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Palliative Care and Physician Assisted Death

Sándor Kőmüves

(University of Debrecen, Debrecen; komuves.sandor@med.unideb.hu)

Abstract: In the recent decade quite a few countries and regions legalised physician assisted death. While palliative care is already or becoming the standard end of life care in many countries, the increased availability of physician assisted death coupled with the secularisation of hospice in more settings require – where this has not happened yet – a clear response of palliative care specialists to patients' requests for physician assisted death. The paper analyses the World Health Organisation's current description of palliative care with a special focus on its prohibition of hastening death. Some palliative care professionals do not agree with the ban on hastening death, and these professionals' non-conventional interpretation of palliative care actually seems to meet the wishes of some patients.

Keywords: Palliative care; physician assisted death; euthanasia; physician assisted suicide; secularisation; responses to suffering.

I. The Current Landscape of Physician Assisted Death

In this article I take *physician assisted death*[1] as an umbrella term which refers both to *euthanasia* and *physician assisted suicide*. By *euthanasia* in this paper, I mean the intentional or foreseen termination of the patient's life by act or by omission at the patient's request.[2] By *physician assisted suicide* I use the often-formulated definition of provision of life-ending medication to the patient.[3]

Currently, *euthanasia* is legal in the Netherlands, Belgium, Luxembourg, Spain, Canada, Colombia, New Zealand, and some states of Australia (New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia). *Physician-assisted suicide* is legal in some countries, including the Netherlands, Belgium, Luxembourg,

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[1] The term *assisted dying* encompasses euthanasia, physician assisted suicide, and assisted suicide. As I limit my investigation to health care settings, I use the narrower term *physician assisted death*.

[2] For an explanatory theoretical framework of this definition see: Keown (2018).

[3] I am fully aware of the fact that both *euthanasia* and *physician assisted suicide* and many elements of their definitions are contested terms with various definitions by various organisations, scholars and others concerned. I am also aware that some find any or both terms inappropriate to describe the event(s) at stake. I decided to use these definitions because these are very often used, so they work smoothly in the service of the paper, and not because I consider them as the only possible or correct names for referring to the concerned actions, or because these terms necessary carry more truth than other candidate terms.

Switzerland, Austria, Spain, Canada,[4] New Zealand and some states of the United States (California, Colorado, Hawaii, Maine, Montana, New Jersey, New Mexico, Oregon, Vermont, Washington and Washington DC) and Australia (New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia). Although the Constitutional Courts of Colombia, Germany and Italy legalized assisted suicide, their governments have not legislated or regulated the practice yet.

II. Definitions of Palliative Care

The most often cited[5] definition of palliative care has its origin in the article *Palliative Care: The World Health Organization's Global Perspective*, which was written by Cecilia Sepúlveda, Amanda Marlin, Tokuo Yoshida and Andreas Ullrich. The paper was published in 2002 in the prestigious *Journal of Pain and Symptom Management*. In this article, palliative care was given the following description:

> Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
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> Palliative care:
> - Provides relief from pain and other distressing symptoms
> - Affirms life and regards dying as a normal process
> - Intends neither to hasten or postpone death
> - Integrates the psychological and spiritual aspects of patient care
> - Offers a support system to help patients live as actively as possible until death
> - Offers a support system to help the family cope during the patient's illness and in their own bereavement
> - Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
> - Will enhance quality of life, and may also positively influence the course of illness.

Other definitions of palliative care exist.[6] We have definitions developed by small

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[4] It must be noted here that concerning the situation of Canada physician assisted suicide is not a fully adequate term, because not only physicians but also nurse practitioners, where this is possible, can provide assistance in dying. Canada's official term is Medical Assistance in Dying (MAID) which means "(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death" (Section 241.1 of the Criminal Code of Canada).

[5] Here it is important to make a distinction between how popular a definition is and if a given definition is the official definition of a given organisation. Although the WHO's definition is the most often cited and therefore the most popular definition, some organisations, see for example the new Strategic Plan of the American Academy of Hospice and Palliative Medicine (American Academy of Hospice and Palliative Medicine 2020, 7), adopted their own definitions of palliative care.

