Palliative Medicine 2003; **17:** 393–394

Correspondence

Letter to the Editor

Sir – The EAPC article seems to be distancing palliative care from euthanasia rather than saying it is wrong. For such a short article I think there is an amazing lack of clarity about what they are saying. The bottom line is that palliative care, medicine and society should not be involved in killing people at the end of their lives. That is an ethical standpoint and as such is open to debate. The EAPC article confused me in that it pursued neither the scientific evidence approach nor the ethical approach rigorously. Dr Rajgopal made some very important comments about the implications for countries such as India (which has a sixth of the world's population!). What message are established palliative care authorities sending to countries attempting to develop services in difficult circumstances?

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Palliative care and euthanasia in countries with a law on euthanasia

Sir – In the last issue of *Palliative Medicine* the EAPC Ethics Task Force presented its position paper on euthanasia.[1] This position paper constitutes an intelligent and sensitive evolution compared to the previous blanket rejection of (legalisation) of euthanasia.[2] Especially the relinquishment of the qualifiers 'voluntary' (henceforth a pleonasm) and 'passive' (henceforth an oxymoron) greatly clarifies discussions. Nevertheless, the position paper probably reads differently in countries or states with a euthanasia or physician-assisted suicide law than in countries without such a law. As researchers in the areas of palliative care and end-of-life decisions in Belgium and the Netherlands, we are privileged observers of the relevant societal and legal developments on this issue in the Lowlands.

In a study examining death certificates, relating to about 2000 deaths, the estimated incidence of euthanasia in medical practice in Flanders was 1.1% of all yearly deaths.[3] This study was carried out before the new euthanasia law in Belgium and even before the start of the societal debate. For Belgium this would be more than 1000 euthanasia cases per year. From Dutch studies we know that the number of euthanasia requests is four times higher than the actual cases and that these requests are being discussed with other care givers and family members.[4] Hence, euthanasia does exist and has a significant position in medical end-of-life care practice in a country where it is considered murder under criminal law. The question is, therefore, not whether euthanasia is to be part of end-of-life care, but how is it practised and integrated in end-of-life care. In countries where euthanasia is legalised, the focus of the debate moved from an ethical and ideological debate towards the development of requirements of prudent practice and of guidelines for good medical practice at the end of life.

The position paper and some of the commentaries expressed concern about the pressures that vulnerable people would be exposed to if euthanasia were to be legalised. There is no evidence for this argument in the Netherlands and in the Belgian data: euthanasia was practised significantly more often among higher educated patients than among lower educated ones.[3] On the contrary, the data rather suggest social inequalities in the traditional sense. Furthermore, in the Netherlands, there seems to be a growing societal concern about requests for euthanasia not being honoured by physicians, while there are no signs of any societal fear of becoming a victim of involuntary life termination.

The data give no support to the slippery slope argument that is often invoked against (legalisation of) euthanasia. One of the important motivations for legally regulating euthanasia in Belgium was the high ratio between the rates of life termination without explicit patient request and proper euthanasia: 3.2% versus 1.1% of all deaths in Flanders in 1998.[3] We have argued that under the former repressive legal circumstances, in the utterly unacceptable worst of cases, Belgian patients were more likely to die with intolerable suffering if they requested euthanasia than if they did not.[5]

In this respect, the Belgian situation strongly resembled that in Australia[6] and formed a glaring chiasma with the Netherlands. There, under jurisprudential regulation of euthanasia, the ratio of nonvoluntary to

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voluntary physician-mediated deaths came down from 0.8% versus 2.2% in 1990 to 0.7% versus 2.8% of all deaths in 1995.[4] Thus, if anything, regulation of euthanasia appears to be associated with a reduction of ethically dubious practices of life termination.

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Letter to the Editor

Sir – The position paper on euthanasia from the Ethics Task Force of the EAPC has helped us all to a certain extent to examine where we as individuals and as an association stand in this debate on euthanasia. However, to avoid confusion and compromise, we who are practising palliative care must ask ourselves what is our goal/our vision in palliative care? 'Intent' is all important in distinguishing between euthanasia and terminal or palliative sedation. But even more important is our goal and our vision. Therefore, it is critical that we first agree on what our goal/vision is. If our vision is 'restoring wholeness' in the person who is dying and in his family who will be left behind, then euthanasia will have no place whatsoever. Then the intent of relieving intolerable suffering through a process of terminal sedation is in keeping with our goal/vision, and is only a part of the total care for that person and his family. However, if our goal/vision is limited to 'achieving death without suffering', then we are leaving room for confusion and compromise. So then, it is time to re-examine and rediscover our vision for palliative care, for 'If the vision perishes the people perish'!

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