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From Italy

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As Vice President of the EAPC I warmly welcome and support the position paper of the Ethics Task Force. As a specialist nurse practitioner I have been co-ordinating palliative care services in Italy for 15 years and Albania for four years. I am in general agreement with the euthanasia position paper but wish to comment on two points with specific relevance to my experience in Italy and Albania.

Open communication

Forthright communication regarding diagnostic and prognostic information is widely accepted in most European countries. In my part of 'Mediterranean' Europe, this is still not so for the majority of cases. As suggested in the position paper, understanding the *cultural* components (beliefs, behaviours, sanctions, values) of communities assists in comprehending these attitudes. The cultural approach of both communities towards death and suffering is not based on a strictly religious influence. Family units are strong with a social attitude towards death of defiance or denial.[1] Consequently there is often a 'closing of ranks' by the family, convinced they are 'protecting' their loved ones from any possible form of suffering or unbearable distress, when open communication is attempted. A substantial example of this can be seen from a recent study of 547 terminal cancer patients from our Rome unit:[2]

- Clearly informed and aware of diagnosis and terminal prognosis: 9.9%
- Informed but refused to believe: 1.6%
- Informed of diagnosis but not of prognosis: 22.7%
- Uninformed of diagnosis and prognosis but suspected cancer: 6.8%
- Uninformed of diagnosis, unaware terminal prognosis: 59%

Patient or family attitudes towards the use of narcotic analgesics are often a source of frustration and ethical concern for us. It can be at this moment that 'euthanasia' is mentioned by relatives. Ironically, we often find ourselves required to define the difference between terminal sedation and euthanasia in defence from possible misinterpretation of actually performing euthanasia. Fortunately, this in itself is a form of community education in strong support of palliative care.

Advance directives

Suggesting using advance directives as an alternative action rather than opting for euthanasia is irrelevant to daily practice in Italy. To date, neither advance directives nor proxy decision makers have legal recognition. I am unable to report the legal standing in Albania. Healthcare decisions for nonautonomous patients continue traditionally to be made by physicians to their best medical judgement. While in the last decade there has been growing public concern regarding overtreatment of critically ill patients in acute care settings, this strangely contrasts with a generalized evasion/absence of opinion towards the dying.

My experience of *advance directives* is that once a person becomes terminally ill and their suffering increases, their views change. I personally do not encourage this type of option. I have found that when good comprehensive palliative care is provided euthanasia does not seem to become an issue.

Conclusion

I have briefly explained the difficulties involved with *open communication* in Italy and Albania, which, apart from the legal situation, makes *advance directives* even more difficult.

Healthcare is essentially a moral enterprise where clinical decisions are influenced by personal and cultural values of both the patient and provider together with the social and political contexts of the healthcare system. My overriding concern with the legalization of euthanasia is the possibility of abuses of a more permissive policy. Strangely enough even the most forceful advocates of laws permitting euthanasia/physician-assisted suicide, such as in Oregon, recommend the expansion of palliative care services! Nothing more than this can sustain the Task Force observation '. . . Requests for euthanasia and physician-assisted suicide are often altered by the provision of comprehensive palliative care . . .' The onus lies heavily on us all to make sure that palliative care is available to all in our mainstream healthcare systems. Palliative care aims at the use of compassion and practical wisdom on our behalf to ensure that the patient's total good as perceived by him is achieved. However, if this perception of total good involves a request to kill, whether this be legally possible or not, palliative care staff can respect this but cannot be responsible for it.

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The rest I leave to Hippocrates.[3]

> Life is short, science is long, opportunity is elusive, experience is dangerous, judgment is difficult . . .

References

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