Palliative Medicine 2003; **17:** 180–183

And finally

The position statement and its commentators: consensus, compromise or confusion?

The Ethics Task Force of the EAPC has done a significant job in forwarding the discussion of the relationship between palliative care and euthanasia, as the wealth of international commentary on the document surely illustrates. The position paper is commendably succinct and, in some respects, unambiguous in the views defended. Notably, the document abjures discussion of anything other than voluntary active euthanasia and, in its general tenor, rejects euthanasia as in any way part of palliative care. However, it must be clear from the range of reaction to the position taken that this document leaves many issues unresolved and thus leaves open the possibility of a continuing debate of the issues among those involved in palliative care. This is by no means necessarily a bad thing – on the contrary, a refusal to have a continuing debate would surely reflect badly on the Association – and it is notable that the Association has not adopted the paper as an official statement.

However, there may be some disadvantages in a document that provokes such a range of commentary. To what extent does this represent diversity of moral belief in those invited to contribute and to what extent do ambiguities in the position paper need to be resolved? Is there an inevitable pluralism here, or can we identify an area of shared value in palliative care? We shall consider this key question under the slightly provocative subtitle: consensus, compromise or confusion?

Our commentary falls into several parts. First, we consider the problems of definition in this contentious field, in particular whether the position paper offers satisfactory definitions of two key terms, 'euthanasia' and 'terminal sedation'. Next we look at contrasting views of how palliative care and euthanasia are related to each other (if at all). Thirdly, we discuss the types of ethical arguments used in the debate, and finally, we offer our own brief and tentative conclusions.

There is a truly remarkable volume of commentary in this issue and we cannot possibly do justice to it all. (The editors are to be congratulated on obtaining 55 articles from 32 different countries!) Instead we refer to a small selection of the commentaries from time to time to illustrate the diversity, but in each case many other authors could have been referred to or quoted to illustrate the same point.

Definitions

The first commentary by Saunders expresses gratitude to the Task Force for the care with which they have defined their terms. Many others echo this view. For example, Adler believes that it unambiguously defines terms, identifies misleading phrases and avoids subjective and emotional overtones and Spence believes that the definitions leave no room for doubt. In contrast, Billings finds himself divided by a common language and sees many confusions of both definitions and distinctions; Mori considers that the definitions are misleading and misrepresent the euthanasia position by leaving out reference to terminal illness; Randall finds the definitions to be based on assumptions, which are not themselves explained and justified.

We can explore this further by considering Randall's point about the *stipulative* character of the definitions. As she points out, the document departs from ordinary usage in a number of respects: it omits motivation (the mercy part of 'mercy killing'); it avoids referring to the patient's clinical condition or the patient's possible incompetence; and it appears to limit euthanasia to medical acts. By stipulating that only voluntary and competent requests to doctors to kill by the administration of drugs qualify as 'euthanasia' (which notably echoes the definition adopted in Dutch law), the document avoids exploration of many of the ambiguities and uncertainties in clinical practice that lead people to consider the morality of euthanasia, within or outside the palliative care context. It does appear that apparent clarity and a certain decisiveness of definition have been bought at the expense of simplifying the issues.

Although rigorous attempts to define 'euthanasia' are somewhat thin on the ground,[1] there is, within the philosophical literature, a very lively debate about a number of key issues, which such a stipulative definition simply rules out as 'not euthanasia'. For example, the act/omission (or active/passive) distinction is by no means as

10.1191/0269216303pm761ed

straightforward as the Task Force implies, nor is the definition of futile treatment a value-free zone.[2] There is also a key philosophical debate about whether the distinction between act and omission is a morally relevant one, when the consequence of hastening death is clearly foreseen.[3] If these were merely philosophical, 'ivory tower' worries, perhaps the EAPC could happily ignore them, but it is obvious from the commentaries from clinicians, not just from philosophers, that everyday practice raises exactly these problems of boundary and scope. It is hardly surprising, then, that there are polarised positions in the commentaries about whether the definitions offered are helpful.

Turning to another definition, that of 'terminal sedation', we find ourselves again in hotly contested territory.[4] The document relies on one aspect of the classical doctrine of 'double effect', identifying the intention to relieve suffering rather than to kill as the factor that distinguishes terminal sedation from euthanasia as it defines it. This again provokes a range of commentary. Meijburg is supportive of this distinction, but makes the point that 'lived experience' makes a difference to how we understand such definitions. He wants to see more emphasis on the issue of consent by the patient and suspects that often the phrase can be a cloak for euthanasia. With this in mind, Currow argues for the phrase 'sedation in the terminal phases of a life limiting illness', arguing that the physiological effects of such sedation are often over-estimated. Luczak and Kluziak point out that sometimes sedation may prolong the life of patients rather than hasten death, but they also believe that, with consent, patients have a right to deep sedation, recognising that it can hasten death. Van der Wal is more forthright still about the ambiguities in practice. He agrees that intention is crucial, but argues that the doctor can not escape from the other consequences, including earlier death, just because they are not intended. For this reason, he sees the absence of any discussion of the patient's consent as a serious omission.

