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From Poland

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Professor Luczak is Chairman and Dr Kluziak is a secretary of the Board of Directors of Eastern and Central Europe Palliative Task Force Association (ECEPT).

I remember the sense of shock shared by me (JL), at that time a newcomer to the hospice movement, and the thousands of participants of the Montreal Congress of Palliative Care in 1988. Shock that was evoked by the emotionless presentation by Dr Admiral from Holland who described the procedure of euthanasia. The patient – a young woman suffering from a pharyngeal cancer, increasingly breathless, refusing tracheostomy and gastrostomy, demanding euthanasia, suicidal. Euthanasia was performed for the sake of mercy. A question to the audience: 'What would you do?' was unanswered.

Six years after its creation the EAPC made an official statement regarding euthanasia. At the same time the National Council for Palliative and Hospice Care at the Polish Ministry of Health issued a statement advocating palliative care and opposing euthanasia. A new statement emerged eight years later from the EAPC Ethics Task Force (which unfortunately lacked a representative of Central and Eastern Europe) – after a period of improvement in palliative care availability, and of increasing tendencies to accept euthanasia within legal systems. Carefully prepared, the document systematizes definitions and terminology dealing with euthanasia and physician-assisted suicide, as well as palliative care in its wider definition proposed by the WHO. It also succeeds in conveying a clear attitude towards euthanasia and physician-assisted suicide.

The statement does not discuss so-called cryptoeuthanasia, an alarming phenomenon happening not only in the countries officially accepting euthanasia, and which can not be accurately estimated in terms of numbers of cases.

The previous position statement considered euthanasia unneeded, outlined many arguments against it and against its legalization. Not so much sense of protest is evident in the new document but the authors mention unwanted results of euthanasia legalization – causing the internal conflict in physicians (in a way, obliged by law to perform euthanasia), negative social impact – loss of emphasis on developing palliative care and increasing social acceptance of mercy killing.

The example of two European countries of high living standards that have legalized euthanasia together with predominance of proeuthanasia attitudes in most societies in Western Europe indicates the possibility of escalation of the process, even where palliative care is well developed.

I support the statement that unrelieved suffering is the main reason for euthanasia requests. Suffering that casts a shadow over every aspect of the patient's life, that demands empathic and respectful attention. Physicians should be prepared for challenges during their undergraduate training. Workshops on cases of patients demanding euthanasia were added years ago to the curriculum of palliative medicine training for students in Poznan University of Medical Sciences.

It is proper (though possibly difficult) to demand a consultation from a palliative care specialist when dealing with a request for euthanasia. The obstacle is underdevelopment of palliative/hospice care – especially in some countries of Central and Eastern Europe, where basic preparations of strong opioids are still unavailable despite the progress of the last few years.[1] One may doubt whether in the countries exercising the right to euthanasia doctors would choose consultations from palliative care specialists – because of prejudice or doubts as to the usefulness of any other solutions for terminally ill patients when there is a law enabling legal euthanasia, physician-assisted suicide may be considered as an option less disturbing for the conscience. Economic factors can play a role: a 'prescription' for euthanasia is the cheapest end-of-life procedure ($75!) in Oregon, where physician-assisted suicide has been legalized.[2]

Specialized palliative care is an alternative to euthanasia. Despite all the modalities of holistic care, there should be space for controlled sedation – applicable for almost 30% of patients in the terminal phase of their disease. I agree with the Task Force that starting moderate and deep sedation requires the patient's consent and careful deliberation from doctors. The patient has the right to continuing deep sedation whenever needed, not only as a way of relieving physical suffering (i.e., severe dyspnoea) – even if potentially hastening

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death. By the way, some trials indicate that sedation may prolong the life of some patients.

The Task Force encourages research work to find arguments for discussion with euthanasia advocates and especially with those who perform it. This is a difficult task but I find it indispensable as secularization of the society progresses, as patients start to make various choices for end-of-life care and for the mode of life ending itself, often difficult to accept for a palliative care physician.

This paper should be translated into as many languages as possible, to serve palliative and hospice care activists to be used as guidance and an argument when addressing Ministers of Health (and other officials responsible for healthcare) to acknowledge the important role of palliative care in healthcare systems, especially in countries with difficult economic situation.

References

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