From the UK

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The document from the EAPC Ethics Task Force has much to commend it. It takes a reasonable stance on the way that requests for euthanasia are to be dealt with, supporting the patient with palliative care but not expecting palliative medicine specialists to administer euthanasia drugs. The document recognizes the different cultural and political settings in which medicine is practised, such as the disastrous effect on British medicine of Shipman's murders. The recent World Health Organization modification of the definition of palliative care, as used in the document, has focused palliative care beyond routine good clinical practice. Educators in particular will welcome the clarification around withholding and withdrawing treatment, and the encouragement of open dialogue should ensure a heightened awareness of and focus on the patient's needs.

Yet it is precisely those needs that are poorly understood. The patient needs control over a situation that is by and large quite beyond controlling, i.e., when disease has shown itself non-responsive to all the interventions that have been attempted. Perhaps this fundamental need for control warrants further exploring in the patient's terms rather than the healthcare professional's parlance of treatments and interventions.

Perhaps there are some important issues in this whole debate that have been argued from the wrong starting point. Should we be talking of euthanasia and physician-assisted suicide as two separate entities, or should we be talking of physician-assisted death only? In other words, is there any difference in ethical terms or in intent if the patient takes the lethal dose of medicine by mouth or proffers a vein for it to be injected intravenously? I think not.

I would suggest that it is more accurate to talk of intravenous euthanasia or oral euthanasia; in both instances the doctor has undertaken the same discussion with the patient and in both instances has also supplied the drug to induce death. In one instance the patient lifts the glass to his or her lips, in the other the patient lifts an arm for the substance to be injected. In the former, failed induction of death orally will require the physician to intervene and to induce death with an injected dose of barbiturate and muscle-paralysing agent.

One must ask oneself why so few patients commit suicide and anecdotally they do not seem to be the same cohort of patients as those who discuss euthanasia. When the patient expresses the wish of 'just wanting to die' is the patient asking for something other than death? Is he or she asking to have some control, any control over fate; and the only thing that can be asked for reasonably is control over the timing of death. It may be worth for a moment considering why patients whose disease has put them metaphorically 'on death row' do not commit suicide. Many are waiting, indeed hoping, for a 'reprieve' through medical intervention. Yet there are many people, especially young men in Britain's jails, who do kill themselves every year and who join the swelling ranks of suicides in the Registrar General's tables of causes of death, listed with others whose despair was so great that they could not live any longer.

Perhaps suicide is so fundamentally different because it is the ultimate in self-harm through despair and self-loathing, whereas the request for euthanasia represents a need to regain some control over one's destiny while still having capacity; interestingly, the Dutch experience suggests that many requests for euthanasia do not result in a lethal dose of drug being administered, but in the patient feeling they could have it 'if things get too bad to bear'. All through our lives we live as if we have control over destiny; we feel that we must live with the consequences of our actions and that our decisions are therefore major self-determinants. Those who commit suicide are diametrically opposite – they feel totally worthless and valueless to the extent that life has no value and so the anger, self-loathing and low self-esteem erupt into suicide.

Perhaps the EAPC ethics group should reconsider their nomenclature. They should be clear that suicide and euthanasia are driven by fundamentally different needs and should not be confused. Euthanasia is always physician-complicit even when not directly physician-administered, so oral or intravenous euthanasia is more accurate and more honest than talking of physician-assisted suicide. Suicide is the ultimate act of self-harm; euthanasia is a desperate way to gain the last vestige of control over a situation. Euthanasia has as its final outcome the destruction of self with help.

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