Palliative care with adequate pain relief challenges the need for euthanasia legislation

Renald Blundell1,*, Martina Cini1, Kimberley Blundell1

1Department of Physiology and Biochemistry, Faculty of Medicine and Surgery, University of Malta, Msida MSD2080, Malta. 2Centre for Molecular Medicine and Biobanking, University of Malta, Msida MSD2080, Malta. 3Faculty of Law, University of Malta, Msida MSD2080, Malta.

*Correspondence to: Renald Blundell, Department of Physiology and Biochemistry, Faculty of Medicine and Surgery, University of Malta, Tal-Qroqq Msida, Msida MSD2080, Malta. E-mail: renaldblundell@gmail.com.

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Abbreviations
MDT, multi-disciplinary team.

Citation

Abstract
Background: In today’s society the ongoing discussion about euthanasia triggers emotionally charged debates surrounding the delicate balance between valuing life and respecting an individual’s autonomy. With the persistence of this debate, there has been the emergence of the concept of the so-called alternative: palliative care. Positioned as a substitute for euthanasia, palliative care aims to alleviate suffering in terminally ill patients without engaging in the ethical dilemmas associated with euthanasia. Methods: This paper explores the facets of palliative care highlighting its core objectives such as providing adequate pain relief as a compassionate alternative to euthanasia. Results: By examining palliative care as a comprehensive approach to end of life support, this study challenges the perceived necessity of euthanasia and advocates, for compassionate and dignified end of life experiences. Conclusion: In conclusion, palliative care emerges as a viable and ethically sound alternative to euthanasia, emphasizing the importance of compassionate end-of-life care and pain management.

Keywords: palliative care, adequate pain relief, euthanasia legislation, end-of-life care, patient-centered care, policy development
**Background**

In the field of healthcare, palliative care serves as a guiding light of empathy and solace for individuals grappling with illnesses and debilitating ailments. With its roots in age traditions of tending to the sick and dying, palliative care has evolved into a specialized discipline aiming to improve the quality of life for patients with life limiting conditions [1].

The origins of care can be traced back to ancient civilizations, where easing suffering and providing comfort in the face of illness were core principles in medical practice. Throughout history diverse cultures and medical practices have acknowledged the significance of accompanying individuals on their end-of-life journey with dignity and compassion [2].

Similarly, the discourse surrounding euthanasia, which involves ending a person’s life to alleviate suffering has deep historical foundations. From ponderings in ancient Greece to ethical deliberations, in modern day bioethics, whether individuals should possess the right to decide when and how they die, has remained a subject of substantial moral and societal importance [2].

Embedded within the narrative encompassing palliative care, Euthanasia is an understanding that pain constitutes an essential element contributing to human anguish.

Throughout history, the understanding and treatment of pain have evolved in ways thanks to advancements in medical knowledge and the development of therapies to relieve discomfort. From medical texts to modern practices in managing pain, societies have grappled with comprehending and addressing the multifaceted nature of pain and its impact on human well-being [3].

In years discussions around palliative care challenges in pain relief and laws regarding euthanasia have become significant topics of debate from ethical, legal and medical perspectives. Despite progress made in palliative care and pain management there are still situations where traditional approaches fall short in meeting the complex needs of patients nearing the end of their lives [1].

Given this context, this article aims to delve into the dynamics involved in palliative care while also examining the ongoing challenges faced in providing effective pain relief. Additionally, it will explore the increasing calls for measures that encompass a wider range of end-of-life care issues, including the highly debated topic of euthanasia. By analysing examples considering ethical aspects and examining current medical practices we hope to shed light on navigating through these complexities at the intersection of palliative care, pain management and end of life decision making.

**Understanding palliative care and its benefits**

To fully discuss the benefits of palliative care, one must define the parameters of the subject. According to Willemsen et al., palliative care is a very tailor-made and patient-oriented form of medical care which is designed to alleviate the holistic suffering of a patient with a terminal illness [4]. This means alleviating the patient’s physical, emotional, psychological, spiritual, social, and also at times financial suffering. This type of care is similar but is not to be confused with hospice care.

Hospice care is when one cares for the patient without any curative intent. This would be as the patient will no longer have any curative routes to pursue or has opted not to go down those routes as the side effects outweigh the benefits [5]. In the case of palliative care, this would be happening alongside the treatment the patient would be taking for their illness and would happen regardless of their stage or potential for recovery [5].

