From the UK

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The EAPC Task Force stated two goals: to inform and build on current debate in the area, and to develop a viewpoint from the palliative care perspective.

In their attempt *to inform and build on current debate*, the Task Force stipulate definitions. Unfortunately, they do not explore and justify the assumptions inherent in their choice of definitions. Since their choice of definition for euthanasia differs from that in ordinary usage, the paper is fundamentally misleading and so fails to build on current debate. Their chosen definition of euthanasia is:

> A doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request.

The problems of this definition are as follows:

1) The Task Force have not mentioned motivation, thereby assuming that motivation is irrelevant to the definition. But in popular usage 'euthanasia' is mercy killing (regardless of whether the person is competent or incompetent). In other words the motivation is built into the ordinary meaning. Indeed this is the most important element in the meaning.
2) In terms of the ordinary meaning (mercy killing) it is not necessary that the patient is competent. By defining the killing of incompetent patients as 'murder', the Task Force has assumed that such killing is necessarily wrongful. But when such killing is an act of mercy some people may regard it as justifiable. The Task Force can not settle this moral argument simply by defining such killing as 'murder' and not euthanasia.
3) The Task Force does not mention the clinical condition, the state of unrelievable suffering or indignity, which is necessary in normal language to describe an act of killing as euthanasia. Instead, their definition assumes that the clinical condition of the person is irrelevant, and would include as euthanasia the killing of people who are not ill but simply weary of life. So why, in 4.7, do they note that the 'clinical criteria' for euthanasia might be widened?
4) The Task Force's definition assumes that the act of killing must be performed by a doctor. But why not a skilled technician, a nurse, a soldier on the battlefield, even an unemployed philosopher? Indeed, some of the arguments against legalizing euthanasia are based on the premise that doctors *in particular* should *not kill* people.
5) According to the Task Force, the person killed is not necessarily the doctor's patient, but simply 'a person' (who may not be the doctor's patient and therefore not in a relationship of trust with the doctor). The definition assumes that a doctor killing *any* person at that person's request is euthanasia!

All five of these assumptions require defence, if it can be provided.

The viewpoint on euthanasia from the palliative care perspective is not entirely clear from the paper. The EAPC considers it a duty to 'promote the importance of caring for patients . . . in accordance with the WHO 2002 definition', which states that palliative care 'intends neither to hasten death . . .'. Thus the EAPC is committed to the view, cited by the Task Force in 4.5, that 'the provision of euthanasia and physician-assisted suicide should not be part of the responsibility of palliative care'.

Yet the Task Force also state in 4.10 that the 'EAPC should *respect* [my italics] individual choices for euthanasia and physician-assisted suicide', and they further note that 'Respect for Autonomy is an important goal of palliative care, which seeks to strengthen . . . autonomy'. This position clearly suggests complying with patients' requests for euthanasia. But this is contrary to the official EAPC position as above.

The confusion lies in the ambiguity in the term 'respect', which can mean either 'take into account in a serious way' or 'implement'. A patient's request for euthanasia should clearly be 'respected' in the sense of 'explored and taken into account' but not necessarily in the sense of being implemented. The Task Force has not explained what they mean by *respecting* autonomy.

In the end, the questions of whether or not euthanasia should be legalized, and if so, who should carry it out, are matters of public policy. As public policy the questions are ultimately to be settled by the consideration of issues of harm and benefit for the whole community, with some consideration of individuals' rights and others' duties. The Task Force clearly did not want to enter this broader area of discussion, but the issue cannot be settled without such discussion.

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