From France

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The consensus opinion of the Task Force of the EAPC is that the terms euthanasia and assisted suicide be reserved for the voluntary intention to shorten the life of a conscious patient who has requested help, by administering a drug.

This consensus raises issues concerning the numerous disadvantages of legalizing euthanasia. These definitions raise questions about the competence of the patients, who sometimes do not appear to be fully competent. How can we be sure that a patient's autonomy is not altered by a psychiatric or neurological disease? No scientifically validated scales are available to define the competence of patients or the doctor's intentions. The definitions of the Task Force focus on the intention of an intervention but do not indicate which objective elements characterize this intention. Such objective criteria are essential for practitioners if they are to apply this ethic to end-of-life care on a daily basis. Unfortunately, the EAPC Task Force has not stressed the indispensable nature of collective decision making in such situations. Group decisions may help to limit the risk of the treating doctor being forced into a decision based on his or her convictions. In fact, the line between weaning from a medicine that is considered to be 'futile' and euthanasia is often a fine one. What should we think about stopping the ventilator of a conscious patient that is dependent on the ventilator for survival? According to the Task Force paper, the difference between euthanasia and discontinuation or withdrawal of treatment is that in the latter situation, death does not result from the injection of a drug, regardless of whether the death is or is not the main aim in the doctor's mind and whether or not the treatment can be considered to be 'futile'. The irrelevance of the latter point was clearly demonstrated by the American Society for Critical Care, who claimed that the term 'futile' should be reserved for treatments that have no physiological effects. How many patients receive such treatments? Does not the argument based on the fact that a drug is not used give too much weight to what is in fact just a technical procedure to achieve a certain goal? This leaves the argument based purely on the intention behind an action. Apart from the highly subjective nature of this argument, we may reasonably be surprised that a medical act of euthanasia (as defined by the Task Force) is only viewed as inducing death rather than aiming to relieve the suffering of the patient. It goes without saying that the argument of intentionality has the advantage of banning any cases of euthanasia with eugenic purposes, but is this really essential in the twenty-first century? The position paper does not discuss cases of euthanasia when patients are unconscious or incompetent, which includes most patients in intensive care units. According to the paper, killing these patients quickly by injecting a drug is 'murder', whereas stopping dialysis, which is conceivable in long-term situations, is legitimate. However, both situations inevitably result in death. The problems raised when we consider an incurable illness and constantly advancing technology are complex. Thus, the aims of our doctors are to relieve the suffering of patients. The definition of death according to whether death is the desired outcome or a secondary effect of a therapy or manoeuvre aimed to relieve the patient's suffering probably does differentiate euthanasia from other causes of death, but there are very few objective arguments that allow us to evaluate the situation. This position paper is, therefore, a declaration of the intentions of palliative care physicians, aiming to exclude the concept of euthanasia from their practice in which death is only a secondary effect. This affirms the pureness of their intentions. However, the reality surrounding the end of life deserves a multidisciplinary study including doctors from all specialities to observe the conditions surrounding the deaths of patients in hospitals, to evaluate the roles played by the families (when faced with an unconscious patient with a very poor prognosis is it wrong sometimes to want to relieve the family from this difficult and dead end situation?) and to study the actual conditions surrounding decision making. In fact, in parallel with the convictions and subjective intentions, the procedural nature of ethics may be a big advantage in end-of-life situations. This position paper and associated commentaries would open up discussion that could make it possible to initiate such a process.

10.1191/0269216303pm737op