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Eutanasia, suicidio assistito, sedazione terminale e Cure Palliative una discussione internazionale

lanciata dalla E.A.P.C.

Novara giugno 2003

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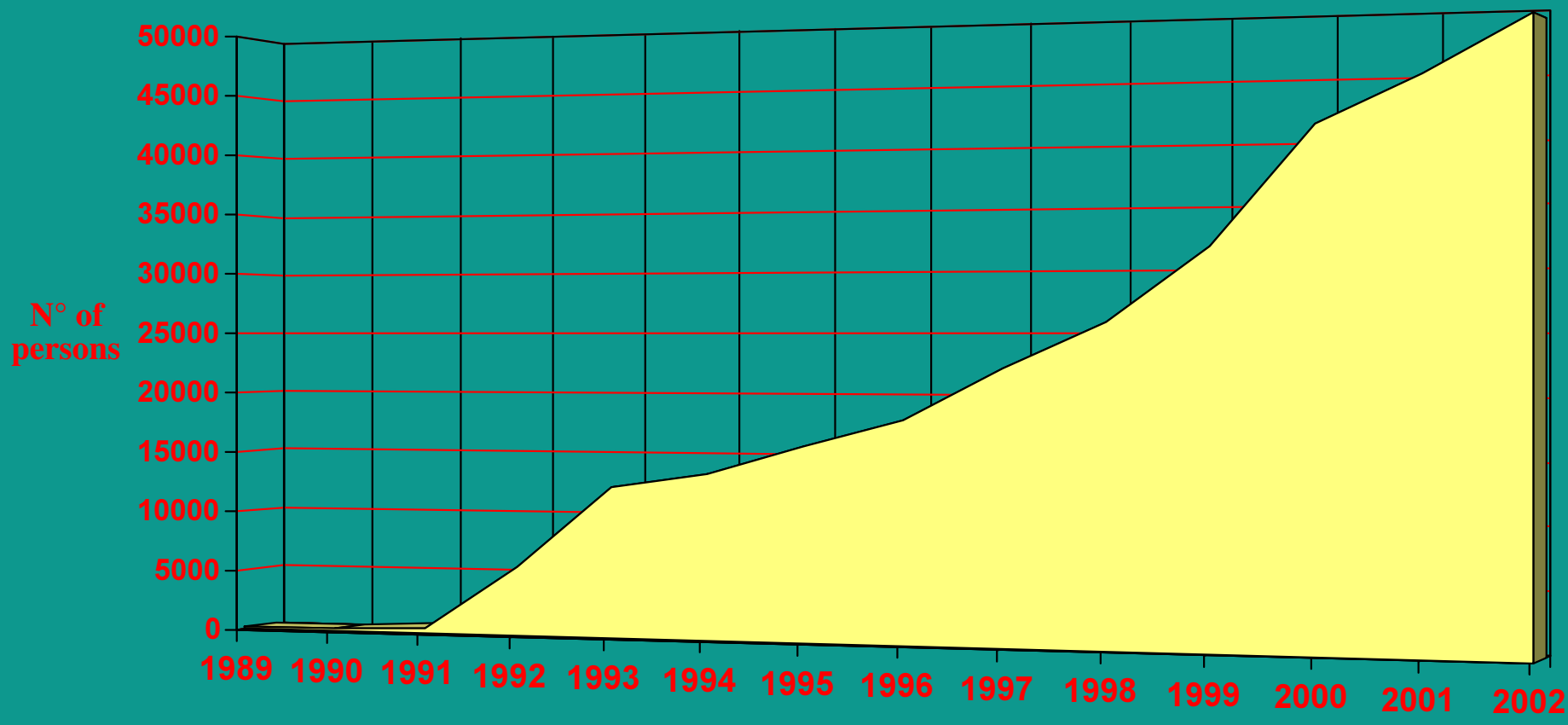
European Association for Palliative Care

E.A.P.C



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2003 Collective members of the EAPC

