

Assisted suicide and euthanasia requests in early palliative care

Assisted suicide and euthanasia (ASE) represent a legal practice recognised in numerous countries around the world and are on the agenda of legislators in many states including France and Spain. In Italy, sentence no. 242/19 of the Constitutional Court on assisted suicide has started a lively debate on the topic.

A recent demographic study¹ conducted on 13 countries (8 of them in Europe), in which these practices are legalised, found that most of the population expressed a clear support for ASE as an option to put an end to 'intolerable pain'. In the case of Belgium, these practices, present since 2002, are considered part of palliative end-of-life care.

To ensure more effective responses to cancer suffering for patients and caregivers, since 2010, medical research has demonstrated how the anticipation of palliative care (early palliative care (EPC)) today represents a new standard of care for patients with metastatic cancer, which allows improving not only the quality of life and alleviating total pain but also being able to encourage coping with an incurable disease, possibly lengthening of survival.²

The purpose of this study is to report on the frequency of initial and final requests for ASE in a cohort of patients who received EPC. This is a secondary analysis of a study by Bandieri *et al* on 350 patients and caregivers.³ Among 195 patients with advanced cancer, 31 (15.9%) patients, on the first visit, spontaneously expressed desire for suicide assistance, to be pursued outside Italy (most in Switzerland), due to the perception of intractable suffering. Relevant to this, the median (IQR) of Numerical Rating Scale pain score at first EPC consult was 7 (6–8) and the median (IQR) Edmonton Symptom Assessment Scale (ESAS) overall

score was 50 (50–60). To the first question of the study³: 'Discuss your disease experience prior to EPC', the patients, unanimously, responded that the reason was the severe physical pain and concomitant suffering. After a mean time of 13.6 months after the EPC consultation, they did, progressively, dismiss the purpose for ASE. The patients who expressed an initial favourable attitude to the ASE hypothesis, on first accesses, responded to the specific question³: 'Discuss your disease experience during EPC'. Answers converged in the description of EPC as an alternative to the original idea, linked to an irreducible suffering of resorting to ASE, outside Italy. The motivation was not only to have achieved unexpectedly rapid responses to physical pain but also to have found a 'safe place' in the doctor–patient relationship (represented with various metaphors as the 'oasis' and 'salvation') which allowed them to keep hope alive and helping them to face preparation for dying, also for their beloved ones. The clearly prevalent metaphors of 'light', referring to care, testify to the importance of the needs of patients/caregivers for spirituality.³ While on outpatient EPC, a shared decision to die at home was made and home palliative care service was successfully activated for all the 31 patients. We also noted that 90.3% of patients, in favour of assisted suicide, identified themselves as atheists, supporting previous reports on the association between ASE and religious belief (online supplemental reference 1). Of further interest is the fact that 23 of the 31 patients' primary caregivers expressed disagreement with the intent of assisted suicide of their beloved ones.

Implementation of ASE may have an impact on health services. In Oregon, for example, legalisation was followed by an increase in severe, untreated pain among terminally ill patients. During a period when 1832 hospices opened in other states, only five opened in Oregon. In other states that have

legalised assisted suicide, the use of hospice care has fallen below the national average.⁴ ASE has also been perceived by physicians and nurses from Canada to potentially negatively impact consumption of palliative care resources to support assisted death programmes.⁵

Recent studies showed that patients with incurable cancer in palliative care services support (52%) the legalisation of euthanasia (online supplemental reference 1). The determining factor for the contrary opinion was belief in God (online supplemental reference 1). ASE, nowadays, represents a medical challenge with potentially important repercussions on the very concept of the human, in medicine. Our findings suggest that early access to PC in the outpatient setting, by providing impeccable symptom control, psychosocial spiritual and rapport building with the patient and family, may influence views regarding life being worth living. EPC may also give an effective response not only to patients' suffering but also to caregivers' needs, which have always remained unchanged over time. While it is very unlikely that EPC will successfully prevent all situations of request for ASE, our findings are encouraging. A reduction in the number of requests for ASE not only reflects less patient and caregiver suffering but it also results in the reduction of the severe level of burnout experienced by physicians exposed to these requests (online supplemental reference 2).⁵

The Greek etymology of the word *eu-thanasia* (ευθανασία) means 'good-death'. A desirable 'good death' may also be considered when: (1) you no longer suffer from unbearable pain, because of appropriate analgesic therapy; (2) you no longer receive acts of therapeutic fury; (3) you are not dying alone; (4) you are helped to communicate your suffering; and (5) your bereaved primary caregiver is supported. Relevant to this, the Go Wish card game has been developed to facilitate conversations

about end of life, by contributing to identify patients' priorities. The most common patients' wishes include, among others, to have family present, to be free of pain, to avoid being a burden to the family and to have family prepared for death, reminding us that patients with advanced cancer assign to spirituality (online supplemental reference 3).

An open and truthful doctor-patient relationship is to be preserved, which can establish a relationship of trust and can protect the patient from influences, even those unconscious ones, on the part of the doctor itself, linked, for example, to the fear of death. The doctor should avoid transforming into a mere provider of services and keep preserving a more complex vision of humanity, with inherent relational, psychic and spiritual components (online supplemental reference 2).

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