Thus, most would state that the care of the patient would initially be palliative care then slowly blend into hospice care if the patient unfortunately deteriorates further. It is important to note that the main aim of the palliative treatment will always be to provide relief, including pain relief, to patients with a serious illness whilst supporting them and their families [6].

Palliative care includes key aspects such as pain and symptom management. This will involve a care team which will work on alleviating symptoms like nausea, shortness of breath, pain and discomfort caused by the illness, or the treatment being carried out [7].

Another aspect would be emotional and psychological support to the patient and their family members. This would mean that the psychiatrist and psychologist work together to support the family and patient to cope with the newly founded challenges the illness has presented them with and also helps disseminate the impact the illness has on their lives [8].

Palliative care also makes sure to assist the patient and the family in making the correct and fully informed decisions about the care the patient receives. This is enabled through the discussion of treatment options available, be it local or abroad, the discussion of goals of the care, and also end-of-life choices needed to be made. All this is carried out whilst the patient is cared for holistically, thus seeing that all of the aspects of care are coordinated and covered [6].

**Euthanasia: an ethical dilemma**

**Definitions and classification of euthanasia**

Euthanasia, which is widely discussed in the context of end-of-life care, covers a range of practices aimed at easing suffering and providing comfort to individuals facing illnesses or pain [9]. At its core, euthanasia involves ending a patient’s life to alleviate their distress. Within the realm of euthanasia, there are categories that highlight its various forms, shedding light on the complex ethical and legal considerations linked to its implementation.

The distinction between passive euthanasia is fundamental in this discussion. Active euthanasia entails administering a lethal substance or intervention, with the explicit intention of ending the patient’s life [10]. On the hand passive euthanasia refers to withholding or withdrawing life sustaining treatments or interventions such as removing ventilator support allowing the natural progression of the patient’s condition [10].

Adding complexity to the landscape, there are the voluntary and involuntary classifications of euthanasia that emphasize patient agency and consent in decision making. Voluntary euthanasia occurs when patients explicitly request discontinuation of life sustaining measures or administration of an intervention [10]. On the hand involuntary euthanasia occurs when a patient is unable to make decisions due to their condition leaving others responsible for determining their end-of-life care [10].

These classifications not only define the various ways in which euthanasia takes place but also highlight the complex ethical and moral considerations that surround discussions about end-of-life care. The differences between passive, as well as voluntary and involuntary euthanasia are significant points of debate that lead to deep reflections on the sanctity of life, personal autonomy and the role of medical professionals in shaping end of life experiences [11].

As discussions about euthanasia progress, with changing values, cultural norms, and advancements in medical ethics, it remains crucial to have a nuanced understanding of its classifications and implications. By navigating the complexities involved in euthanasia, policymakers, healthcare providers and society, as a whole can engage in conversations and decision-making processes that prioritize the dignity, autonomy and well-being of individuals facing end of life challenges.

**Considerations and debates around euthanasia**

It is widely known that euthanasia is not the most ethically compatible solution to the pain and long suffering a person might have to endure. Yet there are very strong arguments for and against this.

People in favour of euthanasia argue that the patients as individuals have the right to make their own decisions regarding their lives. This extends to their right to choose when and how they should die. Particularly, this is accepted more when a person has a terminal illness or is in unbearable pain. Proponents argue that giving them the right...
to euthanasia gives them a bit of control in the chaos they must be feeling in their illness [12].

On the contrary, the opponents of euthanasia argue that it is morally wrong to end a life intentionally, under any circumstance. These people argue that we should not be playing God, thus, have no right in deciding who gets to live and who gets to die [13].

Thus, euthanasia legalisation is considered a slippery slope. This is as euthanasia may be expanded to the vulnerable people, including people who can not provide their informed consent, like people with severe disabilities or mental illnesses. Thus, this may easily lead to the misuse and abuse of euthanasia laws [11].

People against euthanasia give an alternative considered valid by most; palliative care including adequate pain management. Many ideologists argue that if the palliative care is holistic, and the pain management is adequate, the patient’s perceived need for euthanasia may decrease [14]. This is mostly the idea in very religious countries such as Malta as studied by Blundell et al., and discussed later on [15].