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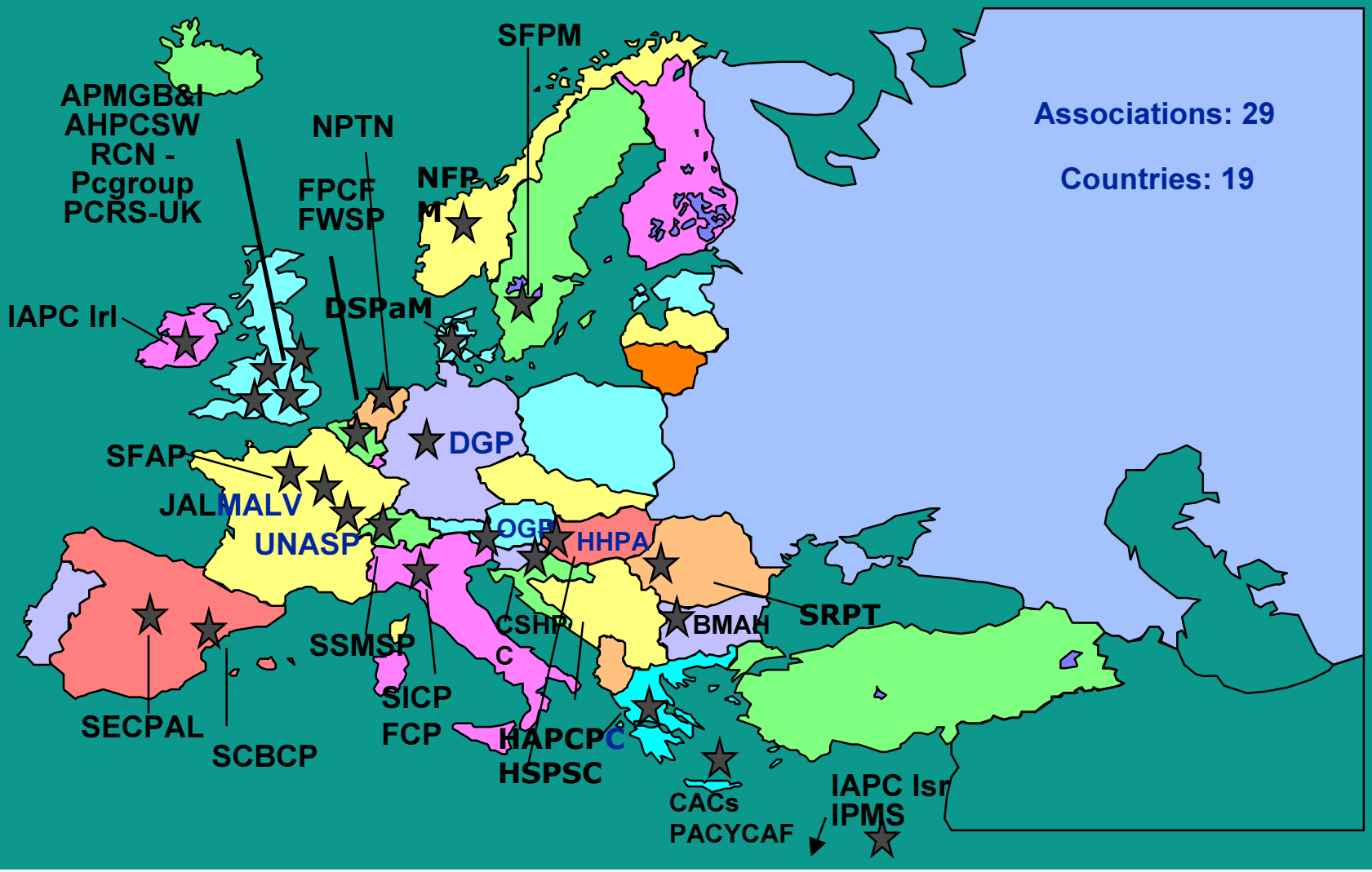

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The stated goals of both euthanasia and P.C. are to achieve death without suffering

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Euthanasia remains a criminal offence in almost every countries with the exception of: Oregon, Netherlands, Belgium, North Australia

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Three "Classic" arguments relating to euthanasia:
1
The sanctity (or less theistically, inviolability) of life position has the longuest history

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Argument 2

Those who argue that euthanasia can be a legitimate response to suffering or a low quality of life.

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Argument 3

This focus on the patient's views and wishes introduces a third perspective, which derives from the obligation to respect patient autonomy, which has assumed central importance in much bioethical theorizing and, indeed, medical practice

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Roy DJ., Rapin CH.: Regarding Euthanasia. Eur. J. Pall. Care 1994; 1: 57-59

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Materstvedt L.J.: Euthanasia and physician assisted suicide: a view from an EAPC Ethics Task Force. Palliative Medicine 2003; 17: 97-101

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1

It is recognised that within Europe several approaches to euthanasia and physician-assisted suicide are emerging and active debate surrounding this is to be encouraged

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2

Studies of attitudes to euthanasia and physician-assisted suicide among professionals, patients and the wider public as well as studies of their experiences of these issues may inform the wider debate.