[6] David Hui and his colleagues for example searched MEDLINE, PsycInfo, EMBASE, and CINAHL

groups of individuals and now we also have a new, so-called consensus-based definition developed by the *International Association for Hospice and Palliative Care*.[7] The new consensus-based definition was presented to the WHO in September 2018:

> PC [Palliative Care] is the active holistic care of individuals across all ages with SHS [serious health-related suffering] (suffering is health related when it is associated with illness or injury of any kind. Health-related suffering is serious when it cannot be relieved without medical intervention and when it compromises physical, social, spiritual, and/or emotional functioning. Available from http://pallipedia.org/serious-health-related-suffering-shs/) because of severe illness (severe illness is a condition that carries a high risk of mortality, negatively impacts quality of life and daily function, and/or is burdensome in symptoms, treatments, or caregiver stress. Available from http://pallipedia.org/serious-illness/) and especially of those near the end of life. It aims to improve the quality of life of patients, their families, and their caregivers.
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> PC [Palliative Care]:
>
> - Includes, prevention, early identification, comprehensive assessment, and management of physical issues, including pain and other distressing symptoms, psychological distress, spiritual distress, and social needs. Whenever possible, these interventions must be evidence based
> - Provides support to help patients live as fully as possible until death by facilitating effective communication, helping them, and their families determine goals of care
> - Is applicable throughout the course of an illness, according to the patient's needs
> - Is provided in conjunction with disease-modifying therapies whenever needed
> - May positively influence the course of illness
> - Intends neither to hasten nor to postpone death, affirms life, and recognizes dying as a natural process
> - Provides support to the family and caregivers during the patients' illness, and in their own bereavement
> - Is delivered recognizing and respecting the cultural values and beliefs of the patient and family
> - Is applicable throughout all health care settings (place of residence and institutions) and in all levels (primary to tertiary)
> - Can be provided by professionals with basic PC training

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for published peer-reviewed articles from 1948 to 2011 that conceptualized, defined, or examined "supportive care," "best supportive care," "palliative care," and "hospice care" in the published literature, dictionaries, and textbooks (Hui et al. 2012). It is important to note that the article developed a preliminary conceptual framework unifying these terms along the continuum of care to help build consensus toward standardized definitions. For a better understanding of the WHO's approach to palliative care, their findings are informative: „In contrast to 'supportive care,' 'palliative care' was relatively more homogeneously defined. 'Palliative care' involves interdisciplinary care focusing on improving patients' quality of life by addressing their physical, emotional, and spiritual needs, and on supporting their families. Our findings are consistent with those of a concept analysis study [Meghani S. H. 2004]. The WHO definition captured the essential features of 'Palliative care' and was cited the most often" (Hui et al. 2012, 6). We also have a concept analysis of palliative care in the United States (see Meghani 2004).

[7] *The Lancet Commission Global Access to Palliative Care and Pain Relief (The Lancet Commission)* identified the need to review and revise the WHO's definition of palliative care and the *International Association for Hospice and Palliative Care (IAHPC)* took on this task. It must also be noted that in the three-phased consensus process *consensus* was not defined as an event requiring total agreement on a given proposed element of the definition of palliative care by all people questioned. Consequently, minority views are not reflected in the proposed definition: the criteria for consensus used by the researchers differ from how criteria for consensus is generally understood in ordinary language.

- Requires specialist PC with a multiprofessional team for referral of complex cases (Radbruch et al. 2020, 22, Table 4).

According to a discourse analysis of definitions of palliative care (a total of 37 English and 26 German definitions were identified) many definitions have taken up the prohibition of hastening or postponing death, although this prohibition has also been criticised (Pastrana et al. 2008, 225). In phase one of the three-phased consensus process of the new consensus-based definition of palliative care, the majority (72.3%) of the members of the expert group voted "stays as is" for the WHO's definition's component "intends neither to hasten or postpone death," nearly one-fifth (19.4%) of the members voted for the option "needs revision," and nearly one-tenth (8.3%) opted for "delete" (Radbruch et al. 2020, 20, Table 3). As the WHO has not modified its existing definition of palliative care (yet?), in the remaining sections of this paper I will be concerned with the WHO's current description of palliative care.

III. Fully Reconstructive and Partly Deconstructive Attitudes toward the WHO's Description of Palliative Care

The WHO's official description of palliative care might be labelled as a *non-conventional definition* if by conventional definition we mean one sentence in which the necessary and sufficient elements of the concerned entity are given. According to this reading[8] the first sentence of the description might be identified as the definition of palliative care, containing the *essential elements* of palliative care. Consequently, the subsequent characteristics of palliative care might be interpreted theoretically as *accidental features* of palliative care.

