know about the variability of health status in old age, basing medical decisions on chronological age alone becomes ever less defensible.

It would be far better to improve health care providers' and policymakers' knowledge of the needs of elderly people and to invest more research into outcomes and assessment of technology so that new technologies are applied where they are most likely to have the greatest effect, regardless of the patient's age. Here again, it might be argued that extensive treatments to delay death from cancer or heart disease for a short time may be less cost effective than hip or knee replacement operations if these maintain people's independence long term. Such decisions go far beyond the adoption of simple, age based criteria to ration health care;

they reflect a more prudent and enlightened approach to medical care as we move into the 21st century.

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Euthanasia: can be part of good terminal care

Regulations required to safeguard against misuse

It makes no sense to discuss euthanasia in terms of being for or against it. The basic question is whether we accept the right of human beings to decide for themselves how their lives will end.

The backbone of ethics is respect for human life, and many doctors have interpreted their duty as being to keep patients alive at all costs and for as long as possible. Patients are sometimes treated even when the chances of success are slight, which the recent explosion in medical knowledge has made more likely.¹

The request for euthanasia is in many respects a response to this. People now understand that treatment can lengthen not only life but also the suffering that may accompany treatment. They have a choice where once they had none: they can opt for treatment or, if they find their level of suffering unacceptable, they can ask their doctor to stop their treatment and give them a good death. Requests for euthanasia may reflect people's needs to maintain a sense of "intactness" and to retain control over events.

Euthanasia refers to a medical act that deliberately shortens the life of a seriously ill patient at his or her request. It is the rarest of three types of medical decisions concerning the end of life; the two others are decisions to withhold or withdraw treatment that would probably prolong life and decisions to alleviate pain and symptoms, with treatments that may shorten the patient's life.² As van der Wal and Dillman clearly stated in their recent *BMJ* paper,³ euthanasia differs from other medical decisions concerning the end of life: it is an act whose primary intention is to cause death.

Euthanasia has always been practised, but requests for it were rare in the past. The topic is now discussed more openly as part of the general tendency for people to want to have a say where their own wellbeing is concerned. But emotions will always run high in such discussions, which is logical as they concern life and death, and death is something we want to prevent for ourselves, our loved ones, and those we care for.

Recent reports on euthanasia in three countries come up with similar findings: a sizeable proportion of patients want to discuss the medical decisions concerning the end of their life, including euthanasia, with their doctor.^{2,5} That the proportion of patients is highest in the Netherlands reflects the openness of Dutch society with regard to this issue. Ward and Tate have

also found that 60% of doctors in Britain have been confronted with medical decisions concerning the end of life and nearly half with a request for euthanasia.⁴ These proportions may rise when discussion about euthanasia comes more into the open.

Ward and Tate's survey of doctors in Britain argued strongly for the regulation of euthanasia. In fact, regulation is the only way to create sufficient safeguards against its misuse. No doctor needs to be involved in euthanasia against his or her conviction, but if patients' views conflict with those of their doctor they need the right to be referred to another doctor. Euthanasia may have a role in good terminal care. Although some people believe that euthanasia is the easy option for difficult problems and can be avoided by good palliative and terminal care, we know from the study of van der Maas *et al* that doctors may work hard to find alternatives. In the study by van der Maas *et al* three times as many patients requested euthanasia as eventually received it.² Van der Maas *et al* and van der Wal *et al* found that in only 5% of cases was pain the most important reason for euthanasia; avoidance of futile suffering and humiliation were mentioned in about half the cases.^{2,6}

These figures contradict assertions that adequate palliative care renders euthanasia redundant. The opposite is true: euthanasia entails detailed preparation with patients and their families. It can take place only as part of terminal care provided with considerable personal concern.^{7,8} The time has come to give this care a solid legal basis, for the benefit of patients and doctors alike.

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