The legalisation of euthanasia varies across countries and also jurisdictions. The policymakers and lawmakers are to thoroughly look at the ethical considerations, culture, social values, individual liberties and human rights before permitting or prohibiting euthanasia [16].

Another consideration to be made with respect to euthanasia is the psychological effect it may have of the family and broader community. This is as some may argue that euthanasia may enable the closure necessary for the loved ones and may be the key to elevate the prolonged suffering for the patient and the rest of the people involved. Yet, opponents may discuss that the relatives and loved ones may feel guilt, grief and moral distress over the decision they had arrived at with the patient [6].

From a religious point of view, euthanasia is never the right solution. This is as most religions perceive pain and suffering as a way to purify one’s soul, ultimately contributing to one’s earlier redemption [17]. Many religious people would not pass off the offer of redeeming one’s soul, as they are told by even their spiritual advisers that this is the way to go, and to relish in the pain as they would then be pure, and so, who would really put their soul on the line if this is what they’re told to believe?

Contemporary religious speakers have gone out of their way to remind people that the God they believe is of love would not want to see them suffering, far from agreeing to euthanasia, these activists encourage the seeking of palliative care with good pain relief, as to help the patient die a peaceful death rather than an excruciatingly painful one. Being given appropriate pain relief will help the patient receive the sacrament of the anointing of the sick more fully, which is believed to strengthen the spirit and the body, believing to better the chances of both the soul and body [14].

Euthanasia also impacts the healthcare professionals since they would feel conflict between the oath to keep the patient alive and to provide compassionate care to the dying. Although Hippocrates himself stated that we must not over-treat or undertreat, both euthanasia and palliative care preserve this in their own way. This is as euthanasia gives a stop to the invasive treatments, thus, not over-treating a patient, and does not undertreat the patient as it helps one get out of the stuck painful state they would be in [10].

Over-treating a patient can be seen when a physician attempts to maintain life at any cost, irrespective of the amount of medical interventions or acts necessary, making death very difficult to achieve, yet with no actual prospect of recovering life or any sense of wellbeing.

This phenomenon is known as dysthansia and happens very often in people with life-threatening diseases. Knowing this, one would question whether this is even worse than euthanasia. This is as euthanasia hastens the death of a patient who is still alive, and dysthansia painfully extends the life of the patient who is already dead [18].

Legal perspective on euthanasia
Claudia Taylor-East has referred to palliative care as an option which should never be considered as a luxury. She states that is necessary to have a ‘multidisciplinary team’ consisting of the patient, the family, nurse, doctor and other health professionals [19]. However the concept can bring about certain legal issues which will stop palliative care from being provided. Another issue relates to the small amount of literature which is present in relation to palliative care in Malta. This can be countered by looking through foreign literature on the subject as to gain an insight into the solutions provided by other countries [20].

The area of palliative care can bring discussions in various different aspects of law which makes it a complicated issue. To add to the complexity, having different legal systems means that there are no one fits all solutions which can be used in various states.

In Malta, same as in all common law jurisdictions, there is the presumption that a person has the mental capacity to consent or to refuse medical intervention. This is a rebuttable presumption. This right to refuse treatment persists even if the decision may bring on further harm to the patient. This has been seen in the case of Pretty vs. The United Kingdom, which showed that the right to refuse treatment is found in Article 8 of the ECHR [21].

In common law countries, the biggest issue in relation to palliative care has been considering the use of opioids in the final stages of life as to alleviate patient’s suffering, especially if such may cause death. This has been seen in the case of R vs. Adams in the United Kingdom, where Lord Justice Devlin stated that a doctor “is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measure he takes may incidentally shorten life” [20]. This means that the death of patients is to be attributed to the underlying disease, even if the dose given is high.

On the other hand, France gives priority to the European Union law, as all EU countries do. Here EU law would take precedence over national law. After the May 1999 draft recommendation of the Council of Europe to encourage providing palliative care to incurable and dying patients, the French Parliament enacted a law which provides palliative care for anyone “whose state of ill health requires it”. In this law, the emphasis is on alleviation of any suffering and on preserving the quality of life of the dying person with “avoiding any unreasonable obstinacy in pursuing investigations and treatments” [21].

While this ECHR line of thinking could be applied to each country, each country addresses pain management and end of life in their own unique legal perspective. There however, is a consensus or near-consensus on a few issues including; the right to refuse treatment and the “impermissibility of active euthanasia” [20].