With this reading *two views of the palliative care specialists on the place of hastening death in palliative care* can be constructed, the *majority view* and the *minority view*. The *majority view* prohibits hastening death, and this prohibition is shared by most palliative care specialists and most organisations of palliative care and hospice. The *minority view* of palliative care specialists allows hastening death in exceptional cases.

The *majority view* of palliative care specialists and hospice workers basically claims that all features of the description of palliative care of the WHO must be taken as essential features. It states, consequently, that palliative care is not only "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness," but essentially "intends neither to hasten or postpone death." With taking all characteristics of the description of palliative care as essential features, every restatement of this definition of palliative care is an *affirming reconstruction* of the WHO's original description. Departure from the original version is often interpreted as false and

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[8] I doubt that the WHO would endorse this reading. According to the *conventional interpretation*, the WHO's description of palliative care is a definition consisting of two sections: an *initial concise statement* and a *list of bulleted and more specific components* (see for ex. Radbruch et al. 2020, 8).

consequently unacceptable definition of palliative care.

An example for the majority view of palliative care specialists and hospice workers could be the official position of the *European Association for Palliative Care*. The Association in its white paper cites the WHO's initial concise statement of palliative care, then a few pages later it states: "[t]he provision of euthanasia[9] and PAS [physician assisted suicide][10] should not be included into the practice of palliative care" (Radbruch et al. 2016, 111).

The minority view of palliative care specialists interprets the WHO's description of palliative care in a different way. This view claims that only the features given in the first sentence of the description of palliative care must be taken as necessarily essential features of palliative care, i.e., the essence of palliative care is found in the initial statement. Some or all of the remaining, bulleted features might be interpreted as accidental ones. Consequently, those who make a place for physician assisted death in palliative care generally cite or restate the first sentence of the WHO's description of palliative care but neglect the prohibition of hastening death. With this act, advocates for integrating palliative care and physician assisted death are partly deconstructing the WHO's original description of palliative care. Their act or strategy might be interpreted as *partial deconstruction* of the WHO's description of palliative care with an attempt to create a partly new construct, a partly new understanding of palliative care.

An often-cited example for the minority of palliative care professionals is the position held by the protagonists of the *Federation of Palliative Care Flanders*. This position is often labelled as 'integral palliative care': "Integral palliative care is conventional palliative care that has embraced and embedded euthanasia" (Vanden Berghe et al. 2013).

Although the two views share the initial statement of the WHO's description of palliative care, this shared understanding is not a guarantee for understanding palliative care the same way. While the majority way holds on to the prohibition of hastening death, the minority view endorses the possibility of physician assisted death in palliative care.

IV. The Theological Basis for the Prohibition of Hastening Death and the Consequence of Secularisation of Palliative Care Philosophy

If we wish to understand the spiritual foundation of the modern palliative care/hospice movement, especially its strict prohibition of hastening death, then we must go back to Cicely Saunders.[11] She was concerned with euthanasia and physician assisted suicide in many of her writings. Some of these writings were exclusively dedicated to

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[9] The EAPC's definition of euthanasia: „a physician (or other person) intentionally killing a person by the administration of drugs, at that person's voluntary and competent request" (Radbruch et al. 2016, 108).

[10] The EAPC's definition of physician assisted suicide: „a physician intentionally helping a person to terminate his or her life by providing drugs for self-administration, at that person's voluntary and competent request" (Radbruch et al. 2016, 109).

[11] For a comprehensive account of Cicely Saunders' contribution to palliative care see: Clark (2016).

the topic, others only touched upon this issue while discussing some different topic. A good example for the foundation of the majority view of palliative care specialists – the prohibition of shortening life in palliative care – is her paper *Voluntary Euthanasia* (1992) (Saunders 2006, 231–236), in which she writes: "Whatever our views on euthanasia, it surely cannot and should not be introduced as a logical part or extension of palliative care" (Saunders 2006, 231). Here she talks about the patients' requests for death, then she calls our attention to the possible fear behind the request:

