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From Australia

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The EAPC Task Force statement on euthanasia and physician-assisted suicide represents another attempt by the international palliative care community to articulate the difference between palliative care and euthanasia. At first glance this may seem like an easy task, but those who attempt it know that it is not. In Australia it is safe to say that most palliative care workers oppose the legalization of euthanasia, and were very uneasy about the brief interlude in the Northern Territory when it was legal in that jurisdiction.[1] However, while being clear that euthanasia is not a part of palliative care practice, the two main professional associations have acknowledged the diversity of community and professional views (as does the EAPC), including within the field itself, and have tried to avoid setting palliative care up in opposition to euthanasia.[2]

Despite significant ongoing reticence about acknowledgement of the dying process, referral for palliative care and cessation of life-prolonging treatment, the central goals of palliative care, namely to support and alleviate suffering for people with a terminal illness, are relatively uncontroversial and enjoy wide community support. However, palliative care practitioners and their professional associations have a serious public relations challenge in most countries concerning euthanasia. It is a deeply divisive issue that cannot come to a tidy resolution, as it taps into deeply entrenched political and religious fault lines within societies.

Most palliative care workers oppose euthanasia, whereas the public tend to strongly support it, and think this is what palliative care frequently does anyway. Those who advocate legalization of euthanasia want it to be part of accepted palliative care, whereas most practitioners do not see it as part of medical practice at all. Parliaments (with a few notable exceptions) have not passed legislation to allow euthanasia, and have been very supportive of palliative care once they have been made aware of it. Courts, in the absence of legislative change, understandably tend to find for the status quo, which is that euthanasia is unlawful, but nonetheless that palliative care interventions may contribute to the cause of death. This is justified where the primary intention is to relieve symptoms, due to a public policy imperative to relieve pain and suffering and avoid needless prolongation of the dying process.[3–5]

The central question is therefore essentially causal. Modern medical practice, based on the Judaeo-Christian tradition of law and ethics, takes a forensic view of ‘natural’ death and does not permit human agency to be implicated.[6] Of course palliative care interventions or treatment abatement decisions in the setting of terminal care may alter the timing of an otherwise inevitable and foreseen death, but do not alter the underlying cause in law. Palliative care practitioners over three decades have worked very hard to try and reassure their colleagues and the public that their interventions, especially the skilled and appropriately titrated use of opioids and sedatives do not bring causation into question. The basis of modern palliative care practice was well expressed by the Ontario coroner, Dr James Young, 1997, when he set out four conditions that need to be satisfied for palliative care interventions to be legal in his jurisdiction:

> (1) the care must be intended solely to relieve suffering; (2) it must be administered in response to suffering or signs of suffering; (3) it must [be] commensurate with that suffering; and (4) it cannot be a deliberate infliction of death. Documentation is required, and the doses must increase progressively.[7,8]

Unfortunately false perceptions about what the law and ethics require, and long entrenched myths about opioids still influence public opinion and professional practice. The section in this EAPC document on sedation was clear and helpful. However, it was surprising that no specific mention is made of opioids. Surely this would still have to be one of the greatest areas for causal confusion.

This EAPC document is clear in its definitions and it is welcome that it strips away the unhelpful concept of so-called ‘active’ and ‘passive’ euthanasia. The introduction of the word ‘kill’ is strong, and probably tactical. While it is clear and explicit, and a reasonable description of the act, its contemporary usage carries strong connotations of death against one’s will (would a person who requests medical assistance to die say ‘I want to be, or I am going to be killed’?). Surely adoption of the Dutch definition would be sufficient as a basis for making the point intended.[9] The introduction to the concepts and definitions section was very hard to follow and the appeal to the philosopher David Hume, and the allegedly sharp distinction between ‘what is’ and ‘what ought to be’ passed this reader by, despite multiple readings.

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Dealing with false perceptions which impair the delivery of necessary palliative care by providing sound and clear information about standards of practice is an ongoing task for the global palliative care community. Stating the distinction between palliative care and euthanasia is a necessary part of this process. By leaving safe territory about what palliative care is and is not, and endorsing slippery slope and vulnerability arguments against euthanasia, EAPC enters terrain where palliative care workers probably speak with less authority. In the final analysis, at the coalface in the community, palliative care is always likely to be better known for the delivery of necessary services than for its public policy pronouncements.

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