

of the team. Our clinical encounters need to become spiritually informed with enough time and opportunity for reflection so that we are able to talk about illness trajectories, treatment, and medical decisions on the basis of personal values, self-worth, spiritual and religious beliefs, and spiritual and religious support systems, struggles and what gives the patients meaning and purpose. Our calling to help creating a healing environment for everybody—for patients and caregivers in suffering as well as for team members.

‘We all are part of the collective soul... Integrative care with multidisciplinary approaches... to provide a touch of hope... a touch of love... to decrease suffering and to improve the quality of life of patients and families/caregivers in distress’.

Symposium 3

Euthanasia, physician assisted suicide and their connection to palliative care

S3-1 THE ETHICAL, LEGAL AND PROFESSIONAL LANDSCAPE OF PHYSICIAN HASTENED DEATH

Richard Huxtable. *University of Bristol, UK*

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Although many countries prohibit physician assisted dying, an increasing number of jurisdictions are making moves to allow the practice. Opinion remains sharply divided over the rights and wrongs of making such a move—disagreement continues about which practice(s) should be accommodated, how such practices such be labelled, and the strength of the ethical and professional arguments on either side.

Building on my previous research, I will first address some *preliminary matters*, specifically introducing the (contested and confusing) range of terms used in these debates, as well as providing a snapshot of some of the different legal responses around the world.

Against this backdrop, I move to consider important *moral matters* by focusing on the main ethical arguments for and against allowing (physician) assisted dying. Arguments in favour of the practice essentially claim that choice matters and suffering matters. Arguments against the practice, meanwhile, claim that life matters, medicine matters, and consequences matter. I will therefore engage with key claims about respect for autonomy, quality of life, the intrinsic value of life, the integrity of medicine, and the prospect of embarking on ‘slippery slopes’.

These are well-worn arguments, and understandably so, given the strength of feeling and the apparent strength of the claims on each side. Moving to *end matters*, I consider the merits of a different way forward. In a departure from many contributions to this longstanding debate, I suggest that a case can be made for striking a balance between the opposing camps, such that each side can make gains, whilst also incurring losses. On such a contested landscape, there may be worst places to be than the ‘middle ground’. I will sketch some of the options which can occupy this middle ground, in the hope this offers a fresh perspective and a different way forward.

S3-2 MISSING GOLDOLOCKS AND KILLING KANT: THE PRICE OF CANADA’S HEADLONG ASSISTED DEATH EXPANSION

K Sonu Gaiind. *University of Toronto, Canada*

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At the conclusion of this session, participants will be able to:

(i) Be aware of the scope of physician assisted death (PAD) frameworks, ranging from PAD for terminal illness to PAD outside near end-of-life conditions

(ii) Appreciate challenges assessing irremediability, intolerable suffering, capacity and decision making when considering potential requests for assisted dying in the context of mental illnesses

(iii) Understand proposed safeguards, and their limitations

(iv) Appreciate the tension between ‘overinclusion’ and ‘underinclusion’ in the context of potential assisted dying requests

Physician Assisted Death (PAD) has been legalized or decriminalized in well over a dozen jurisdictions around the world, and assisted dying policies continue to evolve rapidly. Many jurisdictions are exploring whether to introduce assisted dying laws, or expand existing laws. There is wide variation in how policies address potential applications for assisted dying for mental illness. PAD for sole criterion mental illness is available in the Netherlands, Belgium, Luxembourg and Switzerland, and recent Canadian legislation will permit psychiatric euthanasia by 2023.

This session will explore medicolegal, scientific, ethical and public policy issues related to PAD, focusing on the particular challenges posed with mental illnesses in the context of PAD, including challenges determining irremediability and the overlap between suicidality and psychiatric PAD. Dr. K. Sonu Gaiind, a University of Toronto professor and psychiatrist, a past president of the Canadian Psychiatric Association and panelist from the Council of Canadian Academies Expert Panel reviewing psychiatric euthanasia, will review the Canadian experience with PAD, including recent policy developments expanding PAD to non-dying disabled. Issues that have driven Canada’s PAD expansion will be discussed. This session will also explore differences between groups who seek PAD for different reasons, and discuss potential impacts of expanding PAD laws on marginalized populations suffering from life distress.

S3-3 WHEN IS MEDICALLY ASSISTED DYING APPROPRIATE?

Madeline Li. *Princess Margaret Cancer Centre, Canada*

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Medically assisted dying is increasingly garnering global support, now permitted in thirteen countries and being considered in several more. This growing legalization has occurred largely in Western and European countries, a reflection of its impetus in societal factors such as an increasing emphasis on individual autonomy, secularism, consumerism and patient empowerment in these more individualistic or less collectivist cultures. Although the drive for assisted dying has not primarily come from medicine, physicians have been invoked as

the gatekeepers. This has created personal distress for some clinicians and professional challenges for some disciplines such as palliative care. Yet, the majority of those who pursue assisted dying do receive palliative care services and there has been little global evidence of assisted dying being disproportionately provided to unwilling or vulnerable populations. The fact is that despite the availability of adequate palliative care, a small minority of patients will still want medically assisted dying. Assisted deaths have also been associated with better family bereavement outcomes than deaths due to other causes.