We consider that this range of commentary again shows that the document's attempt to isolate palliative care practice from the possibility of euthanasia fails to work, both theoretically and clinically. The doctrine of double effect has proved very valuable in both clinical practice and legal judgements, but it is far from straightforward or self-evidently valid. It can appear as an attempt to dodge the dilemma of treating a patient whose suffering is so intractable that only total unconsciousness and early death seem the right ways to provide care. Like the act/omission distinction, the double effect style of arguing has been heavily criticised by some philosophers, who regard the claim to not intend some foreseen consequences as merely doublethink.[5] It is unfortunate that the document pays so little attention to such criticism, for it does reveal the considerable ambiguity in some claims that killing patients is being avoided (though death is the outcome). This does not mean that the doctrine should be wholly abandoned, but rather that its application and its potential misuse need to be more fully discussed. Clearly, there may be some situations, even if mercifully rare ones, when the foreseen hastening of death is the outcome hoped for by patient and clinician alike. In such situations the double effect argument, as van der Wal seems to imply, could be an evasion of moral responsibility for one's actions.

Are euthanasia and palliative care incompatible?

This leads us to the next question: should there be a clear separation between euthanasia and palliative care? We can distinguish two ways of asking this question: an empirical one and a theoretical one. The empirical response suggests either that allowing euthanasia could be a threat to palliative care or that it could support and enhance it. Rajagopal, looking from a global perspective, believes that there is a serious danger from tolerant attitudes to euthanasia, especially in countries with weak legal systems or where there is widespread corruption: 'Killing is easier and cheaper than providing care'. Hendin believes that euthanasia legislation has led to the neglect of palliative care. On the opposite side, Loop, reflecting on the newly introduced Belgian law, believes that such legislation can lead to a revaluation and strengthening of palliative care, a point partly endorsed by Botterman.

Such empirical claims are hard either to refute or substantiate, since there are only a few countries where euthanasia or physician-assisted suicide has been legalized, and even there, it seems likely that other factors will affect how fully palliative care is provided. However, it is possible to discuss whether these measures, both related to dying, should be in partnership or should be kept in separate spheres. The Task Force states unequivocally: 'The provision of euthanasia and physician-assisted suicide should not be part of the responsibility of palliative care' (4.5). This is strongly supported by several commentators. Klaschik argues that they are 'under no circumstances' compatible with palliative medicine; Moyana sees them as opposites, with entirely different aims; Welshman can accept that palliative care workers may respect a request to kill but not that they can be responsible for implementing it. Yet there is equally strong support for the compatibility of the two approaches.[6] Tännsjö believes there can be 'mutually trustful co-operation', pointing out that the WHO definition (1990) contains phrases which are entirely compatible with euthanasia. Pogge argues that society need not make an exclusive choice between palliative care, euthanasia and physician-assisted suicide. All three should be options available to patients and need not be in conflict. Hänninen believes that at the very least palliative care workers have a responsibility to be involved in the debate about euthanasia and cannot merely dismiss it as outside their area of practice.

What are we to make of this diversity? It suggests to us that the palliative care community has many shared values, focussed on a commitment to relief of suffering of all kinds, on acceptance of dying as a natural event, and on respect for the dignity (and autonomy) of the individual patient. This consensus on fundamental values leaves open the question of whether active steps to end a person's life are compatible or incompatible with the ethics of palliative care. The consensus ends at this point and plurality of moral view enters, a point which seems to be acknowledged by the document when it speaks of 'understanding and respect of alternative viewpoints' (4.9). What the commentaries illustrate is that this plurality of view is to be found within the group who support palliative care, not only between that group and others outside it. In light of this, we shall comment briefly on a possible confusion between ethics and ideology in the debate about euthanasia.

Ethics or ideology?

We may best capture the distinction between ethics and ideology in the disappointment expressed by Hendin that the document represents a 'retreat' from the EAPC's unequivocal opposition to legalising euthanasia. This implies an unwavering commitment to one view, explicitly endorsed by Glare, when he requires of the EAPC a strong anti-euthanasia stance because of the 'political battle' over euthanasia legislation; equally Zenz criticises the paper for being balanced and fairly neutral, when the topic requires a 'clear, highly biased position'. Edenbrandt adds a further ideological element by suggesting that if the Association 'abandons an uncompromising stand against euthanasia', then national medical associations will have to leave the organisation.