Palliative care versus euthanasia
In the section of this article, we delve into a detailed comparison between palliative care and euthanasia exploring their philosophies, goals and societal impacts in the context of end-of-life care. By examining these approaches, we gain insights into how they diverge in their efforts to alleviate patient suffering and improve quality of life during critical moments.

Palliative care, as a cornerstone of compassionate end-of-life management, centres on providing holistic support aimed at comforting patients grappling with life-limiting illnesses [12]. This approach emphasizes pain management, emotional support and addressing the multifaceted patient needs that encompass physical, psychological, social and spiritual dimensions. On the hand, euthanasia involves an intentional intervention aimed at terminating the life of the patient to relieve their suffering often through administering a lethal dose of medication [12].

At the core of care is a commitment to enhancing quality of life and upholding patient dignity throughout their journey towards the inevitable end. It promotes a team-based approach involving healthcare professionals, family members and the patients themselves with an emphasis, on communication and shared decision making [22]. On the hand when it comes to euthanasia, there is a collaboration between medical professionals and family members in decision making. However, this could result in relatives feeling
unsupported after the persons passing because they miss out on the care provided by palliative measures [22].

Furthermore, palliative care distinguishes itself through its personalized and tailored approach that takes into account each patient’s unique circumstances, values, and preferences [22]. It acknowledges the dignity and value of every individual by advocating for interventions that respect the sanctity of life while also prioritizing patient autonomy as much as possible. In contrast, euthanasia brings about a sudden and irreversible end to life without considering these intricate factors or providing personalized care like palliative approaches do [19].

By comparing the philosophies and practices of care with euthanasia this analysis sheds light on the complex ethical and moral aspects involved in end-of-life decision making. It encourages us to reflect on how medical ethics, patient autonomy and societal values intersect in these situations. This emphasizes the significance of discussions and compassionate care when navigating through the complexities of end-of-life experiences. Ultimately, this section contributes to our understanding of the wider landscape encompassing end of life care. It informs practices, policy development efforts and ethical debates, within both the medical community and society at large.

Process of pain management in palliative care

In Palliative care, addressing the pain of the patient is a critical component in ensuring that the patient is comfortable, as pain in palliative patients has been proven to decrease one’s quality of life [7].

Assessment

The first step in pain management is assessing the patient’s level of pain. This will include understanding the nature of the pain, for example, whether it is nociceptive or neuropathic in nature. One will also assess the intensity by means of scales, the location of the pain and will look for any factors which will exacerbate or alleviate the pain [23].

Medication

Once the nature of the pain is well defined, the physician will see if the patient has any drug allergies, or conditions which dictate the analgesia given. For example, the doctor will see if the patient is asthmatic, in case non-steroidal anti-inflammatoryatories (NSAID) like Diclofenac or Ibuprofen would be avoided since these may induce bronchospasm and may in rare cases lead to death. NSAID induced bronchospasm has been reported to affect between 8% to 20% of adult asthmatics [24].

Usually, patients are started on analgesia like Paracetamol, which may be aided with Ibuprofen. This can be taken orally if at home or may be given intravenously if at hospital as the bioavailability of the medication given intravenously is the highest from all the alternative routes. Pain medication can also be given rectally, but there are wide variations of bioavailability after rectal administration with over 50% of the drug still undergoing a first-pass metabolism since it is delivered through the portal system to the liver. Furthermore, rectal drug absorption is considered irregular, nonlinear, and often incomplete. Yet, this route at times may be preferred as it may be quicker than the oral route in alleviating the pain [25].

If the above is not enough to alleviate the pain, which most of the time they are not, the physician may opt to give opiates such as Codeine, Morphine and Pethidine. Opiates work by reducing the pain transmission at the dorsal horn by the dorsal horn projection neurons, thus inhibiting the excitatory neurotransmitter release. More specifically, they are said to act centrally on the periaqueductal grey matter by enhancing their descending inhibition, thus in return the patient perceives less pain [26].

It is important to note that apart from nausea and constipation, a major side-effect of opiates is respiratory depression, known as Opiate-induced respiratory depression (OIRD). OIRD is induced via the activation of mu-opioid receptors found at sites in the central nervous system such as the pre-Botzinger complex which is a respiratory-rhythm generating area located in the brain [27].

