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From Australia

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> Medical theories always represent one aspect of the civilization of a period, and in order to understand them fully we must be familiar with the other manifestations of that civilization, its philosophy, history, literature, art, music . . .
>
> Henry Sigerist

These words of the eminent mid-20th century medical historian Henry Sigerist are relevant to considerations concerning euthanasia – understood (in the medical context) as the compassion motivated, deliberate, rapid and painless termination of the life of someone afflicted with an incurable and progressive disease (EAPC statement of 1994),[1] and to the current deliberations of the Ethics Task Force of EAPC.

The Ethics Task Force draws attention to the fact that there have been major advances in patient care: improved possibilities for symptom relief; for personal/family support; in the science of clinical decision making; and in medical ethics. But we have little evidence of how much these advances are translated into clinical practice at a population or institutional level.

Colleagues in the USA have, during these years, undertaken courageous research on a large scale into the care of those in the closing phase of life (e.g., the SUPPORT study). The deficiencies have been laid bare: poor decision making regarding life-prolonging treatment; systemic failures in care (e.g., pain relief); and the difficulty in ensuring respect for patients' wishes even expressed in advance directives. But in the face of this, collaborative efforts by clinicians, administrators and palliative medicine consultants have resulted in clear recommendations to the nation: the report of the Committee for Care at the End of Life ('Approaching Death'[2]) and the impressive programme entitled Education for Physicians on End-of-Life Care[3] are worthy of much international respect, reflection and even emulation. In other countries, and including Europe, research has been done at institutional and population levels with regard to end-of-life care – but has to some extent been fragmented.

One of the fundamental principles of palliative care is that appropriate care should be available to *all* persons in the closing phase of life in any context within the mainstream healthcare system: home, nursing home, hospital – including emergency departments, intensive care units, oncology clinics and so on. 'Palliative care' does not always require specialist intervention. The professionals in the mainstream healthcare system may, on occasion, need the assistance, usually by consultation, of doctors, nurses, social workers and other professionals with special competence in an aspect of palliative care, matched to the needs of the particular patient. This is a smorgasbord approach: buttons should be chosen and pressed by referring staff with such solid education in palliative care that they know what their patient needs and what they themselves can provide. So most palliative care will be provided by 'generalists' in hospital and community. The use of the words 'palliative care' in documents should reflect these distinctions – unless EAPC prefers to focus only on specialist palliative care services and not on the care of all persons with eventually fatal disease approaching death in which such services have a small but important part. Palliative care is maybe best considered as an inverted pyramid with a tiny segment at the bottom (specialist palliative care services) supporting the whole.

What would we expect of a document concerning euthanasia emanating from EAPC in 2003 seeking to build on the excellent 1994 document?

One might expect:

1) An awareness of the impact of the catastrophic events of the last 10–15 years on the cultures of the healthcare systems within Europe at least.
2) Documentation of the approaches being taken by the European Parliament and Council of Europe in relevant working parties – and references to relevant documents – on matters broadly related to end-of-life care.
3) Clear statements on the balance to be achieved between respect for diverse points of view and affirmation of a central or core position on fundamental matters.
4) Precise recommendations for (difficult) collaborative research with respect to end-of-life decision making, diversity in end-of-life outcomes and therapeutic approaches at a population level.
5) Plans for educating and energizing the community (including health professionals) to embrace end-of-life decision making, which embraces life but does not obstruct death.

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Does the current position statement assist in fulfilling these (possibly unreasonable) hopes?

It clearly seeks to avoid offence: it is true that clarity may sometimes seem barbaric because it avoids nuances of language. Diversity is a feature of multicultural societies or aggregations of societies – and diversity is enriching for the generation and debate of ideas. Yet clarity is needed – even if only to declare the preferred position of EAPC (and to add maybe recognition of some alternative stances) regarding whether or not euthanasia is or is not to be accepted or legalized as a legitimate aspect of the care of patients with incurable conditions.

The 1994 statement concluded: 'The issue of euthanasia is rarely raised (or discussed) in the course of our clinical practice. We should maintain an uncompromising stand against a law that would prevent the administration of death'. Does EAPC intend to change from this position? The medical world and especially colleagues throughout the healthcare systems – those in mainstream healthcare systems calling on specialist palliative care staff to supplement their efforts – all need to know. Careful clarification of definitions, restatement of some arguments against euthanasia (with maybe more stress on the need for rightness/integrity of processes), expressions of hope that advance care directives may prevail (even if the clinical subculture is so driven by other forces that they may be disregarded). All of these need to be supplemented by a far firmer statement on the central question. It is an issue of direction: which sign post to follow when at a crossroad? This may not be the time for crossing the Rubicon (by tending towards legalizing euthanasia): there is so much to be done, here and now, at striving for comprehensive care for all, improving clinical decisions, increasing trust and connectedness between persons in community, even and especially, in the face of death.

References

1 Roy DJ, Rapin CH. Regarding euthanasia. *Eur J Palliat Care* 1994; **1**: 57–59.
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3 Lickiss JN. Education for physicians on end-of-life care: EPEC trainer's guide on CD ROM. Review. *Lancet* 2001; **357**: 1051–52.