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The Ethics Task Force of the European Association of Palliative Care has made an important contribution to the discussion on euthanasia. The statement acknowledges the wide spectrum of prevailing societal and professional views on this complex issue. At the same time, it presents unequivocal conclusions.

Ultimately, society as a whole needs to decide about issues such as euthanasia. Mostly, societies continue not to condone euthanasia. Euthanasia's popularity at the end of the twentieth century, when there is a wide perception that technology can maintain basic life functions without supporting living, is an understandable social response. Given the vehemence of debate, the small number of people that access euthanasia in jurisdictions where it is available is a surprise.[1]

There is an inherent tension between the rights of the individual and the needs of the whole community. Finding this balance is the continuing challenge for all who wish to participate in a discussion about euthanasia.

Why should palliative care have a stance on euthanasia? Euthanasia and palliative care are totally separate issues. One can never be substituted for the other. In palliative care, we work with people with ultimately fatal illnesses who teach us through their proximity to death. This qualifies palliative care providers to contribute to the community's deliberations about end-of-life decisions.

The debate about euthanasia is not limited to people with life-limiting illnesses. If we are to espouse a paradigm of equitable access to services, euthanasia can not be limited to those with life-limiting illnesses. It must available to all that ask for it, if it is to be available to any. As such, the vehicle of using people with life-limiting illnesses as the catalyst for change has been a less than honest approach.

Suffering is subjective. Not only are there physical aspects of suffering but the emotions of new and, at times, unwanted life experiences, narrowing options and lessening independence contribute, fear of the journey ahead is also a source of suffering. It must be acknowledged that there are genuine requests for euthanasia, sustained in a small number of cases. As pointed out in the document, these requests do need to be acknowledged and heard sensitively.

Any new intervention requires careful, thoughtful, prospective evaluation – those who access it, those who choose not to and the total impact on the individual and society. Such evaluation needs to be rigorous and paint the whole picture. The issue of people feeling under pressure to choose euthanasia has not been studied in this manner. A headlong move to social change in an area as fundamental and irreversible as euthanasia does not serve society well. The silent pressures that are at times felt by the vulnerable and disenfranchised need voice. The potential impact on medical practitioners being involved bears careful reflection.[2]

Whatever society decides about euthanasia, the entire population should have access to excellent palliative care for the full spectrum of life-limiting illnesses. This is clearly not the case around the world, where structural, financial and workforce barriers continue to limit access. In countries where universal healthcare is not available, the debate on euthanasia is even more problematic. The pressure on people with a life-limiting illness in a prognosis-funded healthcare system should not be ignored in this discussion.

The most important statement is that providing euthanasia is not part of the role of a palliative medicine physician. One could argue that years of medical school and subsequent specialist training are not necessary to end life. There is a fear in the community that the medications used in palliative care may shorten life. In someone where medications are used with an intent consistent with their indication, this should not be an issue.[3]

The term 'terminal' or 'palliative' sedation is open to misinterpretation (paragraph 4.6). Instead the phrase 'sedation in the terminal phases of a life-limiting illness' is far clearer. When we actually start to look at the evidence around sedation at the end of life, there is a wide range of practices in place. When we look at the science, we may be surprised by how little our interventions in the terminal phase of a palliative illness actually impact physiologically.[4]

Advance directives and living wills have a role. An advocate who can speak on one's behalf and deal with the complexities of changing situations and adapt as those situations evolve is more important. The complexity of decision making in this setting is, at times, overwhelming.[5,6]

The bottom line in the discussion about euthanasia is not about people with life-limiting illness but rather

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about anyone who wants to die. Whatever society decides, access to quality palliative services is a hallmark of a caring society. Such care needs to guarantee timely access to supportive, palliative or hospice care in line with the updated WHO outline for services.[7]

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