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Introductory paper

Palliative care and the euthanasia debate: recent developments

Euthanasia, as with other forms of medical involvement in the end(ing) of life, has long attracted the attention of health professionals, ethicists, lawyers and of course society more generally. So familiar are the main arguments that, as long ago as 1958, a prominent British lawyer referred to the debates as 'jaded'.[1] In recent years, however, the debates have not only rehearsed established positions, they have also become increasingly nuanced. As this edition of *Palliative Medicine* contains a position statement on euthanasia from an Ethics Task Force of the European Association for Palliative Care, this is an ideal opportunity to take stock of current concerns at the end of life.

Naturally, numerous authors continue to defend one (or sometimes more) of three 'classic' arguments relating to euthanasia. (1) The sanctity (or less theistically, inviolability) of life position has the longest history, and it still commands much support. In the UK, the Church of England has recently updated its well-known document opposing euthanasia, *On Dying Well*.[2] The sanctity of life position has also underpinned a number of other scholarly contributions, in particular prominent anti-euthanasia writer John Keown's recent book, which collects and connects much of his writing on the topic to date.[3,4] For authors like Keown, life is of such intrinsic value and the 'slippery slope' dangers are so evident that euthanasia can not be tolerated, least of all on a legal footing; the 'quality of life' claims inherent in proposals for euthanasia are considered unjustifiable.

(2) At the other end of the moral spectrum are those who argue that euthanasia can be a legitimate response to suffering or a low quality of life. Some contemporary bioethical and legal theorists are therefore content to defer to such judgements, at least when made by the patient him or herself. (3) This focus on the patient's views and wishes introduces a third perspective, which derives from the obligation to respect patient autonomy, which has assumed central importance in much bioethical theorizing and, indeed, medical practice. Taking this focus, Margaret Otlowski has published a thorough analysis of the law in numerous common law jurisdictions, and has argued that voluntary euthanasia ought to be a valid legal option.[5] More controversially, a recent edition of the *British Medical Journal* carried a guest editorial that argued to identical effect, and which – perhaps inevitably – prompted a flurry of antipathetic and also sympathetic correspondence.[6]

Some new perspectives have recently been brought to the debate. 'Dignity' is a concept long associated with euthanasia, particularly among those lobbying for what has been termed 'death with dignity', yet its precise meaning has seldom been clear. Fortunately, at least two new texts have sought to tackle the concept.[7,8] The debate will not cease here, however, as both texts favour an interpretation that would justify voluntary euthanasia. Those who see life as of intrinsic value will surely protest that this is a misinterpretation of the dignity inherent in human life. Liezl van Zyl has also offered an innovative account of the ethics of euthanasia, which examines the issue from the perspective of 'virtue ethics'. With so many discussions to date dominated by the language of principles, duties, rights and consequences, this renewed concentration on moral character is a refreshing development.[9]

Of course, a focus on the ethical values at stake sometimes risks missing another, increasingly relevant area of concern: that of the very concepts under discussion. There has, on occasion, been too little attention paid to what 'euthanasia' and related terms can be taken to mean. That is less so the case today, but increased attention to the concepts does not necessarily mean that we are any closer to agreed definitions. Verbal battles still rage, for example, over the existence or otherwise of 'passive euthanasia'.[10] Similarly, the doctrine of double effect, which permits death to occur provided it is merely a side effect of one's intended – and justifiable – goal and has played a key role in justifying some of the practices of palliative care, has come under attack: its defenders are still called on to distinguish the administration of opioids and opiates and the use of 'terminal sedation' from 'slow euthanasia'.[11,12] Another theme, most prominent in the USA, concerns the distinctions (if any) between 'active voluntary euthanasia' and (typically physician) 'assisted suicide'.[13]

That latter development has spurred, and has been spurred by, some legislative developments in the USA. In

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1997, Oregon adopted a law permitting physician-assisted suicide; notably, this was not the only American state to contemplate such a reform, and the issue has also been considered by the American Supreme Court.[14] There have been analogous developments in Europe, as Belgium has recently legislated to allow voluntary euthanasia, while the Netherlands has formalized its long-standing tolerance of the same practice.[15,16] Perhaps understandably, given its familiarity with the practice, the Netherlands has also presented some controversial cases of assistance in death. The interest created by the case of Edward Brongersma, assisted in his suicide by his general practitioner, Dr Philip Sutorius, on the basis that he was merely 'tired of life', again illustrates the increasingly novel and technical nature of the contemporary debates.[17]

In the UK, there have been a number of high profile legal cases. The reactions to the ruling that authorized the separation of the Maltese conjoined twins, despite the certain result that the weaker twin would die, amply illustrated the diversity of, and tensions between, the ethical stances adopted on the ending of life.[18] That ruling was followed by two equally challenging cases, the first concerning tetraplegic 'Ms B', who sought to have her artificial ventilation discontinued, and the second concerning Dianne Pretty's request that her husband be immune from prosecution in the event of his assisting in her suicide.[19,20] The former application was granted; the latter was denied. In Mrs Pretty's case, the highest English court, the House of Lords, rejected the argument that the prohibition on assistance in suicide (in the Suicide Act 1961) was inconsistent with the applicant's 'human rights', as enshrined in the recently enacted Human Rights Act 1998. That Act brought the European Convention of Human Rights directly into force in English law. The Lords' ruling – and the subsequent similar decision in Strasbourg[21] – brings us full circle, for it essentially boiled down to the traditional conflict between the right to (or sanctity of) life and the right to autonomy.

All the courts felt that the right to life had to take precedence. The courts recognized that Mrs Pretty's plea had to be balanced against, and was ultimately outweighed by, societal interests. The European Court of Human Rights in Strasbourg has long recognized the right of member states to act and legislate within a 'margin of appreciation', in determining rights claims by reference to the norms of the particular society. The English prohibition on assistance in suicide was therefore allowed to stand; a claim from a different jurisdiction might have been resolved differently, however, such as one from the Netherlands, where the ethical positions are arranged differently. The availability and importance of different perspectives should not be underestimated; plurality – and open debate – is surely to be encouraged and it is interesting to note that both in the conjoined twins case and the Pretty case, the English courts welcomed submissions from both the 'pro life' and 'pro choice' camps.

Does this emphasis on plurality and open debate mean that consensus is impossible? Clearly not, as recent documents show. Professional medical associations, for example, often succeed in issuing policy guidance, which convey a uniform position, at least within an individual jurisdiction. To use England and Wales as an illustration again, guidance has been issued concerning the initiation and discontinuation of life-prolonging treatments, ranging from the general to those focussed on particular interventions (such as cardiopulmonary resuscitation).[22–24] This is not to claim that practitioners are always adequately informed or that practices are necessarily consistent, but the point still stands that some norms can be agreed.[25] In a similar vein, professional organizations in the same jurisdiction remain opposed to euthanasia and assisted suicide, as evidenced by the statements and discussion papers resulting from the British Medical Association's physician-assisted suicide project to investigate members' views and reach a consensus position.[26]

We turn now to the recent endeavour by an Ethics Task Force of the European Association for Palliative Care to formulate a position statement on euthanasia and end of life care that expresses a viewpoint acceptable to those across Europe who work within palliative care. The position statement is published next, followed by an international range of commentaries. It will be interesting to consider whether the position statement and commentaries represent a consensus among palliative care practitioners and others associated with the field, or merely an illustration of continuing disagreement and debate. We shall return to this question in our own commentary at the end of this section.

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Centre for Ethics in Medicine,
University of Bristol,
UK

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