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From Italy

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There are some good points in the EAPC Ethics Task Force Position Paper. One is advice to EAPC members 'to engage in direct and open dialogue with those within medicine and healthcare who promote euthanasia' (paragraph 4.9). However, the position paper is disappointing on some main issues. My remarks are intended to be a contribution to the above-mentioned open dialogue.

A major fault is to be found in the presupposition that it makes sense to develop 'a viewpoint from *the* palliative care perspective' [my italics]. This idea could be plausible in the infancy of palliative medicine, when it had to fight against curative medicine and medical vitalism. Since vitalism had a general philosophy, possibly the best way to defeat it was to propose a correspondent opposite philosophy, i.e., *the palliative care perspective*.

However, if not *in practice* at least *in theory,* we all know that vitalism is now dead and that it is an illusion to think that there is just one ethics built into medicine. To assume that there is *the* palliative care perspective is to repeat vitalism's old mistake: there is no 'palliative care Holy See' to decide who is orthodox and who is heretical in facing ethical issues at the end of life.

From *the palliative care perspective* the position paper derives that 'the provision of euthanasia . . . should not be part of the responsibility of palliative care' (paragraph 4.5), and that 'the establishment of palliative care . . . is one of the most powerful alternatives to calls for the legalization of euthanasia' (paragraph 4.10). However, these conclusions are reached throughout a misrepresentation of the euthanasia position. Euthanasia is defined as 'a doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request' (paragraph 3.2.1). This definition is clearly inadequate because euthanasia requests are justified *only* in situations of a diagnosed terminal illness. Without such a crucial condition, this definition can be presented as a 'technical description of the act' and euthanasia can be used for any purposes, even the most bizarre ones. When the terminal illness condition is included in the definition, euthanasia is allowed only in medical contexts, and euthanasia ceases to be a mere 'technical act' good for any purpose, to become – exactly like palliative care – a 'practice', i.e., a co-ordinated activity with its own 'underlying values and norms' (paragraph 3).

This means that possible contrasts between palliative care and euthanasia are to be found in different values and norms underlying the two practices and precisely in different attitudes toward dying and responsibility for nature's actions. In the position paper, dying is regarded 'as a normal process' (paragraph 3.1), and this is seemingly enough to support both that palliative care 'intends neither to hasten nor postpone death' (paragraph 3.1) and that it 'is applicable . . . in conjunction with other therapies that are intended to prolong life' (paragraph 3.1). Since 'to prolong life' is the same as 'to postpone death', *the palliative care* attitude towards dying is unclear, to say the least. Similar remarks hold for the position's claim that 'terminal sedation' is not a form of 'hidden euthanasia' (paragraph 3.2), even though I cannot show this point here.

A more adequate stand should consider that – given our knowledge of natural processes and our ability to change them – it is impossible to draw a sharp distinction between nature's action and people's action, and that sometimes we are responsible for nature's actions. In terminal situations patients may have to face what I call an 'infernal condition', i.e., a condition so desperate that for the person it is better to die than to go on living in such a condition. In these cases it does not matter whether the 'infernal condition' is brought about by overtreatment or by nature: we are as responsible for nature's actions as we are for the pain caused by nature. Palliative care can prevent some 'infernal condition' but people have a right to avoid or come out of it through euthanasia.

In this sense, palliative care is *complimentary* to euthanasia and not *alternative* to it. Patients may at first ask for palliative care, but when this is not enough to avoid the 'infernal condition' – as sometimes (alas!) is the case – they have the right to ask to be euthanized. Palliative care doctors are in the best position to help these patients and have a strong moral to do it.

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Since co-operation is better than contraposition, I hope that the EAPC will abandon both opposition to euthanasia and the idea that legalization of euthanasia will possibly lead to some 'devaluation of palliative care' (paragraph 4.7.2 ii). This last statement is without any empirical basis and is possibly motivated by some lobbying or corporative efforts, which are incompatible with the main goal of palliative care: to promote a good death for everyone.