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From the UK

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This careful presentation from the international Task Force gives a balanced and informed basis for discussion and I believe is true to the considered approach of the Palliative Care Movement as a whole.

In 1959 I first wrote opposing euthanasia, as I was beginning my own research on the nature and management of terminal pain. As I wrote then, 'This is not to decry that patients do suffer in this country but to claim that the great majority need not do so. Those of us who think that euthanasia is wrong have the right to say so but also the responsibility to help to bring this relief of suffering about.'[1] In a guest editorial for *Palliative Medicine* in 1992, I added 'After more than 30 years of work, after facilitating and studying much research, watching the spread of hospice and palliative care nation and worldwide, studying much literature and, more importantly, after listening to hundreds of patients, their families, and many fellow professionals, that is still my position. I do not think any legalised 'right to die' can fail to become, for many vulnerable people, a 'duty to die' or at best the only option offered.'[2] The decade since then has seen the developments noted by the Task Force, but my approach remains unchanged, while others have rightly taken on the debate.

We should all be grateful for the care with which the Task Force has defined the terms commonly used. As they point out, euthanasia is voluntary by definition and the term 'passive euthanasia', which has led to much confusion, is certainly a contradiction in terms. The paragraph concerning 'terminal' or 'palliative' sedation is clear and many will be grateful for this as a reference in future debate.

Many of us have long been concerned about the pressures that vulnerable people would feel if euthanasia were to be legalized and will find the implications stated here clearly and powerfully put. All this will help those engaged in the field of end of life care to express their own judgement with clarity, while still giving individual requests respect and attention, even though it is not possible to accede to them. Where the provision of euthanasia or physician-assisted suicide is possible, the Task Force points out that these should not be the responsibility of palliative care.

The Task Force documents points to the number of cancer patients who do not receive palliative care but it should, in my opinion, also draw more attention to the growing body of educational programmes, journals and textbooks that have spread information far more widely. Many more peer-reviewed research papers are undoubtedly called for if knowledge of the relief of the often complex suffering that can occur at the end of life is to continue to reach patients beyond those referred to palliative care teams. But we can already point to a considerable body of evidence and practice. The call for an expansion of research and practice in the treatment of noncancer patients also commands attention well beyond the established teams. That people should reach despair calls us all to listen and help.

The paper is careful in its description of appropriate treatment. This was emphasized in 1994 by the House of Lords Select Committee on Medical Ethics. Its unanimous conclusion was that the right to refuse medical treatment is far removed from the right to request assistance in dying. They added that the arguments in favour of the latter were not sufficient reason to weaken society's prohibition of intentional killing and they feared the repercussions that could follow. As Lord Walto, the neurologist and Chairman, reported in the House of Lords, 'One compelling reason underlying this conclusion was that we do not think it possible to set secure limits on voluntary euthanasia.'[3] Judge Devlin made a clear legal judgement which endorses their position in his summing up in the Bodkin Adams' case:

> If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten life. This is not because there is a special defence for medical men but because no act is murder which does not cause death. We are not dealing here with the philosophical or technical cause, but with the commonsense cause. The cause of death is the illness or the injury, and the proper medical treatment that is administered and that has an incidental effect on determining the exact moment of death is not the cause of death in any sensible use of the term. But . . . no doctor, nor any man, no more in the case of the dying than of the healthy, has the right deliberately to cut the thread of life.[4]

As I concluded in my 1992 editorial

> We still have further to go in giving patients truly informed control over what happens to them, in supporting them at home – so often the place of

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choice – through better community services and in making effective palliative care available wherever they may be. If these are not offered by both statutory and voluntary services, more and more people will find their lives not worth living and it will be society's indifference rather than any lack of potential that their lives still have that will lead them to ask for a 'right to die'. To reach this point would, it seems to me, be a sad failure on the part of society.

The challenge to those working in any branch of palliative medicine is surely clear. Those working in the field have the responsibility not only for carrying out their practice but also for making it better known. We do not only have to work continually on our own professional standards but also to spread the knowledge that already exists. We need also to emphasise to our colleagues and the public that there is an acceptable form of appropriate treatment that needs no laws for its establishment. On no account should it be designated as a form of euthanasia.[2]

References

1 Saunders C. Care of the dying 1: the problem of euthanasia. *Nursing Times* 9 October 1959: 60–61.
2 Saunders C. Editorial: voluntary euthanasia. *Palliat Med* 1992; **6**: 1–5.
3 House of Lords. *Hansard Parliamentary Debates*. London: HMSO, 9 May 1994, volume 554: 1344–1350.
4 Devlin P. *Easing the passing: the trial of Dr. John Bodkin Adams*. London: The Bodley Head, 1985: 171–82.