where cardiopulmonary resuscitation (CPR) discussions may take place between patients and professional carers who are not known to each other, in an unfamiliar environment. These discussions may be forced to take place in an acute situation, which is neither helpful nor appropriate for sensible, logical decision making.

Discussing such complex end-of-life issues with patients is not easy. However, health care professionals should be supported and encouraged, as they build up close relationships with patients over time, to be more proactive in addressing the possibility of sudden deterioration, and ensuring that patients are fully informed of the possible consequences of potentially life-prolonging interventions. This should be reviewed on a regular basis during the illness trajectory, facilitated by the specialist palliative care team. By so doing, we will be in a better position to avoid stressful, unwarranted and inappropriate resuscitation attempts and complicated bereavement issues.

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Euthanasia: on slippery slopes and vulnerable patients

Sir – In a letter to *Palliative Medicine*, taking as their point of departure our paper on palliative care and euthanasia,[1] Deliens and Bernheim make some remarks on the evidence base in relation to euthanasia.[2] Thus, they address an issue that we decided to leave out in our reply to critics.[3] It therefore seems appropriate to respond with a short comment.

There is much disagreement over what exactly the idea of a 'slippery slope' may be taken to mean. Several interpretations are possible.[4] Against this backdrop, it is an oversimplification for Deliens and Bernheim to refer to 'the slippery slope argument',[2] since there is no such single argument. They further claim that 'the data give no support to the slippery slope argument which is often invoked against (legalization of) euthanasia'.[2] That claim is open to debate, to say the least.[5]

Yet in one particular sense there appears to be a slippery slope of some sort or other: the *interpretation* of the clinical criteria has become more liberal so that these now include nonsomatic, mental suffering.[6] The Royal Dutch Medical Association (KNMG) has, since 1984, rejected the requirement that the patient must be in the 'terminal phase' as medically meaningless, thus extending euthanasia and physician-assisted suicide to the chronically ill as well.[7] In 1992, the Dutch Association for Psychiatry issued a report arguing that a psychiatric disorder may also be a ground for physician-assisted suicide.[7] In 1993, a commission of the KNMG (the CAL 4) said the same about psychiatric patients.[7] The year after, in 1994, the Dutch Supreme Court's verdict in the Chabot case meant the legal acceptance of physician-assisted suicide for mental suffering.[6,7] What has been called the 'third Remmelink report', in the year 2001, was newly published in *The Lancet*.[8] Unfortunately the article contains no information on assistance with suicide in those mentally ill or those 'tired of life'.[8] It is to be hoped that the researchers will disclose this information to the English speaking audience.

Deliens and Bernheim also state that there is no empirical evidence of pressure on vulnerable patients to cause them to ask for euthanasia.[2,9] Van der Wal and colleagues have made similar statements.[10] But only looking at what numbers of people in what social category are given euthanasia is not an appropriate way of trying to find out whether there is pressure on vulnerable groups. It might even be that the smallest group is made up of exactly those patients who felt the heaviest pressure. It would be most welcome if both Dutch and Belgian researchers would now initiate patient-centred studies concerning this very important topic. The time has indeed come for such research.

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Concepts and definitions: a source of confusion in the euthanasia debate

Sir – As several of the criticisms of the EAPC Ethics Task Force's statement on euthanasia and physician-assisted suicide show, our conceptual agreement when talking about euthanasia is far from being settled.[1] A crucial point to an understanding of the Task Force's position is the question of what exactly does the concept of euthanasia refer to.

One dictionary gives two meanings of the word euthanasia: '1) The action of inducing the painless death of a person for reasons assumed to be merciful. 2) An easy or painless death.'[2] The *Encyclopedia of Bioethics* states (p. 554) that the word 'euthanatos' historically refers to four meanings: '1) inducing death for sufferers; 2) ending the lives of the unwanted; 3) caring for dying; and 4) letting people die'.[3]

The Ethics Task Force proposed to define euthanasia as 'a doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request.'[4] This definition does not include any of the elements of the traditional concept of euthanasia. In fact, it points towards a quite different concept. This 'new concept' arbitrarily limits euthanasia exclusively to: 1) a physician's action; 2) an administration of drugs; 3) a response to a voluntary request. The 'new definition' of euthanasia disregards the fact that – according to the traditional concept – an act of euthanasia could be committed, in principle, by everyone, by an action or by an omission, and in harmony or even against a person's voluntary request. Explaining the reasons for choosing this definition, Materstvedt states that they followed the 'Dutch way'.[5] This argument confronts us with the question of whether in speaking of euthanasia we refer to an individual's or a society's interpretation of a given fact. A few thoughts on the term 'concept' and its relationship to 'definitions' may help shed light on this question.

A concept is richer than a definition. It is possible to have many definitions corresponding to one concept.[6] This shows that a concept is more than a linguistic entity, while we could consider a definition to be such. But a linguistic formulation should succeed in equivocally pointing to its object. Hence, any definition presupposes understanding of the concept to be defined. Recognizing this dependence of definitions on concepts shows the priority of clarifying concepts.

But the notion of 'concept' is itself not an undisputed matter, as any basic course in logic soon makes clear. In a realist understanding, a concept corresponds to our grasping the nature or essence of reality. A nominalistic

understanding of concepts, on the other hand, sees concepts as reflective of an individual or collective structuring of the world or of the use of language. Thus, the resolution of this dispute depends ultimately on epistemological and ontological investigations. So, if we want to accurately understand the position statement of the EAPC Ethics Task Force on euthanasia and physician-assisted suicide, we would need to first clarify its philosophical standpoint. Therefore, the 'method of avoidance'[5] does not seem to be a suitable way for the Task Force to fulfil its specific commission.

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