From France

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Accurate definitions (of physician-assisted suicide, of euthanasia, of the mission of palliative care teams) are necessary to discussion about medical participation in any 'active' end of life procedure. The Task Force paper clearly provides them.

Three comments arise from our reading: first, about the notion of causing death; second, about medical involvement in euthanasia and assisted suicide; and third, the value of living wills.

The general notion of causing death includes three different concepts. The verb killing refers to any act that causes death. This is the opposite of natural death. The word murder implies voluntary killing. In law, assassination means premeditated murder.

Therefore, euthanasia fulfils the criteria of assassination with particular specifications: at the request of the patient and by the intervention of a doctor.

We agree with the idea that the social debate is mandatory. The subject of such a debate should be focused on the notion of premeditation. Talking about 'killing in intolerable end of life circumstances' runs the risk of forgetting two major issues for the wider public: who carries out the act and the nature of the premeditation.

The contradiction between medical involvement in actively ending a life and the mission of palliative medicine as defined in this article is clear. This question can be widened to all practitioners. At a personal level, a practitioner should always be free to refuse to be involved in the provision of euthanasia. Sometimes, the physician is neither free nor autonomous (and may have a conflict of interest). As a general principle, should special professional group(s) be devoted to possible euthanasia, while other groups (such as palliative care teams) refuse it? Should a special group be created in order to practice euthanasia?

The freedom and autonomy of a person who demands euthanasia or assisted suicide are prerequisites to any further discussion about whether euthanasia should be carried out. Paragraph 4.2 (of the Task Force paper) illustrates well the difficulties in evaluating this freedom and autonomy. Paragraph 4.8 suggests that living wills could be helpful by contributing to 'enhance the autonomy of the patient'. We disagree with this statement. Living wills and advanced directives anticipate a particular set of circumstances. But the situation now may be different from the situation when the living will was written, or, in others words, frozen. Respecting the autonomy of a person implies re-evaluating with the person the validity of the request previously formulated. Therefore, living wills should not be considered as authority for providing euthanasia.

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