EAPC news and views

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EAPC Elections of Board of Directors 2003

The Election Committee is a sub-committee of the Board of Directors, with a fixed term of office from April 2002 to April 2003. The committee consists of two outgoing members of the Board (Friedemann Nauck, Germany and Michèle Salamagne, France) and five individual members proposed by the members of the association (Augusto Caraceni, Italy; Carl-Magnus Edenbrandt, Sweden; Kyriaki Mystakidou, Greece; Daina Petracchi, Italy and Gabriela Rahnea-Nita, Romania).

We aim to have some continuity on the Board as so many members of the Board are not available for re-election. The functions of the Election Committee are to organise and to conduct the next election of the Board of Directors. The Committee will communicate with the members to ensure that all relevant information has been disseminated. The Committee will clarify which members of the Board are eligible for re-election at the General Assembly in The Hague and how many vacancies there will be for new members on the Board.

The Election Committee will act as a point of reference for information about the election. It will ensure that there is a sufficient number of nominated candidates within the deadline and that the choice of candidates is as representative as possible in terms of countries and disciplines. Members of the Election Committee are not eligible for election to the Board and are responsible to the Board of Directors of the EAPC. Information on the role of a board member can be found on our website (www.eapcnet.org) in the section entitled ‘Internal rules for the election of EAPC Board of Directors’. It also explains what is expected from the members of the EAPC Board. The maximum number of members on the EAPC Board of Directors for 2003–2007 will be 13.

We would like to hear from our collective members. If you are interested, please get in touch and get involved in the process of looking for candidates. We would like to nominate candidates from countries that are not currently represented on the Board. It is important that candidates are willing to commit themselves to helping to improve and promote palliative care in Europe and can expect full support from their home countries. If you have any further suggestions or questions, please contact me (Friedemann.Nauck@malteser.de) or the head office (eapchoh@istitutotumori.mi.it).

I look forward to a democratic and successful election in The Hague.

Friedemann Nauck

Ethics, palliative care and euthanasia

An influential article, published in 1973, by philosopher Stephen Toulmin bears the telling title, *How medicine saved the life of ethics*.[1] After the Second World War medical ethics and, more broadly, healthcare ethics, have become ever-expanding areas of research and debate. For instance, the new technological capabilities of prolonging life, such as the possibility of putting a patient on a respirator, immediately led to the ethical challenge of when, if at all, one is justified in taking a seriously ill patient off it. Another issue that has sparked much debate is that of ‘do not resuscitate’ orders in the terminally ill.[2]

Palliative care is a special branch within healthcare, and here too there has been an enormous growth in the literature on ethics; that is, on end-of-life care ethics. People affiliated to, and engaged in research for, the EAPC have made many, ground-breaking contributions to the literature on the ethics of palliative care – literature that is well worth considering for anyone interested in palliative care.[3] Also, these researchers have managed to highlight the huge cultural differences that exist even within Europe with regard to attitudes towards palliative care ethics – attitudes that are also reflected in professional practice.[4]

While medicine has saved the life of ethics – meaning, I would like to stress, the life of applied ethics, not of theoretical ethics (such as meta ethics) which has been alive and well ever since ancient Greece – it is no less true that ethics has managed to give new life to medicine. Ethicists may think in ways foreign to physicians, and sometimes physicians will react by wondering if the ethicist is out of his mind. But in this exchange a meeting point is created where new ideas may be born – and ethicists will learn much from having their ideas being confronted with the real clinical world. It is, however, worth remembering that clinicians sometimes disagree fiercely over ethical issues too. For example, even though research reveals that across the world most doctors who work with the terminally ill reject euthanasia as both clinically and ethically indefensible, many Dutch doctors who care for the same category of patients obviously think differently. So whereas doctors on either side of the divide may be said to find themselves pretty much within the same, real clinical world, their perception of it is strikingly different.

