

Title.

Response to Letters about “Palliative Care and Assisted Dying: Uneasy bedfellows.”

Authors.

1. James Downar**, MDCM, MHSc
 - a. Division of Palliative Care, Department of Medicine, University of Ottawa, Ottawa, Canada.
2. Nancy Preston, PhD, BSc, RGN, FAcSS

**Corresponding author: 60 Cambridge St. N. B-103, Ottawa, Canada K1R 7A5
jdownar@toh.ca

Word Count:

Key Words: Euthanasia, Active, Voluntary; Assisted Suicide; Palliative Care; Editorial

Disclosures: JD has received honoraria from Joule, Inc. for developing educational material relevant to assisted dying, and is a former unpaid member of Dying with Dignity Canada’s Physician Advisory Council. NP no disclosures.

Text.

We appreciate the differing perspectives on this topic, but would like to correct some of the claims made by Regnard and Proffitt. First and foremost, their conclusion that we believe palliative care and Medical Assistance in Dying (MAID) to be “comfortable bedfellows” was squarely contradicted by our title, which described them as “uneasy bedfellows”.

Second, contrary to their claims, Canadian palliative care providers always have a choice about whether they will assess for eligibility or perform MAID. Many choose not to be involved in MAID, while others choose to participate based on their own views on MAID,(1) or because they wish to avoid disrupting their relationship with their patients, as outlined clearly in the letter by Runacres et al.

Third, the claim that participation in MAID results in “persistent psychological harm in up to a fifth” of healthcare professionals is not supported by any of the three references they cite. Rutherford et al.(2) do not report persistent psychological harm, and actually

suggest that “repeated participation becomes less fraught, or at least does not serve to disincline them from practice.” The estimates of persistent psychological distress reported by Kelly et al. were taken from surveys conducted prior to legalization of MAID, where respondents had no training or support;(3) they cannot and should not be extrapolated to the context of legal MAID. Archer et al. reported that participating in MAID can be emotionally “heavy”, but this is not tantamount to persistent psychological harm.(4) These comments must be interpreted in the context of studies showing high rates of burnout among palliative care providers worldwide (up to 66%),(5) and the profound emotional strain that end-of-life care has on physicians in general.(6)

Fourth, Regnard and Proffitt question whether the palliative care provided to MAID recipients was of high quality, or was simply “general end-of-life care.” Many have expressed concern that MAID is driven by poor availability or quality of palliative care, but without an accepted gold standard measure for the quality of palliative care delivered, this is always going to be a subjective argument. Notably, the assessment of Palliative Care provision in federal reports as judged by MAID assessors(7) aligns very closely with the assessment of nurse investigators working for the Office of the Chief Coroner of Ontario.(8) And studies have repeatedly shown that the populations known to receive the best palliative care (e.g. sociodemographic privilege, people with cancer) also have the highest incidence of MAID.(9) This is not something we would expect to see if MAID was a symptom of palliative care deficiency.

1. Close E, Jeanneret R, Downie J, Willmott L, White BP. A qualitative study of experiences of institutional objection to medical assistance in dying in Canada: ongoing challenges and catalysts for change. *BMC Med Ethics*. 2023;24(1):71.
2. Rutherford J, Willmott L, White BP. What the Doctor Would Prescribe: Physician Experiences of Providing Voluntary Assisted Dying in Australia. *Omega (Westport)*. 2023;87(4):1063-87.
3. Kelly B, Handley T, Kissane D, Vamos M, Attia J. "An indelible mark" the response to participation in euthanasia and physician-assisted suicide among doctors: A review of research findings. *Palliat Support Care*. 2020;18(1):82-8.
4. Archer M, Willmott L, Chambaere K, Deliens L, White BP. Key challenges in providing assisted dying in Belgium: a qualitative analysis of health professionals' experiences. *Pall Care Soc Prac* 2025;19:1-19.
5. Dijkhoorn AQ, Brom L, van der Linden YM, Leget C, Raijmakers NJ. Prevalence of burnout in healthcare professionals providing palliative care and the effect of interventions to reduce symptoms: A systematic literature review. *Palliat Med*. 2021;35(1):6-26.
6. Granek L, Ariad S, Nakash O, Cohen M, Bar-Sela G, Ben-David M. Mixed-Methods Study of the Impact of Chronic Patient Death on Oncologists' Personal and Professional Lives. *J Oncol Pract*. 2017;13(1):e1-e10.

7. Fifth Annual Report on Medical Assistance in Dying in Canada, 2023: Health Canada; 2024 [Available from: <https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html#a2.1>].
8. Downar J, Fowler RA, Halko R, Huyer LD, Hill AD, Gibson JL. Early experience with medical assistance in dying in Ontario, Canada: a cohort study. *CMAJ*. 2020;192(8):E173-E81.
9. Downar J, MacDonald S, Buchman S. What drives requests for MAiD? *CMAJ*. 2023;195(40):E1385-E7.