



Dear Readers,

Today we present you with the special issue of *Advances in Palliative Medicine*. It is mostly based on the materials regarding the conference: "The Limits of Medical Therapy", organised by the Human Ecology and Bioethics Center, Cardinal Stefan Wyszyński University in Warsaw and Chair of Palliative Care, Collegium Medicum in Bydgoszcz, Nicolaus Copernicus University in Toruń. The conference, which will take place on October 22, 2008, is an effect of over a year of efforts of experts working as part of the Polish Working Group on End-of-Life Ethics. During this time we have been trying to review the medical, legal, ethical and theological conditionings of discontinuation of the overzealous therapy. Despite the fact that the term "overzealous therapy" is used in Poland in the Polish Medical Code of Ethics (sec. 32), until now it has not been clarified which conditions must be met to recognise the treatment method as overzealous. We are aware that the discussion on not starting or discontinuation of the overzealous therapy may be misunderstood as the acceptance of euthanasia. Recently, this is how it has been shown in the media. We would like to strongly emphasise that we are against euthanasia. However, we believe in the philosophy of the palliative medicine, which affirms life but it's resigned with death as a natural process, does not accelerate the death but also does not overzealously elongate dying [1].

In this issue you will find the consensus of the Polish Working Group on End-of-Life Ethics: "Definition of Overzealous Therapy". We have also published a series of reviews and research papers written by the experts of the Working Group, where they try to challenge various aspects of this problem (Bołoz, Aszyk, Machinek, Zyllicz et al.). As it results from these papers, the overzealous therapy may be treated as the violation of the rights of the dying person. The Catholic Church's teachings are also in favour of such a view: "The right to live becomes concrete in a lethally ill person as the right to die in peace, keeping the human and Christian dignity". This cannot be interpreted as the power to kill oneself or to give this power to others, but to experience dying in a human and Christian way and not flee from it „at any cost" [2]. It is similar to the observations from the studies conducted in patients who come closer to death. They indicate that what patients expect the most from their doctors is the ability to trust them and the certainty they would not be exposed to the „therapeutical tyranny" [2] during dying [3].

In the second part of the issue, the authors try to bring us closer to various problems of the end of life of patients with cancer or heart failure (Sobański). Thus, there are mentions of hope (Ratajska) and also fear (Rogiewicz). Moreover, the attitude of Polish nephrology experts towards the palliative care for patients with end-stage renal failure (Lichodziejewska-Niemierko). The readers also have the chance to read the memories of the family members of the patients dying because of lung cancer many years after their death (Krajnik et al.).

Most people know the definition of palliative care well as the treatment aimed at improving the quality of life of patients and their families [1]. However, the quality of life of a living patient is equally important as the quality of dying that is ahead of them. The latter is based on the assessment of the effectiveness of the alleviation of pain and other symptoms in the last period of life and on the fact whether the patient's will regarding the treatment priorities and the place of dying is fulfilled. Has the dying been unnecessarily and overzealously extended? Was the patients dignity respected and were they dying in peace, having resolved all important matters, including spiritual needs? Did they reconcile with the family? [4]

It is true that palliative medicine requires solid medical knowledge in the first place, especially in the field of symptomatic treatment. However, palliative care does not mean the treatment of pain and other symptoms only. It is an attempt to help at maintaining/restoring the patient's feeling of dignity, who is "changed" by their

disease and dying. The knowledge of mental functioning of the patient and the family, the awareness of ethics and the aspects of spiritual life should help. However, I deeply believe that the most important value to be offered by palliative care is the creation of the safe conditions of coming close to dying and dying safety.

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1. <http://www.who.int/cancer/palliative/definition/en/>
2. Pontifical Council for Health Pastoral Care 1995; 119.
3. Heyland D.K., Dodek P., Rocker G. et al. What matters most in end-of-life care: perceptions of seriously ill patients and their family members. *CMAJ* 2006; 5: 627–633.
4. Cohen L.M., Poppel D.M., Cohn G.M., Reiter G.S. A very good death: measuring quality of dying in end-stage renal disease. *J. Pall. Med.* 2001; 2:167–172.