Franz Josef Illhardt raises a key ethical question for palliative care, ‘What makes a terminal and perhaps miserable life important and worth living for the dying person?'[5] This question, I think, touches on the very foundation of palliative care. Those working within it must be able to 'give people a reason to live', as it were; otherwise, euthanasia may appear as an option. To do so is clearly no easy task, and requires much effort. Furthermore, euthanasia may even become a reality for both patients and doctors if efforts to legalise it bear fruit in parliamentary processes, and such a development may take place much faster than one might think. The recent legalisation of euthanasia in Belgium is a case in point.[6]

Arguably, the euthanasia issue is the biggest challenge to palliative care today. The issue is extraordinarily complex and ethical theory does not necessarily resolve the question, 'Is euthanasia right or wrong?' However, the professional ethicist's 'tool box' of various concepts, theories, and perspectives is helpful in shedding new light on the issue. Incidentally, this could mean that one will end up being 'more confused, but at a higher level', as has sometimes been said. But that may not be such a bad thing; in the real world, no one can avoid taking a stand in the euthanasia debate and being able to see the issue from a vast variety of angles at least will make one's standpoint a much more informed one.

References
1. Toulmin S. How medicine saved the life of ethics. *Perspectives in Biology and Medicine* 1973; **25:** 736–750.
2. Shapiro GR. Are there limits to oncology care? (Futility). In: Angelos P (ed). *Ethical issues in cancer patient care.* Dordrecht: Kluwer, 1999; 49-63.
3. Ten Have H, Clark D (eds). *The ethics of palliative care: European perspectives.* Facing Death series. Buckingham: Open University Press, 2002.
4. Ten Have H, Janssens R (eds). *Palliative care in Europe: concepts and policies.* Amsterdam: IOS Press, 2001.
5. Illhardt FJ. Scope and demarcation of palliative care. In: ten Have H, Janssens R (eds). *Palliative care in Europe: concepts and policies.* Amsterdam: IOS Press, 2001: 109–116.
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Lars Johan Materstvedt, Chair of Ethics Task Force on Palliative Care and Euthanasia, Norway

Danish Society of Palliative Medicine (DSPaM)

Palliative care is a very new field in Denmark, with only a few pioneering units, teams and hospices. As such, palliative medicine is not a specialty in Denmark and is not even a recognised area of interest. Although the Danish health authorities recognise the need and recommend the establishment of specialist palliative care services, there remains only a moral obligation for the district health authorities to provide palliative care. A legal obligation seems far away. As a consequence there is no training or agreement as to which qualifications doctors (and other staff) actually need to provide palliative care.

The Danish Society of Palliative Medicine (DSPaM) began in 2001 and now has 73 members.

DSPaM's first priority is the promotion of training and education of doctors in palliative medicine. Consequently, we have initiated a collaborative Nordic task force group that is working hard now to establish a theoretical course for specialists wishing to gain expertise in palliative medicine.

DOLOPLUS

The great prevalence of pain in the elderly has now been demonstrated by numerous studies in Europe and America. Whether acute or chronic, pain prevalence varies from 40–85%, depending on the situation.

The proportion of elderly pain sufferers who are completely relieved is at best 50%. The frequency falls to 20% in elderly subjects presenting with dementia and non-neoplastic pain.

Given the disinterest and the high prevalence of pain in the elderly, particularly among non-communicative or unco-operative subjects, serious assessment of the symptom has become imperative.

The hazards of simply estimating pain are well known, particularly the frequent risk of underestimation. Self-assessment instruments are now widespread, but the limitations on their use in elderly subjects are numerous, such as the overestimation of the abstract thinking capability; memory disorders; lack of sensitivity and specificity,

In 1992 the DOLOPLUS scale by Bernard Wary was created. This was followed by the publication of the 15-item version in the Amaryllis collection.

Given the absence of validated instruments and under the influence of Professors Schaerer and Rapin, a French-speaking study group was created.

In January 1999, the DOLOPLUS 2 scale was officially validated. There followed a press conference at the National Assembly (French parliament) on 28 April 1999, officially launching circulation of the validated scale.

The scale was put on the web in 2000 in French and English (www.doloplus.com).

Currently, the DOLOPLUS group is working on the translation and validation of the DOLOPLUS 2 scale in Spanish, German, English, Swedish, Dutch and Italian.

Fifteen geriatricians and palliative care specialists contributed to validation in a multicentre study in which over 500 elderly patients were included. This was equivalent to over 1000 scale scoring sessions. Saïd Serbouti, a biostatistician experienced in the field, co-ordinated the large-scale study using internationally recognised methodology.

DOLOPLUS 2 is the first assessment scale for pain in the elderly to be validated worldwide.