Medically assisted dying accounts for less than 5% of deaths as compared to the suicide rate of only 0.03% in palliative care, suggesting that the desire for assisted death is distinct from suicide. Contrary to popular belief, unbearable pain or physical suffering is not the main reason patients request medically assisted dying at the end of life. Psychological factors are the most common reasons, including the loss of autonomy and the desire for control. It is often unclear if a psychosocial intervention would be clinically indicated or effective in altering a capable patient's wishes. The paramount clinical responsibility in ensuring that MAiD is delivered safely and ethically is differentiating the desire for death as an indicator of pathology from a rational choice undertaken by a capable patient. This presentation will use case examples to illustrate that this is indeed possible to do, and in some cases, a medically assisted death may be the only and most patient-centered way to relieve end of life suffering. In this new clinical practice of medically assisted dying, medicine must now rise to the obligation to balance the concurrent duties of beneficence through respecting the autonomy of capable patients and nonmaleficence by protecting vulnerable patients.

S3-4 EUTHANASIA AND ASSISTED SUICIDE: 'WHAT'S DIGNITY GOT TO DO WITH IT?'

Harvey Max Chochinov. *University of Manitoba, Canada*

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While death hastening policies are emerging in various constituencies around the world, it behooves us to understand the complexities of what motivates people to seek out these life ending options. Some of the earliest studies in the Benelux countries identified a connection between choosing euthanasia or assisted suicide and loss of dignity. More recent studies have affirmed this association, suggesting that an appreciation of dignity may provide insights into how best to understand and be responsive to the needs of those expressing the wish for a hastened death.

Dignity, defined as the quality or state of being worthy of honour, respect or esteem, conveys the essence of medical professionalism regarding how patients should be treated. Such treatment, or dignity conserving care, can help patients deal with existential issues, maintain their dignity, and lessen psychological distress. Failure to acknowledge dignity by lack of acknowledgment of personhood can undermine patients' sense of self-worth, quality-of-life and will to live. Fractured dignity is further associated with feeling a burden to others, no longer feeling like the person they once were, and loss of autonomy, all of which have been identified as drivers in the wish to die.

Our program of research has explicated the construct of dignity, developed and empirical model of dignity in the terminally ill; outcome measures to track dignity related distress; and trialed psychotherapeutic approaches designed to improve end-of-life experience and achieve death with dignity. The connections between this body of empirical work and the issue of desire for death, loss of will to live, and coveting a hastened death will be further explored.

Plenary Session

Plenary Session 1

Recent progress in the integration of standard oncology and palliative care

P1-1 INTEGRATING ONCOLOGY AND PALLIATIVE CARE TO IMPROVE PATIENT CARE: PROVIDING THE RIGHT INTERVENTION, AT THE RIGHT TIME FOR THE RIGHT PATIENT

David Hui. *University of Texas MD Anderson Cancer Center, USA*

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Over the past decade, a large body of literature has accumulated supporting the integration of palliative care into oncology practice for patients with advanced cancer. The question is no longer whether palliative care should be offered, but what is the optimal model of delivery, when is the ideal time to refer, who is in greatest need of a referral, and how much palliative care should oncologists themselves be providing. This objective of this session is to discuss how different models of palliative care can address the care needs of cancer patients along the disease trajectory. We will provide an evidence-based review of randomized controlled trials on integration of palliative care and oncology. It is important to recognize that these clinical trials have examined many different approaches to palliative care delivery. In the outpatient setting alone, investigators have studied (1) Interdisciplinary Specialist Palliative Care in Stand-Alone Clinics, (2) Physician-Only Specialist Palliative Care in Stand-Alone Clinics, (3) Nurse-Led Specialist Palliative Care in Stand-Alone Clinics, (4) Nurse-Led Specialist Palliative Care Telephone-Based Interventions, (5) Embedded Specialist Palliative Care with Variable Team Makeup, and (6) Advanced Practice Providers-Based Enhanced Primary Palliative Care. The diversity of models has helped to highlight that timely involvement and interdisciplinary engagement are the two essential elements to optimize outcomes. We will highlight the key concept that palliative care, at its best, is a form of preventative care. Timely palliative care interventions can help to prevent catastrophes such as pain crisis and intensive care unit admissions. We will discuss the optimal timing for referral to specialist palliative care. We will review the pros and cons of various specialist palliative care outpatient models, such as stand-alone clinics, embedded clinics and nurse-led clinics. We will also discuss how automatic referral can facilitate systematic access to timely palliative care. The prerequisites to automatic referral include routine screening of supportive care needs, consensus referral criteria, a mechanism to trigger referrals and