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From the Netherlands

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The contents of the position paper of the EAPC Task Force on Euthanasia describes recent developments concerning euthanasia and physician-assisted suicide in Europe. At the same time, based on developments achieved in and through the practise of palliative care during the past decades, the Task Force takes a firm position against legalization of euthanasia. One of the questions one must ask is whether or not this document is helpful for the ongoing debate about euthanasia and physician-assisted suicide. Will it stimulate debate between those who hold different opinions concerning these developments or will it only confirm the beliefs of those who already have positioned themselves in the discussion? If the aim of the Task Force is, as stated, to enter an open dialogue, the document requires some modifications to avoid misunderstanding. In this respect, openness about oneself and fairness with regard to what motivates others are helpful and contribute to the dialogue.

1. A recent overview of palliative care in Europe (ten Have and Janssens 2001[1]) has shown that the practise of palliative care differs from one European country to another. It is clear that in all European countries palliative care is introduced as a practise of a methodologically well-grounded form of care, to aid and comfort those who find themselves beyond the possibilities of treatment and cure. Yet many different approaches exist. If there was more clarity about the interfacing of the concept of palliative care (as perceived by different groups of healthcare professionals in European countries) and the daily practise of palliative care in those countries, it would help the ongoing debate about euthanasia and physician-assisted suicide. Different approaches are not a sign of weakness; on the contrary, they may prove a source of inspiration. Knowledge of different backgrounds will help facilitate good will and understanding.

2. When one speaks about existing regional, national and cultural differences in the approach to and organization of palliative care, one should include institutional differences as well. Institutional policies with regard to palliative care, even within the same country, differ widely. For example, palliative care in an academic hospital may be based mainly on the outcomes of medical research and focussed on the advancement of our knowledge regarding pain and symptom relief. This could be quite different from the palliative care provided to patients in nursing homes or hospices, where relationships, life stories, attentiveness, comfort and intimacy constitute the dominant features of care. Either consciously or unconsciously, institutions create their own specific culture regarding palliative care. The importance of making this distinction lies in the fact that an appreciation of these institutional differences may prove to be related to the way the public at large perceives palliative care services.

3. Definitions matter because they help to clarify our perceptions. Lived experience, however, makes a difference to how we understand and use these definitions. I mention this in relation to the notion of palliative sedation. In lived experience of those working and staying on the wards, palliative sedation, particularly in the terminal phase, is often still referred to as a form of 'passive euthanasia'. This association is simply wrong. But considering this circumstance, I considerate it advisable to come to some clear definition of palliative sedation of the patient, especially in those circumstances where death is immanent. To avoid any misunderstanding we demand utmost clarity of those involved in cases of euthanasia and physician-assisted suicide; equally so, transparency with regard to palliative sedation in those cases where death is immanent is imperative. Crucial in the decision making process is, for instance, the role of the patient. For instance, was there a request for sedation? Has the patient given his consent? These and other matters could expressed in the definition.

4. With regard to what is mentioned under point five in the position taken by the Task Force, I would like to draw the attention to the fact that concepts as such can not carry a responsibility; only people are held accountable. To provide palliative care is a responsibility of those who provide that care. Consequently, those who render palliative care are responsible for what they do and how they do it. I take it, however, that the Task Force wants to remind those who profess to provide palliative care that they can never use this type of care as a disguise for administrating a lethal drug.

5. It is not helpful to engage oneself in a debate on the basis of assumptions as formulated under point 7. In the debate these assumptions will require substantial proof. For instance, the debate on the legalization of euthanasia in the Netherlands has triggered a widespread interest in

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the possibilities of palliative terminal care. In a period of 10 years, this rising tide of interest has resulted in an official government policy to enhance the quality of palliative care in the country (1), in state funding of extensive research in the area (2), in the development of a well-grounded practise of palliative care (3) and in the funding of numerous palliative beds in nursing homes and hospices (4). The outcome is amazing and quite contrary to the assumption that legalizing euthanasia would imply the underdevelopment or devaluation of palliative care.

References

1 ten Have H, Janssens R eds. *Palliative care in Europe, concepts and policies*. Biomedical and Health Research, Volume 48. Oxford: IOS Press, 2001.