Palliative Medicine 2003; **17:** 157

From Colombia

Dr Jairo Moyano Universidad Nacional de Bogota, Colombia

Dr Moyano has a background in pharmacology and is now a Specialist in the Pain Clinic and Palliative Care Clinic of the Fundacion Santafe de Bogota, Colombia.

I found this article very useful because it makes a clear distinction between palliative care developments and attempts to legalize euthanasia and physician-assisted suicide. In the historical and social context both situations run in an opposite manner as has been shown in Holland, where most cases of euthanasia have been reported in the last few years and very few palliative care units and specialists worked at that time. As the public and professional debate grows specialists in the field of palliative care need a clear opinion without ambiguities in the discussion regarding care at the end of the life, including valid treatment options like sedation. The primary desired outcome is symptom control, i.e., a calm patient, in contrast to a dead patient, dying as soon as possible, which is the desirable outcome in euthanasia. It is not a matter of drug doses; it is the purpose of the action itself. In other words, palliative care is one approach and euthanasia is its counterpart.

A good starting point is a structured definition of palliative care which defines relief from pain and other distressing symptoms, improvement in quality of life, and a positive influence on the course of the illness. Most important, palliative care offers a support system to help patients live as actively as possible until death and to help the family cope during the patient's illness. It is clear from this definition that the desirable clinical outcome is relief from suffering and the evaluation is based upon patient and family opinion as the cornerstone of autonomy in palliative care practice. Some well-identified groups are likely to receive less than optimal care: ethnic minorities, very young or very old people, and patients from less developed areas, or developing countries. Commonly-used indicators such as morphine consumption for cancer pain management or availability of palliative care beds are incredibly low in these subsets of patients, so the principle of justice (access to the best treatment available) is actually absent for them and thus the improvement in palliative care is a priority.

Education continues to have a central role in palliative care, for example, in relation to the use of opioids. A wider discussion in national and institutional policies, education and opioid availability are the priorities instead of debate about euthanasia. Of course such a debate is welcome but the real focus should be in basic and advanced palliative care. Finally, I found very important the final statements explaining that palliative care units do not have to feel pressure because of the euthanasia debate as long as the provision of euthanasia and physician-assisted suicide should not be part of the responsibility of palliative care teams.

Patients, legislators and palliative care specialists should publicize the benefits of good symptom control, and they have to be proactive when critical issues such as justice and beneficence are challenged in their own settings. This is the best way to be prepared for the debate regarding euthanasia.

10.1191/0269216303pm730oa