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From Switzerland

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My comments on this paper will first cover general, then more specific points.

First of all, I am thankful that this debate is now open also on the palliative care side. This paper opens the possibility for the different actors to sit at the same table and discuss the problem in terms other than 'for' or 'against'. Just because we are prepared to talk about euthanasia and physician-assisted suicide does not mean that we agree with the idea and it is important to situate this paper as a catalyst for further dialogue.

The key issue of promoting access to high quality palliative care through national and international policies is clearly mentioned and it is meaningful. But in order to promote access to palliative care, it is fundamental that professionals are aware of the needs of severely ill patients and take them in consideration. Therefore, one of the main issues consists of developing palliative care training on a wide scale, tailored to the population's needs, taking into account the interactions with professionals practising in varied health settings.

Some specific comments:

- Paragraph 4.2. I do believe that studies should also be led among surviving families of patients who died by euthanasia or physician-assisted suicide, including children. How was their death discussed within the family during the illness? Who was present at the moment of death and what were their feelings and emotions? How are they going through their grieving process? How does this death affect their family history in terms of communication or the keeping of secrets?
- Paragraph 4.5. According to Article 3.5 of the EAPC By-laws, the provision of euthanasia and physician-assisted suicide shall not be part of the responsibility of palliative care; the grammatical form 'should not be part' opens the door to different interpretations.
- Paragraph 4.10. The phrase 'should respect individual choices for euthanasia and physician-assisted suicide . . . ' might be interpreted as meaning that it could be the professional's individual choice. It is crucial to stipulate that the authors meant the patient's choices and no one else's, otherwise this could open the door to dangerous excesses.

Last, but not least, considering that high quality palliative care can only be provided by different professions working together in multidisciplinary teams, it is regrettable that there was no nurse participation in the Task Force. Even though doctors, philosophers and professors in medical ethics are undoubtedly highly competent to discuss this important issue, I believe that the point of view of nurses, who are in contact with suffering patients day after day and thus provide a permanent link with them and continuing care, could have enriched the debate.

Finally, I would like to thank the EAPC for taking the initiative of opening discussion on the subject. A very positive benefit involves letting new questions emerge rather that giving an unequivocal answer.

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