> The phrase, "Let me die" often refers not to a request for a deliberate hastening of death but rather to a fear of treatment aimed at prolonging a burdensome existence. (…) Many of us would agree with Foley (1991) in pointing out the relationship of pain and symptom management to such patient requests for physician-assisted suicide and how attitudes change when a positive attitude and effective relief are introduced (Saunders 2006, 233).[12]

There are arguments against euthanasia and assisted suicide in other writings of Saunders as well. For example, in her *Hospice – a Meeting Place for Religion and Science* (1989) we read:

> The Christian concern for personal freedom includes a concern that there should be no implied pressure to end life. A right to die could all too soon become a duty to die and life that is becoming burdensome be seen as no more than a burden to others, a burden one has no right to inflict upon them. The hospice movement stands firmly against any legalisation of 'active euthanasia' however hedged about by safeguards and procedures (Saunders 2006, 226).

In her *Templeton Prize Speech* (Saunders 1981) she says: "We believe that euthanasia or assisted suicide is a socially dangerous and negative answer to a problem that should be tackled by other means. But we have a responsibility to work so that no one should reach that desperate place where they feel they would like to ask for that sad way out" (Saunders 2006, 159).

By *secularisation* we mean the widespread decline in religious traditions as their beliefs and values no longer hold popular respect (Bradshaw 1996, 409). As a result of secularisation of hospice care Ann Bradshaw already in the 1990s registered a significant change in the hospice ethos: "There is undoubtedly a profound ideological rejection of the traditional understanding of the spiritual dimension of care exemplified by Cicely Saunders, accompanied by a redefined concept of 'spirituality'" (Bradshaw 1996, 415).

Consequently, it is not surprising today that there are religious, doubter/seeker, and atheist palliative care professionals. A recent quantitative study among Flemish palliative care physicians investigated the effect of worldview on the attitude toward euthanasia, and not surprisingly came up with the following conclusion:

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[12] See the following articles for a better understanding of the desire to die statements from patients with advanced disease: Ohnsorge et al. (2014); Hudson et al. (2006).

> In our research we noted that physicians who have a strong belief in God and express their faith through participation in prayer and rituals, tend to be more critical toward euthanasia. Physicians who deny the existence of a transcendent power and hardly attend religious services are more likely to approve of euthanasia even in the case of minors or demented patients. In this way this study confirms the influence of religion and world view on attitudes toward euthanasia (Broeckaert et al. 2019).

This finding can be interpreted in a broader context, in that religious belief has strong association with end-of-life issues (Chakraborty et al. 2017; Pereira-Salgado et al. 2017).

V. Current Examples for the Relationship between Palliative Care and Physician Assisted Death in Practice[13]

A systematic scoping review of literature on the relationship of palliative care with assisted dying in countries where assisted dying is lawful (Gerson et al. 2020) revealed that various forms of relationship exist between palliative care and assisted dying. After analysing sixteen studies which discussed the relationship between palliative care and assisted dying in Belgium (n=4), Switzerland (n=2), the U.S. (n=9), and Canada (n=1), the study identified no less that eleven forms of relationship: *supportive*, *neutral*, *coexisting*, *not mutually exclusive*, *integrated*, *synergistic*, *cooperative*, *collaborative*, *opposed*, *ambivalent*, and *conflicted*. According to some in parts of *Belgium* the relationship can be characterised as integral and synergistic, the two practices coexist in a largely unproblematic and synergistic way: “Integral palliative care is described and defined as conventional palliative care that offers the option of euthanasia. Synergistic refers to the combined development and promotion of palliative care and euthanasia” (Gerson et al. 2020, 1296). The U.S. states *Oregon and Washington* show various attitudes: cooperative, conflicted, not mutually exclusive, and opposing:

> The terms *cooperative* and *not mutually exclusive* are used to describe the relationship of palliative care with assisted dying here because included studies indicate that many palliative care professionals and institutions cooperate with patients’ requests. Still others may choose to be present with patients at the time of the planned death, even when the law does not require a professional to be there. The terms *conflicted* and *opposed* are also used because the existing evidence indicates that assisted dying is not integrated into palliative care practice, is not without dilemmas, and may depend on individual values that may not concur with organizational or professional policies (Gerson et al. 2020, 1298).