These statements are advocating an ideology, that is to say a fully committed position on a social or ethical issue, which does not necessarily require the backing of evidence or reasoned argument. Stiefel recognises this feature of the position paper, when he points out that it lacks arguments either for or against euthanasia and that assumptions are made about the consequences of euthanasia (4.2 and 4.7) with no supporting evidence.

In contrast with such ideological commitments, ethical analysis seeks to defend a position by means of reasoned argument with reference to widely held ethical norms or principles. A number of commentators believe that the Task Force should have carried out more careful research of this kind prior to reaching its conclusions (d'Hérouville, Lickiss) or should have engaged seriously with the research data on euthanasia and physician-assisted suicide (Billings, van der Wal, Porchet). Others seek a clearer discussion of futility (Taboada) or want a fuller analysis of the nature of suicide, as opposed to euthanasia (Ganzini, Finlay). In all these cases we have a search for ethical argument, related to empirical data, where available. A consequence of this approach, of course, is that the argument and new evidence might lead to a change of one's view on the ethical issues. This possibility of a change of personal view, or of a diversity of view among palliative care practitioners, is what distinguishes an ethical discussion from an ideological one. There seems little doubt that a substantial number of those involved in palliative care are willing to take the risks of unfettered ethical debate, rather than be required to endorse some official stance on euthanasia and physician-assisted suicide.

Consensus, compromise or confusion?

What then are we to make of the position paper and the accompanying commentaries? Space has prevented us from carrying out a full analysis of either. (In particular, there are several interesting discussions of the theoretical background to the debate, which we have not referred to or analysed.) However, even in this brief account, we hope to have answered our headline question about the current state of the debate in the Association. We have already commented on the high degree of consensus about the ethical values underlying palliative care. The document and many of the commentaries articulate these values very clearly, and it is obvious that those involved in palliative care are united in their determination to see them implemented in medical practice worldwide. This is not true of euthanasia and physician-assisted suicide, however, even though they are probably opposed by a majority of practitioners. The position paper seems to have attempted a compromise, in order to deal with the diversity of view. It does this partly by severely restricting the definition of terms through stipulative definitions and partly by offering an olive branch to dissenters through the concept of respect for difference.

In our view, these moves toward compromise have resulted in unhelpful confusion in some respects. As is evident from the commentaries, the Association's attitude towards a plurality of views on this topic amongst its membership has been left unclear. Had all the arguments for and against these contentious changes in legislation been more adequately rehearsed, then the rationale for the conclusions of the Task Force would have been easier to assess. Perhaps, then, the Association could have adopted some agreed position, but its appeal to members would depend on their freedom to weigh the arguments themselves and decide whether their own commitment to palliative care requires such a conclusion. Those who conclude otherwise should expect equal respect, rather than being made to feel disloyal to the Association.

Nevertheless, a most fascinating debate has now begun, and this could not have happened had the Task Force attempted to deny differences in the views of the Association's members. In order to take this debate further, we hope that further work will be done on terminology and on the emerging evidence about possible relationships between palliative care and new legislative regimes around death and dying.

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References

1 Although see, e.g., Beauchamp TL, Davidson A. The definition of euthanasia. *J Med Philos* 1979; **4**: 294–312; Wreen M. The definition of euthanasia. *Philos Phenom Res* 1988; **48**: 637–53.

2 For example, Löfmark R, Nilstun T. Conditions and consequences of medical futility – from a literature review to a clinical model. *J Med Ethics* 2002; **28**: 115–19.

3 For criticism of the distinction see, e.g., Rachels J. *The end of life: euthanasia and morality*. Oxford: Oxford University Press, 1986. For support of the distinction see, e.g., Stauch M. Causal authorship and the equality principle: a defence of the acts/omissions distinction in euthanasia. *J Med Ethics* 2000; **26**: 237–41.

4 See e.g. Williams G. The principle of double effect and terminal sedation. *Med Law Rev* 2001; **9**: 41–53.

5 For criticism see, e.g., Doyal L. When doctors might kill their patients: The moral character of clinicians or the best interests of patients? *BMJ* 1999; **318**: 1432–33; Singer P. *Practical ethics*, second edition. Cambridge: Cambridge University Press, 1993; and Rachels J. *The end of life: euthanasia and morality*. Oxford: Oxford University Press, 1986. For support, see e.g., Keown J. *Euthanasia, ethics and public policy: An argument against legalisation*. Cambridge: Cambridge University Press; 2002; Gillon R. When doctors might kill their patients: Foreseeing is not necessarily the same as intending. *BMJ* 1999; **318**: 1431–32.

6 For some similar arguments see, e.g., Farsides B. Palliative care – a euthanasia-free zone? *J Med Ethics* 1998; **24**: 149–50.