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2

Most of these studies however suffer from significant methodological weaknesses raising doubts about the evidence base. A more co-ordinated approach to these studies is recommended

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3

Individual requests for euthanasia and phisician--assisted suicide are complex in origin and include personal, psychological, social, cultural, economic and demographic factors.

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3

Such requests require respect, careful attention, together with open and sensitive communication in the clinical setting

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4

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Requests for euthanasia and physician-assisted suicide are often altered by the provision of the comprehensive palliative care. Individuals requesting euthanasia or physician-assisted suicide should therefore have access to palliative care expertise

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5

The provision of euthanasia and physician-assisted suicide should not be part of the responsibility of palliative care

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6

Terminal or palliative sedation in those imminently dying must be distinguished from euthanasia.

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Palliative sedation

Intention: relieve intolerable suffering

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Palliative sedation

Procedure: sedating drug

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7

If euthanasia is legalized in any society, then the potential exists for:

- pressure on vulnerable persons
- the underdevelopment or devaluation of P.C.

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- conflict between legal requirements and the personal and professional values of physicians and other healthcare professionals
- widening of the clinical criteria to include other groups in society

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- an increase in the incidence of non voluntary and involuntary medicalized killing
- killing to become accepted within society

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8

Within the modern medical system patients may fear that life will be prolonged unnecessary or end in unbearable distress. As a result euthanasia or physician-assisted suicide may appear as an option.

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Living wills and advanced directives

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9

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The Ethics Task Force encourages the EAPC and its members to engage in direct and open dialogue with those within medicine and healthcare who promote euthanasia and physician-assisted suicide.

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9

Understanding and respect for alternative viewpoints is not the same as the ethical acceptance of either euthanasia or p.a.s.

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10

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EAPC should respect individual choices for euthanasia and p.a.s., but it is important to refocus attention onto the responsibility of all societies to provide care for their elderly, dying and vulnerable citizens

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55 comments from 32 countries

35 from Europe:
19 palliativists, 9 ethicists, 7 others
20 from ROW:
16 palliativists, 2 ethicists, 2 others

32 countries = 19 Europe, 13 ROW

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Country	"Palliativist"	Ethicist	Other
Belgium	2		
Bosnia-Erzego..			1 G.P.
Cyprus	2		
Denmark	1		
Estonia			1 Pain
Finland	1		
France	1	2	
Germany	1	1	1 Pain
Greece	1		
Island	1		
Israel			1 Neurologist
Italy	2	1	
Netherlands		1	1 G.P.
Norway		2	
Poland	1		
Spain		1	
Sweden	1	1	
Switzerland	1		1 psychiatrist
U.K.	4		
Total 19	Total 19	Total 9	Total 7

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Country	"Palliativist"	Ethicist	Other
Argentina	1		
Australia	4		
Canada	1		
Chile		1	
Colombia	1		
Hong Kong	1		
India	2		
Jamaica			1 Oncologist
New Zealand	2		
Singapore	1		
Taiwan	1		
Uganda	1		
U.S.A.	1	1	1 Psychiatrist
Total 13	Total 16	Total 2	Total 2

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CHRISTOPHERS
HOSPICE

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Dame Cicely Saunders:
"I do not think any legalised right to die can fail to become for many vulnerable people a duty to die or at best the only option offered"

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Dame Cicely Saunders:
We should all be grateful for the care with which the Task Force has defined the terms commonly used.
The paragraph concerning "terminal" or "palliative" sedation is clear and many will be grateful for this as a reference in future debate

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Dame Cicely Saunders is in accord with the statement 5: where the provision of E. or P.A.S. is possible, these should not be the responsibility of P.C.

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Prof. Illhardt:

P.C. opened the way for the experts to explore the problems of the patients with a terminal disease and to find a pragmatic answer and not a dogmatic one

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Prof. ZENZ

When not providing possibilities for this total (palliative) care we should not be surprised by requests for euthanasia

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Prof. Klaschik

Palliative medicine/care is a real alternative to euthanasia.
Therefore it should now be absolutely clear that euthanasia is under no circumstances compatible with palliative care and palliative medicine

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"Methodology for Palliative
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Stresa, Lago Maggiore (Italy)
4-6 June 2004
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The City of Charlesmagne

- Beyond the borders

6. - 10. April 2005 Aachen, Eurogress

Aken, Aix-la-Chapelle, Aquisgrana

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