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[13] My paper is not concerned with representations of palliative care, euthanasia and assisted dying within declarations or with declarations on euthanasia or assisted dying. Rather, I wanted to focus on what is going on in practice. Those readers who are interested in how declarations represent palliative care, euthanasia and assisted dying, and what positions various declarations have, are advised to read the following papers: Inbadas et al. (2019); Inbadas et al. (2017); Inbadas et al. (2016).

The situation in *Switzerland* was characterised as ambivalent, cooperative, and opposing:

> The two included studies from Switzerland demonstrate that physicians do not actively participate in offering assisted suicide as part of palliative care. The term *ambivalent participation* therefore describes their orientation, where participation is influenced by their own personal values. The term *cooperative* is also included because there are some physicians in Switzerland whose specific education, training, and belief system are conducive to being favourable to assisted dying requests. However, the term *opposed* is also included because both studies included here indicated that at least a third of participants were opposed to assisted suicide. The studies only narrowly describe practical experiences of palliative care providers with patients who seek an assisted suicide, and details of actual practice are absent (Gerson et al. 2020, 1297).

As to *Canada*, the researchers studied only one paper: this was a retrospective chart review examining a process for implementing MAID in home-based palliative care settings in Toronto. Based on the findings of this paper the researchers labelled the relationship between palliative care and assisted dying in Toronto as integrated and collaborative: ”The study suggests a relationship that is *integrated* and *collaborative* because the institution’s palliative care policy seeks to find alternatives for a patient who requests MAID but whose physician conscientiously objects to being involved” (Gerson et al. 2020, 1297).

We have another study which aimed at gaining a better insight into the relationship between palliative care and assisted dying by conducting semi-structured in-depth qualitative interviews with twenty-nine professionals in Flanders (Belgium), Oregon (U.S.), and Quebec (Canada). Therefore, our pictures of Belgium, the U.S., and Canada are more detailed. Although the overall perception in Flanders is that palliative care and euthanasia are unproblematically integrated, some palliative care professionals questioned this viewpoint. An interviewee, for example, talked about the following experience:

> I think palliative caregivers don’t really have a problem with euthanasia, they have a problem with the demand. (Some) patients are brainwashed with the idea that if you try to talk about palliative care, you’re against euthanasia and ‘you want to make me live longer against my will’. You don’t feel as caregiver you have anything to offer, you’re just burdened by the disrespect of the patient or often also the family (Gerson et al. 2021, 3532).

The authors of the study concluded – reinforcing the findings of a previous study (Gerson et al. 2020) – that there is no clear and uniform relationship between palliative care and assisted dying in these three locations.

Fortunately, since the implementation of Medical Assistance in Dying (MAID) *Canada* has made considerable effort to follow the impact of MAID on palliative care (Joolaee et al. 2022; Freeman et al. 2021; Shapiro et al. 2021; Wiebe et al. 2021; Ho et al. 2021a; Ho et al. 2021b). Some researchers, for example, conducted interviews with 23 palliative care providers (13 physicians and 10 nurses) in Southern Ontario between February 2018 and September 2019 to explore the experience of frontline palliative care providers about the impact of MAID on palliative care practice. One of the recent studies

(Mathews et al. 2021) identified six themes: MAID offers an alternative dying experience to natural death, may pose challenges to traditional symptom control strategies, creates difficult conversations, had an emotional and personal impact on palliative care providers, changes the patient-palliative care provider relationship, and palliative care resources are consumed by MAID requirements. Concerning the emotional and personal impact on palliative care providers, some participants described uncertainty and fear of social stigma around their involvement in MAID. For example, one of the nurses said: "What would my family think that I'm working on a unit that does that [Medical Assistance in Dying]? Do I hide it from them (...) what if people find out that we do it? Are people going to come up here and start protesting? People will see that as evil" (Mathews et al. 2021, 451).

Some of the palliative care providers described a sense of personal and professional satisfaction for supporting the patient's wishes. For example, a MAID provider said: "I'm not going to tell you I look forward to them [providing MAID], but when they happen, I actually find them. . . they're such beautiful experiences with family. It's the shared experience with the family that you're with that you have an opportunity to help" (Mathews et al. 2021, 451).

