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The terminological clarifications provided at the outset of the EAPC Ethics Task Force's Statement are relevant, not only for a proper understanding of the EAPC Task Force's position itself, but also for shedding light on significant ambiguities underlying the current euthanasia debate. I agree with the idea that the often-adduced distinctions between 'voluntary', 'nonvoluntary' and 'involuntary' euthanasia, as well as the distinction between 'active' and 'passive' euthanasia should be rejected, as they only serve to introduce conceptual confusions in this debate. But, in my opinion, the Statement would benefit from a more cogent foundation of this rejection, especially in the case of the distinction between so-called 'active' and 'passive' euthanasia. Arguments in favour of so-called 'passive euthanasia' tend to stress the importance of avoiding a medicalization of death'. Nevertheless, to argue that it is morally justified to omit certain medical interventions in order to allow a person to die with dignity is not equivalent to supporting so-called 'passive euthanasia'. Intentionally hastening a person's death by omitting some medical interventions ('passive euthanasia') is conceptually different from omitting disproportionate medical interventions with the intention not to postpone death. Indeed, from a moral point of view, an essential distinction can be made between these two acts. The act of withholding or withdrawing disproportionate treatments (because they are disproportionate) is morally different from the act of omitting treatments with the 'active' intention to hasten death.

This leads me organically to a second aspect of the EAPC Task Force's Statement that would need further precision, namely the proposition that neither withholding nor withdrawing *futile* treatments can be considered as euthanasia. Nobody would deny that futile treatments should not be implemented. But to define therapeutic utility/ futility is a difficult task. This concept has been widely explored in medical literature. Schneiderman,[1–4] for instance, based on a distinction between *benefits* and *effects,* proposes a patient's benefit-centered definition of medical futility. But his conception of clinical futility excessively emphasizes the patient's conscious experience of benefit. And medical evidence shows that the subjective perception of the benefits of a given therapy is not a necessary condition for its objective utility. A proper understanding of the concept of medical futility should combine both qualitative and quantitative elements. Thus, with Christensen[5] I would rather suggest to make a distinction between absolute, statistical and disproportionate futility. *Absolute futility* refers to those interventions that are completely ineffective in physiological terms. *Statistical futility* expresses the low probability of a specific measure to achieve a given goal. The expression *disproportionate futility* qualifies a value-laden decision to abstain from a certain medical intervention – in spite of its eventual low statistical probability of achieving an immediate beneficial therapeutic effect – because this would not substantially modify the prognosis of unavoidable death. This relevant distinction underlies the ethical *principle of therapeutic proportionality,* which states the moral obligation to implement only those medical interventions that fulfil a *relationship of due proportion* between the means to be employed and the pursued end. Medical interventions that do not fulfil this relationship are considered to be 'disproportionate' (also referred to as 'extraordinary') and can be regarded as morally nonobligatory. But obviously, the concept of utility does not exclusively refer to the goal of restoring health. To preserve or enhance a patient's comfort and general wellbeing, and to prevent other diseases or complications of an incurable condition are also desirable goals of medical interventions, especially in the case of palliative care.

There is a third point of the Statement that may be misleading if the text is not read carefully. This is the idea that 'terminal sedation' is not equal to euthanasia. Not infrequently, the practice of 'terminal sedation' goes along with so-called 'terminal dehydration'.[6] And the combination of both may be equivalent to euthanasia. An eventual misunderstanding of the EAPC Task Force's position with regard to this relevant point is prevented by stressing the importance of initiating adequate hydration and nutrition in those patients who need to be heavily sedated.

My last point refers to the very concept of euthanasia. Traditionally, the concept of euthanasia has been linked to the idea of an act motivated by the desire to alleviate suffering. In the definition proposed by the EAPC Task Force this idea is completely absent. Even though I do not agree with those suggesting that euthanasia can be justified as an act of compassion, I do think that this reference to the subjective motivation of alleviating

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suffering provides the grounds for the conceptual distinction between 'plain murder' and euthanasia. Hence, the Statement gives no foundations for this classical conceptual distinction.

In spite of the need of some specifications and a more cogent foundation of some of its affirmations, I think that the EAPC's statement helps shed light on some difficult issues regarding euthanasia and assisted suicide.

References

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