This risk increases when the patient has multiple comorbidities, is of older age or is in an advanced stage in one’s illness. This is widely known to the physicians administering the opiate and one always faces a dilemma when giving such a pain medication since to relieve one’s pain, the physician risks the patient going into OIRD. Here is when the Hippocratic Oath resurfaces, with the physician balancing over-treating with under-treating the patient. Yet, in the face of severe pain and distress, which will ultimately lead to one’s inevitable death, most physicians agree that the risk outweighs the benefit and hence morphine is still given when its need is indicated. Each and every mediation is titrated to the person’s specific needs and to their response to the medication. The end-goal is to achieve appropriate pain relief whilst keeping the side-effects minimal [28].

It is not unusual that along with the pain medication, other medications to deal with the symptoms of the disease would be given. An example would be giving ondansetron or another anti-emetic if the patient is feeling nauseased. This may be given orally, intramuscularly or intravenously [29].

Non-pharmacological intervention

Apart from having the pharmacological input, the patient may benefit from non-pharmacological interventions as well. These include techniques like massages, acupuncture, relaxation techniques and also alternative therapies like music therapy. These interventions are approaches which aim to enhance the overall wellbeing of the patient and provide comfort to the patient beyond the traditional treatment [30].

Individualisation of the plan and regular reassessment

The multidisciplinary team (MDT) is to consider the patient’s specific pain characteristics such as location and type of pain and what makes it better or worse. The staff is to consider the patient’s medical history and should look at the allergies and sensitivities proven by the patient, remembering that palliative patients have a higher morbidity. Thus, the prescriber is to address any side-effect or complications promptly. One must also assess the emotional and psychological factors influencing the person’s perception of pain. Finally, one must also consider the persons cultural and personal preferences when tailoring the plan as to make it as fitting for the patient as possible [31].

Reassessment is necessary as to monitor the progress of the patient or to see if the patient is responding well to the pain management provided. Thus, one should monitor the patient’s response to the prescribed medications and interventions. Doses are to be adjusted or changed according to the pain intensity and tolerance of the particular patient. Furthermore, one is to look at the effect of the non-pharmacological interventions on the overall well-being of the patient.

Communication

Communication with the patient and caregivers is important so that the multidisciplinary team confirm the plan aligns with the evolving need of the patient maximising the patient’s quality of life as much as possible. This includes but is not limited to shared decision-making where the staff collaborate with patient to determine the most appropriate pain management plan, considering their goals and their values [31].

Furthermore, the MDT is to communicate and work well together as to provide the holistic support of the patients. This involves the doctors, nurses, nursing aides, carers, radiographers, physiotherapists, occupational therapists, phlebotomists, social workers, counsellors, and chaplains. The patient shall reap the full benefits of palliative care only upon the harmonious convergence of these esteemed professions [31].

Thus, the MDT is to practice active listening with the patient. This entails understanding the patient’s experience, concerns, and
preferences regarding the management of their pain. The team is to educate the patient well and provide clear information about the medications, potential side-effect and rationale behind the interventions and pain medications. Finally, the team is to update the patient along the way, address their questions promptly and show empathy by acknowledging their emotional aspects of pain and its impact on their overall wellbeing [32].

Challenges and limitations of palliative care

Palliative care seems to be very ideal on paper. Yet, what is actually feasible in the hospital setting and beyond paints a different picture. Palliative care depends on the ability of the care to be actually transmitted to the patient and to the relatives involved. A major barrier to this could be the fact that the patient and relatives do not know that they can make use of the service since they think that it is only for specifically end-of-life patients when, as discussed, palliative care can be provided to the patient at any stage of their recovery, not only if their prognosis is lethal. This often results in patients and families missing out on this valuable source of support [33].

Another challenge would be the shortage of trained palliative care specialists. This often leads to the uneven access of services as the number of patients being helped at the same time is limited. This could lead to the patients not being helped by this service to be in pain and would also have poor symptom control. This will lead to the person having a very poor quality of life which will result in them wanting to end the suffering as soon as possible, resorting to euthanasia where it is legal or staying in pain in countries where it is not possible [34].