VI. Suffering at the End of Life: Our Response to Suffering

Suffering calls for a response on the side of the individual. Our attempt to relieve or to eradicate it by any means, or our trying to neglect it as much as possible, or our attempt at finding some meaning in suffering are three among the many possible responses. Suffering in some cases can have positive consequences as well. For example, Cicely Saunders did not consider suffering always as an essentially bad thing, something with harmful effects only. For her, preventing suffering was the imperative, but suffering, she said, in some cases can have some beneficial effects: „the understanding of suffering and its creative handling may be as important as attempts at its alleviation" (Saunders 2006, 148).[14] However, eradication of suffering by terminating the patient's life was undoubtably an unacceptable option for her. In *The Management of Patients in the Terminal Stage* she used again a religious argument: "It is not for us to say that the suffering is fruitless nor that there is nothing more for the patient to do or learn in this life. Man is not the master and possessor of his body and his existence" (Saunders 2006, 33).

Today, possibly many people do not wish to experience suffering at all, or do not want too much suffering, or do not wish to risk suffering at all, not even in palliative care. The consequential questions raised by these possible attitudes were formulated in a concise way early by Barbara J. Logue in her paper *When Hospice Fails: The Limits of Palliative Care*:

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[14] The possible beneficial effects of suffering were well known for Saunders from the writings of Friedrich Nietzsche, Viktor Frankl, and Teilhard de Chardin.

> But are all patients satisfied with comfort care? Does everyone enrolled in a hospice program experience a pain-free, dignified death? If not, do all who will face death in the future want to risk being one of the lucky ones? Is the much publicized importance of patient autonomy and empowerment to be limited to palliative care because explicit aid in dying is always prohibited by hospice ideology? Does the patient have a duty to live because palliative care is available? (Logue 1994, 291; for Saunder's response see Saunders 1995).

These are valid questions, especially because *relief of pain cannot be guaranteed by palliative care*.[15] This has recent evidence in the views of those palliative care experts who were working for the new consensual-based definition of palliative care. In Phase 1 of the three-phased consensus project the WHO definition of palliative care was broken down into its main 32 components, then these components were presented to members of the expert group in the first round of the Delphi consensus procedure. In the first Delphi round in Phase 1 "there was no consensus to keep the component *Provides relief of pain*, as the relief cannot be guaranteed, although pain should always be evaluated and managed when present. The experts agreed that *the aim is to relieve pain, enhance quality of life, and relieve suffering, but there is no assurance that these will be completely achieved*" (Radbruch et al. 2020, 9).

It is also a fact that requests to hasten death occur even in palliative care units regardless of the legislative status of any form of hastening death (Leboul et al. 2022, Güell et al. 2015, Guirimand et al. 2014; Ferrand et al. 2012; Ferrand et al. 2011). And in many cases patients and their relatives are grateful for having the option of euthanasia: "In a large number of cases, they [palliative care professionals] witnessed euthanasia that was being correctly administrated from a medical point of view, after thorough clarification of the patient's request and adequate communication, and that had good results. Whether or not all palliative possibilities had been exhausted, the patient was relieved and grateful that their final days did not have to last any longer. This convinced those professionals that euthanasia could be part of genuinely good care" (Vanden Berghe et al. 2013, 267).

VII. Conclusion

The explored varieties and the experienced difficulties of how palliative care specialists respond to a patient's request for euthanasia or physician assisted suicide highlight the importance of clarifying *the role of palliative care specialists in physician assisted death*, defining and supplying arguments for the ethical stances of professionals. This clarification should preferably happen before the patient comes up with a request. Patient care institutions should also have a clear *policy* on how the institution responds to euthanasia and physician assisted suicide requests. And the practicalities of how assisted death is being implemented alongside palliative care need to be monitored

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[15] Therefore, it is hardly surprising that for some „the good death of the original hospice movement has been abandoned in favour of a philosophy of a 'good enough' death" (McNamara 2004, 929).

for many reasons. Experiences can inform future laws (Gerson et al. 2021, 3537), can help professionals prepare for and deal with euthanasia and physician assisted suicide requests,[16] and can help all concerned individuals get fully informed on the different possible details of these practices.

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[16] This is important for those countries as well where euthanasia and physician assisted suicide are still illegal. As it is a fact that in these countries requests for euthanasia and physician assisted suicide occur, professionals should have adequate strategies to deal with these requests, and adequateness can be guaranteed only by being fully informed about the details and circumstances of these practices with a special view on the spirit behind the legislative regulatory background of the country concerned.

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