some reference to the increasing data indicating that physician-assisted suicide and euthanasia are not regularly sought because of intractable physical suffering or even depression, but rather because of concerns about control, independence, and quality of life.[10,11] Likewise, the legalization of physician-assisted suicide in Oregon has led to very few uses of this option[12]and does not seem to have produced many of the 'potential' bad outcomes listed under paragraph 4.7.[13,14] Dismissing the best data we have – from the Netherlands and now from Oregon – as having 'significant methodological weaknesses' reads more like a convenient dodge than a dispassionate appraisal of the literature. The appeal to living wills and advance directives as an antidote to patients' fears of prolonged and unbearable distress may represent wishful thinking, since the bulk of evidence indicates that these instruments are rarely prepared by patients and are then often not available to key clinicians when the documents might be useful, and finally are not respected when patient instructions conflict with what the physician believes is right.[15,16]

The key conclusion of the article seems to come in paragraph 4.5. 'The provision of euthanasia and physician-assisted suicide should not be part of the responsibility of palliative care.' The Task Force should first acknowledge that the major, challenging policy issue –

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should these practices be legalized for the terminally ill under specified circumstances? – has been skirted. The authors might rightly suggest that such policy decisions are not within physicians' expertise or that the Association notes considerable disagreement on the issue. And, of course, our professional code dictates that physicians should not be forced to carry out acts that they feel to be ethically unacceptable. But is legalization acceptable as long as others offer the procedure? As nicely summarized in the paper, who else but a palliative care team is able to assess a terminally ill patient and prevent or treat all forms of suffering, thus perhaps providing an alternative to drastic acts? Whom else would we trust with this option of last resort, this 'least terrible'[17] alternative in the face of intractable suffering? I particularly appreciate the emphasis on exploring patients' inquiries about hastening death,[17] as well being open to the opposing views about euthanasia and assisted suicide. But a related, important question is how an association between palliative care or hospice and hastening death – an association that exists in the minds of many professionals and lay persons in this country – will affect the future of the hospice movement. And what are the advantages of bringing euthanasia and physician-assisted suicide out in the open under public scrutiny, as opposed to keeping these relatively uncommon but hardly unfamiliar practices in the closet?

In conclusion, I hope this document will be reworked substantially in order to contribute to 'informed public debates on these issues.' The Task Force has successfully reviewed a number of familiar issues, confused some important definitions and distinctions, passed over the growing data about which responsible palliative care clinicians and other commentators should be familiar in advising about humane approaches to the suffering of the dying, and avoided without explanation the key policy decisions.

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