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Moving beyond contested debate about assisted dying and palliative care

Dear Editor,

In the last decade, there has been much debate in palliative care on physician-assisted suicide and euthanasia and their relationship if any to palliative care. There is consensus among hospice and palliative care associations, and experts in palliative care, that palliative care does not include efforts to hasten death or end life.^{1,2} However, the expansion of access to assisted dying worldwide demands sensitivity to the complexity of people's wish to hasten death and to the racial, ethnic, and cultural underpinnings of people's attitudes toward assisted dying. Palliative care is focused on preventing or relieving physical, psychosocial, and existential distress. Medically assisting a person to end one's life (and therefore their distress) is viewed in some quarters as compatible with palliative care.³ Do we need to move beyond contested debate that has placed palliative care and assisted dying in opposition to one another?

Preston et al.⁴ recently proposed a de-medicalization of assisted dying. Whilst a de-medicalized approach could solve the problem of some healthcare professionals refusing involvement in assisted dying where it is legal, it does not solve the broader concern that some people who prefer or request physician-assisted suicide or euthanasia would still want advice, reassurance, and direct care from healthcare professionals in palliative care leading up to and for their assisted death. A scoping review of the relationship between palliative care and assisted dying in jurisdictions

where assisted dying is legal,⁵ found that assisted dying and palliative care practices could be conflicted but also integrated, cooperative, collaborative and synergistic.

Palliative care recognizes people as autonomous beings and values their right to self-determination and how they interpret care they request and/or receive. Some patients believe that assisted dying contributes to a better quality of death by preserving dignity and control at the end of life and want healthcare professionals to support them in decision-making pertaining to assisted dying.⁶ The meanings that people attach to death with dignity at the end of life are individual and evolve in societies. Exerting control over one's death is not necessarily limited to exerting control over care that excludes the possibility of physician-assisted dying and/or euthanasia. Healthcare professionals are also members of society, and it would be unwise to assume that all healthcare professionals in palliative care oppose the concept of assisted dying.

It is argued here that adherence to a particular care pathway when at odds with patients' existential needs and preferences is not fully consistent with a palliative care approach. It is possible that not supporting patients in physician-assisted suicide or euthanasia could stymie palliative care providers propensity to adapt to evolving perspectives on autonomy, control, and choice at the end of life. We should not simply assume that palliative care can achieve dignity for people at the end of life without helping patients realize their own preferences for end of life in terms of what is permissible to them. Rather than cementing the viewpoint that palliative care is not compatible with physician-assisted suicide and/or euthanasia, palliative care associations and service providers have a responsibility to regularly (re)examine their principles and philosophy in tandem with patients' evolving perspectives on their palliative care needs. Assuming such responsibility requires moving beyond contested debate that has placed palliative care and assisted dying in opposition to one another.

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