Palliative care, or any care for that matter, comes at a financial cost. In most countries there are many organisations which aim at receiving donations to help these patients financially. These are important as even in countries like Malta where healthcare is paid through the population’s taxes, some treatment has to be paid for through the person’s pocket. Furthermore, the members of the palliative team, including the physicians, nurses, social workers, psychologists and more all have a fee. Thus, the relatives and family might not be financially stable enough to pay for the service since it is costly on its own and worse accompanied by the fees of the treatment itself. Some people may be able to get the services through insurance, yet some policies exclude palliative care from their coverage [35].

Communication can at times be a barrier itself. This is as the family, patient and the healthcare professionals may all have a different end goal in mind and different modes of execution. All the opinions matter since the family knows the patient before the disease, the patients have their autonomy and the health care professionals have seen multiple patients and know what usually works in the situation they’re facing, even though everyone is different. Apart from this triangle, the healthcare professionals themselves often lack coordination leading to the fragmented care of the patient. This can result in conflicting treatment plans with missed opportunities for the holistic treatment of the patient [32].

When dealing with children, the challenges may at times be greater. This is as the parents have the authority to make decisions, thus, as they are grieving the health of their child and questioning their whole existence, they must make hard decisions. This most of the time makes the situation more challenging and emotionally complex. Another consideration to be taken is the culture and religious beliefs the family would have. This will likely influence the preferences for palliative care and the end-of-life decision take, making it essential to provide culturally sensitive and individualised care plans [36].

Consent in palliative care and euthanasia, especially children and individuals lacking decision-making capacity

Palliative consent in children

It is crucial to obtain the consent of patients for palliative care. This is important for respecting their autonomy building trust and ensuring that decisions are made with understanding. Like adults, children have the right to be involved in discussions about their healthcare. This collaborative approach creates a relationship between healthcare providers, children and their families. It also helps children express their concerns and preferences which can be empowering and help them cope with illness [37].

To make decisions it is vital to provide age-appropriate information and address any questions or concerns that children and their families may have. Ethically speaking, involving children in decision making aligns with principles of doing good, avoiding harm, and showing respect for individuals. Recognizing children as participants in their healthcare journey highlights their dignity and right to receive compassionate care. By upholding these principles, healthcare providers can improve the quality of care and support provided to children and families facing life threatening illnesses. It ensures that treatment decisions are aligned with their values and goals [38].

Palliative consent in individuals who lack decision making capacity

Individuals who are unable to make decisions about their medical treatment, personal matters, or other important issues whether due to medical or legal reasons are considered to lack decision making capacity [39]. This includes individuals with conditions like dementia, incapacity caused by sedation or severe intellectual disabilities. From a legal perspective, decision making capacity involves factors such as understanding the nature of decisions appreciating their consequences and effectively expressing preferences. In some cases, this may require the involvement of guardians or psychiatric assessments. For example, individuals with mental illnesses or intellectual disabilities may need guardians to handle financial and healthcare decisions on their behalf [40]. In emergencies, mental health professionals assess an individual’s capacity for voluntary or involuntary treatment. The goal is to respect the individual's autonomy while ensuring their best interests are protected through legal measures. A comprehensive understanding of decision-making capacity allows healthcare providers and legal authorities to uphold principles and safeguard the wellbeing of vulnerable individuals, in various situations [40].

It is important to ensure consent for care when dealing with individuals who lack decision making capacity due to severe cognitive impairments or advanced dementia. While these individuals may not be able to engage in discussions regarding their healthcare in the manner as children or adults with decision making abilities, it remains crucial to prioritize their dignity and rights [41].

In these situations, healthcare providers must partake in a process called substituted decision making. This involves involving family members, legal guardians or designated healthcare proxies who can make decisions on behalf of the individual based on what is in their best interest and any previously expressed wishes if they are available. By following this approach, we not only uphold the ethical principles of autonomy and beneficence but also ensure that the care provided aligns with the values and preferences of each individual. Recognizing the significance of consent, for those lacking decision-making capacity allows healthcare teams to embrace patient centred care principles while ensuring that all patients, irrespective of their abilities receive compassionate and respectful palliative care [39].

Euthanasia consent in children and in individuals who lack decision making capacity

When it comes to children the idea of euthanasia presents ethical dilemmas. Due to their stage of development, children may not fully comprehend the consequences of end-of-life choices. Deciding whether a child has the maturity and understanding to give consent for euthanasia is ethically challenging because it involves finding a balance between respecting their autonomy and safeguarding their interests. Additionally, paediatric euthanasia raises concerns about coercion, the long-term emotional impact on families and healthcare providers involved, as well as the wider societal implications of legalizing euthanasia for vulnerable populations [42].

