

ing a *growing acceptance* of non-voluntary euthanasia by the Dutch. As Dr Van Delden himself accepted in 1993: “[I]s it not true that once one accepts euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request, at least in some circumstances, as well? In our view the answer to this question must be affirmative”.<sup>7</sup>

Finally, we applaud the editorial's emphasis on the need for objectivity in the design, performance and interpretation of studies about euthanasia in the Netherlands. Had this been more widely observed hitherto, the debate would have generated more light than heat. We also welcome Dr van Delden's invited comment and trust that the journal will now lead the way in inviting those *critical* of the Dutch experience to comment on papers *in favour* of it. Too many journals have allowed such papers to pass unchallenged.

## References

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## Medicine, language and ethics

SIR

A not uncommonly used term in German medical language is the word

“Patientengut”, which might be translated as “patient sample” or “case material”. The term “Patientengut” is used to describe patients in an institution, patients with a certain diagnosis, or patients with specific clinical similarities shared with all patients of an institution. A search for “Patientengut” in Evaluated Med-Line<sup>1</sup> over the years 1966-1998 yields 50 results. All these works were published in German, Swiss, or Austrian journals. Respect for our patients should alert us to offending or pejorative ideas, words, and actions. Patients are always human beings, never goods or materials. This is true for a single patient as well as for a group of patients. Hence, I propose banning the term “Patientengut” and substituting for it the words “patient-groups” (Patientenkollektive), “cohort” (Kohorte), or - simply - “patients”.

## Reference

- 1 <http://www.biomednet.com/gateways/db/medline>

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## Life support or molecular maintenance

SIR

I would like to propose a change of terminology for “life support” in the context of brain dead and permanently vegetative state patients and other severely and irreparably brain-damaged patients. It should be designated “molecular maintenance”. Removing persons from molecular maintenance would not be as traumatic to physicians, nurses and family members as removing persons from life support. Notwithstanding a more or less lifeless state, health care professionals and relatives are emotionally charged when confronting “pulling the plug”. Large numbers of persons who depend on ventilators and other heroic devices are not, in fact, on life support, but are on these devices merely to sustain cellular integrity. Under the best of circum-

stances, regardless of the length time persons are sustained on such equipment, they will not be returned to life in any worthwhile sense of the term.

Virtually every bioethics committee at medical centres throughout the United States confronts the issue of life support and its termination. To cite a specific example: an emergency room physician was maintaining a 38-year-old woman, brain dead, on a ventilator and other extraordinary measures for no other reason than waiting for biopsies for organ harvesting. The physician was facing an ethical dilemma over the pointlessness of maintaining the person for an extended period. Another common scenario: a 28-year-old man with multiple organ failure, maintained on a ventilator and intravenous hydration, comatose with no chance of recovery. Wailing family members were facing killing a father and husband removing him from “life support” rather than withdrawing useless medical intervention so as to provide him with a merciful end.

Relatives and friends are made to agonise over decisions to remove the so-called “life support” a loved one who has suffered multiple organ failure with no chance of return to an elemental cognitive state. The physician would have a more relevant reaction to their thought of “life support” - molecular maintenance; it is harmful to the patient and to all parties in decision making roles.

The thought of being responsible for terminating life is a departure from the human ethos. Ending life violates our ethical and moral righteousness. Thus, to remove someone from “life support” makes people feel inappropriately guilty, which would not be if the intervention is *not* life support but mere molecular maintenance. In such cases, using the expression “life support” should be abandoned in favour of a more suitable and correct expression for the sake of both accuracy and compassion for the multitude who will face the wrenching decision to decide the fate of a loved one.

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