# Beyond the borders – where do we go?

**‘An increasing number of hospice providers would argue that, while assisted suicide and euthanasia should not be commonly performed, there may be extraordinary circumstances in which compassion compels actions to shorten life.’[1]**

Is this statement truly compatible with palliative care? One of the most broadly accepted and commonly cited arguments concerning this issue is that calls for euthanasia and physician-assisted suicide would lessen, if an adequate level of palliative care could be provided. For my part, I certainly cannot accept the idea that ‘actions to shorten life’ should be performed as part of hospice services. The position paper on euthanasia from the EAPC Ethics Task Force also states clearly that the provision of euthanasia and physician-assisted suicide should not be part of the responsibility of palliative care providers.[2]

Terminal sedation has been described as an alternative option to euthanasia for those patients still suffering from intolerable symptoms, despite receiving an adequate level of palliative care. However, there are no accepted guidelines or standards for terminal sedation and indeed, workgroups dealing with this issue can seldom even agree on a common definition of the term. Terminal sedation has previously been used in the Netherlands to shorten the patient’s life, when the criteria for the application of euthanasia were not fulfilled.[3]

Is it the case, therefore, that palliative care is losing its focus? Does the ongoing expansion and development of new forms of palliative care services throughout Europe lead to evolution, or mutation of services? Is the extension of palliative care to other regions and other areas of medicine, associated with new views and algorithms, differing considerably from those standards we, in the palliative care community, thought were the consensus?

These are just some of the issues currently facing palliative care providers. Certainly, palliative care should be careful to encourage the repudiation of euthanasia, but there are also numerous other ways in which we are trying to pull down barriers which may currently be preventing the provision of adequate care. For example, palliative care is still provided predominantly for cancer patients and it is often the case that those patients with incurable neurological, or internal medical diseases are not assigned to the specialised services they might need. This is one of the issues that we should be trying to address.

The theme of boundaries and borders in palliative care has inspired the title of the 9th Congress of the European Association for Palliative Care, ‘Beyond the Borders’. The congress will be held in Aachen (situated on the border between Germany, Belgium and the Netherlands), together with the 5th Congress of the German Association for Palliative Medicine, from 8–10 April 2005 (up-to-date information is available at www.eapcnet.org/Aachen2005/index.html). One of the aims of the congress will be to discuss borders within palliative care, from a physical, psychological, social, spiritual or economic perspective and to find ways to cross and move beyond these borders. Plenaries will cover: wasting syndrome; biology and pharmacology in the older patient; refractory symptoms; extending our borders in chronic conditions; communication in a cultural context; bereavement; grief and clinical response; defining the role of volunteers; and a view on palliative care across the borders in Europe. More than 500 abstracts for posters and free communications have been accepted – so come to Aachen and share your views.

**Does the ongoing expansion and development of new forms of palliative care services throughout Europe lead to evolution, or mutation of services?**

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**References**

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