
Guest editorial

Palliative care - a euthanasia-free zone?

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Britain can be justifiably proud of the part its health care professionals have played in the founding and development of palliative care as a discrete medical and nursing specialty. Individuals and institutions deservedly enjoy worldwide reputations, and practitioners from every continent come here to share in the knowledge-base and expertise that has built up. Slowly the public is becoming more aware of what can be achieved on its behalf by specialist palliative care workers, and this despite the fact that an unacceptably low percentage of the population as yet has access to the full range of services.

The World Health Organisation (WHO) defines palliative care as:

“the active, total care of patients whose disease is not responsive to curative treatment. Control of pain, other symptoms and psychological, social and spiritual problems is paramount. The goal of palliative care is the achievement of the best quality of life for patients and families.”

This definition, combined with the history of the specialty, helps to explain its character. First there is the explicit rejection of the dominant medical model of care, which defines success and failure in relation to cure. Being “other” to this model has allowed practitioners to be responsive to a large range of complementary therapies and to work closely with supporting professions. By including the issue of social and spiritual problems the definition brings to the heart of the agenda concerns which in other areas of medicine are deliberately kept at the periphery. The concept of quality of life is also made central to the idea of appropriate goals of care, and although common to other areas of medicine, for example care of the chronically sick and the disabled, the emphasis is slightly different here, as carers are required to give almost equal consideration to the needs of the patient's family. All these facts contribute to an understanding of palliative care services as inclusive, tolerant, patient/family-centred and forward-looking.

These observations are pretty standard and have been discussed in many different contexts. However, I wish to claim that there is another respect in which palliative care is unusual if not unique, and that is in terms of the moral or ethical views its practitioners propound. When addressing this issue it is interesting to note that this is perhaps the only area of health care that has frequently been characterised as a *movement* (although it has been suggested to me that health promotion has been characterised in a similar way, as have certain strands of psychiatry). Whilst there are certainly movements which have attempted to influence particular areas of medicine, for example the eugenics movement, it is unusual for a medical specialty as a whole to be characterised in terms of a set of non-medical beliefs.

In the case of palliative care reference is often made to “the hospice philosophy” and variants thereof; there is also a perceived link with formal religion uncommon to any other area of medicine. What one seems to encounter in palliative care is a uniformity and explicitness of shared moral beliefs around major ethical issues, which is not reflected in other specialties. Even in specialties such as assisted reproduction and neonatology, which confront profound ethical issues, there is a noticeable difference in terms of the multiplicity of moral views represented, with well-known differences of view around all the major issues such as treatment criteria, commercialisation, abortion etc.

In palliative care, despite a very responsible and proactive approach to moral debate there still appears to be a dominant philosophy which some have got close to describing as an ideology. This is not to say that there is total uniformity, there have been very interesting debates recently on matters such as dehydration and rehydration of terminally ill patients, criteria for access to palliative care services, and at a more theoretical level palliative care practitioners have shown willing to explore their frequent reliance on the doctrine of double effect in the context of pain relief. However, the message on one moral issue, which could arguably

be claimed to be *the* moral issue of the moment, always appears to be the same - euthanasia is morally wrong and ought not to be legally acceptable.

This is an interesting observation which invites a number of possible explanations. First, there is the possibility that the goals and principles of palliative care are logically incompatible with euthanasia. This is certainly how many practitioners feel - being pro-euthanasia is seen as incompatible with being a good palliative care worker. However, when you look at the issue objectively it is difficult to argue this point. The goal of palliative care is to maintain for as long as feasibly possible a *quality* of life. The question then arises as to what is to be done when this can no longer be achieved. Morally and legally there is the option of withdrawal of life-prolonging treatment, which is acceptable to most palliative care practitioners, who would not argue in favour of over-enthusiastically prolonging the lives of their patients. This implicitly acknowledges a threshold-type argument relating to quality-of-life considerations, such that below a certain quality a life (rather than the person) loses its value to the extent that it need not be saved, supported or prolonged (assuming that this is the wish of the patient and/or family). But who is to say that this threshold should not be taken to indicate the need for active euthanasia, such that below a certain quality patients should have the right to request that their life be ended?

To deny this possibility one needs to argue independently either that euthanasia is intrinsically morally wrong, most obviously because it is a form of direct killing of the innocent (although here one has the problem that medicine has already accommodated abortion which is even more complex than voluntary euthanasia due to the absence of any known view on the part of the innocent killed), or that the effects of permitting euthanasia are such that it cannot *legally* be permitted whatever its moral status.

Members of the palliative care movement have been prominent in offering both types of objections. So prominent in fact that they have increasingly become the media's choice as the obvious anti-euthanasia lobby. Despite the useful and in many cases decisive advice members of the profession have provided to government committees etc, this is not necessarily a desirable position, particularly given the accompanying tendency to present palliative care as *the* alternative to euthanasia thus precluding the need to discuss euthanasia, an extravagant claim which cannot be supported in all cases. Even the existence of a perfect service and complete access to it will not remove the desire on the part of some individuals

that their life should end sooner rather than later. At another level, if palliative care is too closely equated with anti-euthanasia views the professions involved could lose some valuable potential entrants, who, for the time being at least would be counting themselves out of a career in this area on the basis of their moral views alone. A third problem might arise in terms of a reluctance on the part of those already in the service to express views counter to those dominant within the group as a whole. However, the most serious problem relates to the most important people in the equation, the patients. One needs to ask to what extent a terminally ill patient (current or potential) who desires euthanasia (irrespective of its legal status) feels marginalised by the philosophy of the palliative care movement.

If euthanasia were to be legalised one would surely want to avoid presenting patients with either/or choice between good palliative care and euthanasia. Rather, good palliative care would be the first choice, with euthanasia as a final option for those whose clinical condition or psychological make-up leads them to decide life is no longer worth living. The difficulty is then combining the two in such a way as to allow those who morally object to euthanasia to keep their hands clean.

At the moment we deal only in hypotheticals but the arguments need to be rehearsed. At this stage in its development the palliative care movement can afford to be a broader church, so long as all those who enter it feel able to be honest and open about their views. The best way to test the power of a moral argument is to allow *internal* debate within the group that appears to hold it dear. In this case between professionals with an equal grasp of the realities and complexities of the context within which they operate. To paraphrase Mill, it is wise to keep your friends close but you need to keep your "enemies" closer, and it would be best to know whether the appearance of moral uniformity is an illusion, as there are issues which would need to be tackled if a significant number of pro-euthanasia practitioners were to "come out".

For as long as the palliative care movement is seen as essentially, definitively anti-euthanasia those patients who desire euthanasia might feel that there is always a choice to be made between effective palliative care and euthanasia, gifted professionals might opt for careers in other specialties, and if it is the case that a broader range of views exists amongst practitioners, we will have lost an opportunity for the type of moral debate from which the truth is most likely to emerge.

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