Likewise addressing euthanasia in cases where individuals lack
decision making capacity—such as those with cognitive impairments or advanced dementia—presents significant ethical complexities. In situations the principle of autonomy becomes intricate since these individuals may not be able to express their wishes or preferences effectively.

Determining whether euthanasia is in the interest of individuals especially when considering the potential for suffering and loss of dignity requires a careful assessment of their values prior directives and quality of life. However, allowing euthanasia for individuals raises concerns about abuse and the devaluation of human life. It also highlights the importance of prioritizing care and compassionate support during end-of-life situations [39].

In both cases the ethical and practical considerations surrounding euthanasia emphasize the need for safeguards, comprehensive legal frameworks, and strict oversight mechanisms to protect vulnerable individuals’ rights and wellbeing. Prioritizing quality palliative care, managing symptoms effectively and providing psychosocial support are crucial in meeting the complex needs of people facing terminal illnesses or unbearable suffering. By placing emphasis on end-of-life care and respecting every patient’s dignity healthcare systems can uphold principles like doing good (beneficence) avoiding harm (non-maleficence) and showing respect for individuals while navigating challenging decisions, about end of life scenarios [39].

### Research and Innovation

Palliative care and appropriate pain management are crucial aspects of healthcare, particularly for patients with life-threatening illnesses. Research in this field has focused on various areas, including the impact of early palliative care, the role of palliative care in improving quality of life, disparities in pain management outcomes, and the use of innovative approaches such as digital health technologies [43].

Temel et al. have conducted a randomized controlled trial, highlighting the benefits of early introduction of palliative care for patients with metastatic non–small-cell lung cancer [38]. The study emphasized the potential of timely palliative care in mitigating unnecessary and burdensome personal and societal costs associated with aggressive end-of-life care. Similarly, Zhuang et al. demonstrated that early palliative care significantly improved the overall quality of life in patients with non-small-cell lung cancer [44].

Furthermore, disparities in pain management outcomes have been a subject of research, as evidenced by Chung et al., who explored the impact of race/ethnicity on pain management outcomes following inpatient palliative care consultation [45]. This study highlighted the importance of earlier intervention by the palliative care team in improving symptom management and reducing the length of hospital stays for terminally ill patients.

In addition to traditional approaches, innovative strategies such as digital health technologies have been explored in palliative care. Mills et al. discussed palliative care providers’ perspectives on technological innovation, emphasizing the potential for digital health innovations in client health records, telehealth, and personal health tracking [46].

Moreover, the role of research in addressing disparities in palliative care has been emphasized by Gu et al., who highlighted the potential of palliative care research in diminishing ethnic disparities and contributing to the quality improvement and innovation of palliative care [47].

Overall, the research in palliative care and appropriate pain management has contributed to understanding the benefits of early palliative care, addressing disparities in pain management outcomes, and exploring innovative approaches to improve the quality of care for patients with life-threatening illnesses.

### Conclusion

In conclusion, this thorough exploration has delved into the aspects of palliative care, shining a light on its profound advantages and ethical concerns, especially in the midst of the contentious debate surrounding euthanasia.

Throughout this paper, we have examined care as a comprehensive approach that aims to improve the quality of life for individuals facing life limiting illnesses. The examination of strategies for managing pain underscores the nature of addressing suffering and discomfort in patients receiving palliative care.

Despite the challenges and limitations in this field, our article also highlights the promising realm of ongoing research and innovative interventions. From therapies tailored to meet individual needs, to utilizing artificial intelligence for advanced care planning, the ever-evolving landscape of palliative care provides glimpses of hope and progress.

As healthcare professionals and policymakers navigate the balance between ethical considerations and alleviating suffering, it becomes their responsibility to ensure that palliative care remains at the forefront as compassionate and holistic support during individuals most vulnerable moments.

As this field continues to evolve it is crucial to uphold principles such, as dignity, respect, and patient-centred care in order to affirm the value of each individual’s end of life journey. By working in alliance, educating, and promoting awareness, we can work towards a future where palliative care becomes a symbol of empathy and solace, for those who require it.

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