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From the UK

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For all healthcare professionals, involvement in end-of-life decisions raises the most complex ethical questions. We bring with us, to these discussions, our knowledge of the implications of our actions, our knowledge of the patient and family and an overwhelming desire to ease suffering and comply with the patient's wishes and needs. Therefore, any paper that helps to clarify thought processes and professional expectations is to be welcomed.

The Task Force of the EAPC had an unenviable task in developing a position paper on euthanasia. Not only were they dealing with a subject on which most individuals have a personal view, they were also dealing with many countries that have differing legislation and cultural mores with regard to euthanasia. Because of this, the paper does include some aspects, which while still open to discussion, remain illegal in many parts of Europe. It may also be perceived to be too general to give any specific answers to the questions being asked within healthcare settings.

The first point of the position paper clearly identifies the need for the recognition of the various approaches to palliative care across Europe. This point does not say whether this variety is appropriate, which is quite possible, or whether the EAPC is looking for a consensus decision. The use of the modified WHO (2002) version of a definition of palliative care, though, ensures that this paper is clearly grounded in the premise that palliative care intends neither to hasten nor postpone death.

This paper is very clear in its discussion as to what constitutes 'euthanasia' and 'physician-assisted suicide'. The discussion on the use or 'abuse' of the word 'voluntary' is very instructive and certainly gives voice to a fundamental principle in the debate surrounding euthanasia. How this 'voluntary-ness' will be monitored is of great concern, as it has already raised some concerns in countries where 'euthanasia' is considered an appropriate part of care.

It is also clear that euthanasia should never be seen as an alternative to excellent palliative care or that it is the role of palliative care health professionals, alone, to make these decisions. We are all aware of situations in which symptom management is seen as the 'job' of the specialist palliative care team, when in truth 'excellent' palliative care is the role of all health professionals. The paper clearly identifies that in the presence of excellent palliative care requests for euthanasia may be altered. However, it also acknowledges that requests are very individualized and require acknowledgement and careful attention.

One area that will continue to be debated is that concerned with the issue of terminal hydration and nutrition. The position paper states that these should be initiated when clinically indicated. It does not expand on what 'clinically indicated' really means. And, while it acknowledges that much of the current evidence base for euthanasia and 'decision making' within end-of-life decisions is methodologically suspect and anecdotal, this sentence does little to help professionals when being pressurized by relatives to not 'let my wife/husband/mother . . . starve'.

The comment on 'living wills' also needs further support, as the legal position on these forms of 'pre-planning' remains open to challenge. It is important that health professionals are not further compromised in their decision making from the fear of litigation. It is clearly part of any decision making process that the rights of the individual are fully acknowledged. But the health professional needs to be similarly protected so they are not in the position of 'dammed if they do and dammed if they don't'.

Finally, my only real criticism, rather than comment, on this paper is based on part of the ethos of the WHO definition of palliative care 'Uses a team approach . . . '. If the EAPC paper is to be truly helpful it needs to acknowledge the involvement of the whole team in this decision making. As such, the thoughts, opinions and processes of a range of health professionals should have been included within the task force. Nurses are the group who may often have the closest relationship with the patient during their palliative care and would certainly form the largest workforce in permanent contact. Nurses are regularly involved in intimate discussions of the beliefs and desires of the dying patient. Their contribution and that of other health professionals to the original development of this position paper may have altered little of the context but would have grounded it in the reality of practice and the tone would have been less medical and reflect a team approach to care.

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