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The EAPC Ethics Task Force calls for 'the establishment of palliative care within the mainstream healthcare systems of all European countries supported by appropriate finance, education and research' (paragraph 4.10). While I strongly support this goal, I do not agree that its realization 'is one of the most powerful alternatives to calls for the legalization of euthanasia and physician-assisted suicide' (paragraph 4.10).

Where high-quality palliative care is available, many terminally ill patients prefer it over physician-assisted suicide and euthanasia. But it does not follow that the *availability* of such care is a superior alternative to the *availability* of physician-assisted suicide or euthanasia. For while good palliative care is the best option for many, some patients may nonetheless prefer one of the two alternatives. Moreover, while each patient's treatment must exemplify one option to the exclusion of the others, society need not make an exclusive choice. It can make all three options available concurrently to patients for whom they are appropriate. I think it should.

Persons in affluent countries must reckon with the possibility that their lives will be prolonged in a modern medical care facility well beyond the point when they will be able to *lead* this life in anything like a full and active way. Some welcome this extra time of life; and we should be glad for them to have it and help make it as worthwhile and pain free as possible. But some do not welcome this extra time. I may not want to witness the further unstoppable decay of my mental and physical faculties. I may not want the older memories my loved ones have of me displaced and distorted by long hours they spend with what is left of me in a sterile hospital setting. Like Rear Admiral Chester Nimitz, I may want to die still competent and capable of settling my own affairs.

In advance and from the outside, it is hard to know how one would think and feel about extra months or years of life within a modern medical care facility. One may therefore find it most important that checking into such a facility as a frail old person, one has the assurance that one retains control over the most fundamental aspect of one's life – whether to go on with it or not. One may want to be sure that one's voluntary and competent request for physician-assisted suicide or (should one be unable to co-operate) euthanasia will be honored.

Unlike physician-assisted suicide, euthanasia requires that the physician intends the patient's death. This is not a substantial moral difference when the death is, in both cases, triggered *by the patient's own voluntary and competent request*. Morally, the event is then suicide assisted by another. The extent to which the patient can physically co-operate makes no moral difference.

The Ethics Task Force suggests that, for patients deprived of the suicide option, 'an alternative is to take action through the use of 'living wills' and advance directives, contributing to improved communication and advanced care planning and thereby enhancing the autonomy of the patient' (paragraph 4.8). These good options should indeed be encouraged, but they are in no way a substitute for the option of ending one's life.

Focusing on euthanasia alone, the Ethics Task Force opposes legalization (paragraph 7). The six reasons it gives are underdeveloped and not compelling. Pressure by doctors and insurance providers should be outlawed and punished. There may be economic pressure as continued treatment could bankrupt the patient's family. But may society *force* him to spend his family's savings on extra time in hospital at the expense of his daughter's college education? No. But society may *encourage* him to make this choice. A society that does not force patients but tries to convince them to stay alive has strong incentives to ensure that their treatment costs are covered and that good palliative care is developed and valued.

The values of healthcare professionals can and should be fully respected by allowing anyone to opt out. The three slippery slope concerns, finally, seem empirically far-fetched and morally dubious. What evidence is there that allowing terminally ill patients to choose death would cause 'killing to become accepted in society' (whatever this means) or 'an increase in the incidence of non-voluntary or involuntary medicalized killing'? And even if there were such a causal link, the right response would surely be to attack this link: to stress – much more forcefully than the Ethics Task Force has done – that killing patients is morally worlds apart from allowing them to choose death.

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