Palliative Medicine 2003; **17:** 139–140

From Italy

Dr Marco Maltoni Azienda Sanitaria Locale, Forli, Italy

Dr Maltoni is Head of the Palliative Care Unit in the Azienda Sanitaria Locale in Forli, Italy.

I think that the position paper of the EAPC Ethics Task Force is a useful attempt to define exactly what is meant by palliative care, euthanasia and physician-assisted suicide. The need for clarification is, in my opinion, long overdue, as these issues are still much debated but sometimes based on unclear and contradictory concepts and definitions. I would like to highlight some points that I consider of particular relevance.

It is extremely important to distinguish between 'terminal sedation' and 'euthanasia', as a recent article published in the Italian Journal of Palliative Care (*Rivista Italiana di Cure Palliative*) has seen some authors justify their pro-euthanasia position by saying that all palliative care physicians who administer sedation are, consciously or not, carrying out 'slow euthanasia'. On the contrary, all the studies on this topic have shown that there is no difference in the survival of populations of terminally ill patients, sedated and not sedated,[1–4] and the same applies to patients treated with normal or high doses of opioids.[5,6] With regard to sedation, the data show that even if associated with a reduction in or suspension of food intake, the duration of sedation, and thus the interruption of food intake, is too short (1–6 days in five reports[1,3,6–8]) to have an impact on survival, which is reduced after an absence of nutrition of at least 20–30 days (not all terminal sedations are deep and continuous, thus making a range possible in all other interventions, unlike an all-or-nothing situation such as euthanasia). This is true also in terminal cancer patients.[9,10]

Another important point is the section of the paper in which 'a viewpoint from the palliative care perspective' is presented on euthanasia and physician-assisted suicide. Such a statement implies that the debate on this topic undoubtedly involves palliative care, but it is also more wide ranging. Requests for euthanasia and physician-assisted suicide are rare in a palliative care setting[11] and are not generally a consequence of physical suffering or lack of pain control (under such circumstances, the palliative medical approach must obviously be reviewed and improved to meet patients' needs); when the request for euthanasia is broken down on the basis of different emerging motivations, it can clearly be seen that the principal motives for such a request are psychological and existential.[12–14] On the one hand this implies, for the physician, that the treatment of physical symptoms is necessary but insufficient, and that a more appropriate approach is needed towards depression, anxiety and so on. On the other hand, it must be remembered that the real reason for requesting euthanasia is that of suffering in the widest sense of the word: the loss (or fear of loss) of one's own health, lucidity, dignity, happiness. Such fears are not limited to a stage of advanced cancer, but are part of the human condition of suffering, and need both clinical competence and human empathy. In that sense, the presentation of theoretical 'extreme' cases should be recognized for what it is – a strategy by the pro-euthanasia movement to induce a change in the mentality of European people based on centuries of humanistic and personalistic culture. The 'risks' listed in paragraph 4.7 are thus current risks, which could have been strengthened by reporting the Dutch data on the practice of non-voluntary euthanasia. There is a very serious possibility that, if euthanasia became the last stage of palliative care, everything that came before would be underdeveloped or devalued, or patients would lose faith in our work, not knowing what to expect from us. The definitions reported in the paper are, however, extremely *limited* and do not, for example, consider whether a prolonged and deliberate interruption of life support may be a form of euthanasia. In my opinion, further consideration is needed to clarify whether this issue could also be deemed to be not euthanasia, as discussed in Materstved and Kaasa's review.[15]

In conclusion, I believe that the position paper, open to the discussion of different viewpoints and extremely respectful of the situation of suffering and, at times, despair that some patients and relatives find themselves facing, highlights several important points and gives clear and useful definitions 'to call things by their name' (Italian saying).

References

1 Ventafridda V, Ripamonti C, De Conno F *et al.* Symptom prevalence and control during cancer patients' last days of life. *J Palliat Care* 1990; **6**: 7–11.
2 Chiu TY, Hu WY, Lue BH, Cheng SY, Chen CY. Sedation for refractory symptoms of terminal cancer patients in Taiwan. *J Pain Symptom Manage* 2001; **21**: 467–72.
3 Stone P, Phillips C, Spruyt O, Waight C. A comparison of the use of sedative in a hospital support team and in a hospice. *Palliat Med* 1997; **11**: 140–44.
4 Morita T, Inoue S, Chihara S. Sedation for symptom control in Japan: the importance of intermittent use and

10.1191/0269216303pm721oa

communication with family members. *J Pain Symptom Manage* 1996; **12**: 32–38.

5 Maltoni M, Pirovano M, Scarpi E *et al.* Prediction of survival of patients terminally ill with cancer. *Cancer* 1995; **75**: 2614–22.

6 Morita T, Tsunoda J, Inoue S, Chihara S. Effects of high dose opioids and sedatives on survival in terminally ill cancer patients. *J Pain Symptom Manage* 2001; **21**: 282–89.

7 Fainsinger RL, Landman W, Hoskings M, Bruera E. Sedation for uncontrolled symptoms in a South African hospice. *J Pain Symptom Manage* 1998; **16**: 145–52.

8 Fainsinger RL, Waller A, Bercovici M *et al.* A multicentre international study of sedation for uncontrolled symptoms in terminally ill patients. *Palliat Med* 2000; **14**: 257–65.

9 Kotler DP, Tierney AR, Wang J *et al.* Magnitude of body-cell-mass depletion and the timing of death from wasting in AIDS. *Am J Clin Nutr* 1989; **50**: 444–47.

10 Shike M. Nutrition therapy for the cancer patient. *Hematol Oncol Clin North Am* 1996; **10**: 221–34.

11 Filiberti A, Ripamonti C, Totis P *et al.* Characteristics of terminal cancer patients who committed suicide during a home palliative care program. *J Pain Symptom Manage* 2001; **22**: 544–53.

12 Cherny N, Coyle N, Foley KM. Suffering in the advanced patient: a definition and taxonomy. *J Palliat Care* 1994; **10**: 57–70.

13 Cherny N, Coyle N, Foley KM. The treatment of suffering when patients request elective death. *J Palliat Care* 1994; **10**: 71–77.

14 Suarez-Almazor ME, Newman C, Hanson J, Bruera E. Attitudes of terminally ill cancer patients about euthanasia and assisted suicide: predominance of psychosocial determinants and beliefs over symptom distress and subsequent survival. *J Clin Oncol* 2002; **20**: 2134–41.

15 Materstvedt LJ, Kaasa S. Euthanasia and physician-assisted suicide in Scandinavia – with a conceptual suggestion regarding international research in relation to the phenomena. *Palliat Med* 2002; **16**: 17–32.