

## Peer Review File

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### Reviewer A

Comment 1: On page 5, line 172, there is a minor typographical issue. The citation "Wang et al" should be corrected to "Wang et al." by adding the missing period at the end of "et al."

**Reply 1: Thank you for highlighting this.**

**Changes in the text: Missing period added at line 165, page 7.**

Comment 2. On page 5, lines 189-192, there seems to be a missing reference number. It would be beneficial to include the appropriate reference at the end of this specific sentence to ensure clarity and proper citation.

**Reply 2: Thank you for highlighting this.**

**Changes in the text: The reference to Richardson (2014) has been added at line 177, page 8.**

Comment 3. On page 6, lines 204-207, the authors rightly emphasize the underrepresentation of minority ethnic groups and LGBTQIA communities in hospice care. However, it might be worth considering the inclusion of additional marginalized groups as well. For instance, in Belgium (a country to which the authors occasionally refer as an exemplar of a country with a more holistically developed palliative care system) individuals with severe and persistent psychiatric conditions also face stigmatization in various aspects, including their access to high quality palliative care. Across the globe, this unique population has struggled and remains to struggle to receive the palliative approach they deserve. All the more reason why e.g., Trachsel et al. have been advocating for a palliative approach for this unique patient group for years, as evidenced by their work (see, for example: <https://pubmed.ncbi.nlm.nih.gov/27450328/>). In this regard, the division between 'soma' and 'psyche' persists, despite the palliative federations promoting a holistic approach for every single patient, regardless of the nature of their medical condition. While they aim to include psychiatric patients in this holistic approach, various factors make it a challenging endeavor. It's interesting to note that even in this context, the Catholic wing advocates for a separate yet equally valuable palliative end-of-life care model for patients who are not terminally ill but suffer from incurable psychiatric conditions, known as the 'oyster care model' (see: <https://www.frontiersin.org/articles/10.3389/fpsy.2020.00509/full>).

Would it be worth considering this aspect and subpopulation in your narrative? It's not a necessity, but I suggest it as an idea because this subpopulation of patients is sometimes disadvantaged in healthcare, and historically, they have often been treated differently, much like during the Middle Ages. Please feel free (not) to incorporate it into your main text or conclusion, as this is only a suggestion on my part.

**Reply 3: We agree that those with psychiatric conditions receive inequitable palliative care support (and inequitable opportunity to be involved in research) and have added an additional reference to support this. Debate of the issue of the holistic view of suffering encompassing palliative care *for* psychiatric illness outside of terminal physical illness is an interesting concept and thank you for bringing relevant literature to our attention.**

**Changes in the text: We have added an additional reference (Chochinov et al., 2012), (Trachsel 2016) to inequitable provision of palliative care for those with psychiatric conditions with or without other terminal morbidities (line 204, page 9).**

Comment 4. In addition, the authors reference Leget's research from 2007 to highlight Belgium's leading position, and they use other references to make the same claim about the palliative care situation in the Netherlands. However, it's worth noting that most of these references may be somewhat dated. This doesn't diminish their interest or importance, but it does suggest that they may no longer represent the cutting edge of contemporary relevance, as Leget himself has indeed- as rightly stated by the authors – emphasized in recent years.

It's also worth considering that the article from 2007 was published shortly after the introduction of the Belgian Euthanasia Act, which sent shock waves through the palliative care sector, and its impact continues to be felt. Similar developments occurred in the Netherlands. Both countries are grappling with an increase in euthanasia cases, and these numbers are influenced by factors such as a gray area between deep palliative sedation and euthanasia.

**Changes in text: This contextual point has been added, line 371.**

**Changes in cited references: Line 302, reference 68 (Daniel) has been retained but more recent references 55 (Moriera) and 61 (Raeburn) were added.**

As the landscape of palliative care tends to expand, so does that of euthanasia. Euthanasia claims seem to be increasingly coming from patient groups where the role of palliative care is either less pronounced or still in its infancy. This includes patients suffering from e.g., poly pathology (accumulated non-terminal illness conditions linked to advanced age) and psychiatric conditions. Regardless of the terminality or the nature of the disorder, what ties euthanasia requests together is the significant influence of psychological and spiritual aspects, when e.g., good dying can occur when patients and their families have the opportunity to say their goodbyes. However, the period around the deathbed is substantially shorter in the case of euthanasia compared to palliative care. Therefore, euthanasia is increasingly being considered as a form of ritualistic assisted suicide in a society where traditional rituals are on the decline, but the need for rituals remains. On the other hand, it also shows some determinants of what is sometimes called 'the era of radical individualism and consumerism.'

I'm particularly interested in understanding the connection between how the British perceive palliative care and this other form of medical termination of life, which is gaining legislative ground in more and more countries but has not yet done so in Great Britain: euthanasia.

Do the authors see any specific reasons for this absence in Britain, and how does it relate to their discussion of palliative care? This is merely a suggestion for further exploration within the article's narrative, and the authors are off course free to disregard it.

**Reply 4: As UK authors, after discussion, we made a conscious decision not to comment upon and debate the complex ethical, moral and legal issues of assisted dying or euthanasia in this manuscript. This topic is outside the scope of our expertise and what we feel able to comment upon.**

**Changes in the text: None**

### **Reviewer B**

I read through this interesting and informative manuscript twice, the first to get overall understanding of it and then the second to critically assess it. I appreciate the work to do this review and manuscript and the information in it, but I am suggesting a major revision, as there are 2 rather big issues:

Comment 1: it is not clear to the reader how information was obtained and assessed, and so there are questions as to how trustworthy the information is presented on current/modern and medieval times.

**Reply 1: We acknowledge that medieval sources are biased towards being the perspective of the educated minority and this point is made in the text (line 232, page 10), current literature is from peer reviewed publications.**

**Changes in the text: Further details are added to Methods detailing the broad key search terms and depositories accessed to identify relevant material for this narrative review (Lines 126-136, page 6.)**

Comment 2: It may be better to focus on medieval approaches and views of death and dying, with an introduction orienting the reader to the value of examining life and death long ago before ICUs, modern societal considerations such as smaller families, advanced aging, and high tech life, not to mention palliative care specialization.

As it currently is written, there is an introduction where the purpose of this paper is not 100% clear to the reader, followed by a section on modern death and dying in England (with some mention of the Netherlands) which provides some helpful information to those readers who are not living in England, but this section does not make it easy for the reader to then compare modern versus medieval concepts and practices related to dying and death.

The reader is left to identify how these 2 times compare, and then wonder why does this matter. Does it matter that death was more obvious long ago?

**Reply 2: We agree that the two sections on modern and medieval; end of life would benefit from a linking paragraph to make clearer our rationale for comparison.**

**Changes in the text: A linking paragraph has been added, line 72-78, page 3.**

### **Reviewer C**

I appreciate the authors for bringing up an important topic of considering death as a part of life and living unless dead. There is utmost need to understand that death is not just a medical phenomenon, which the authors have talked about well. Overall, the article is well written and brings up medieval Christian concepts about end of life.

The points where I suggest revisions include:

Comment 1: The UK as well as most modern world now is a multi-cultural, multi-ethnic, multi-religious society with further differences in other aspects too. It would be good to include more literature from medieval times from other religions, ethnicities or societies.

There is ample concentration on death and dying process in Chinese, Indian and Hispanic heritage. This will make the article more inclusive. An example of an inclusive article can be taken as:

Wong K, Camacho J, Dulani S, et al. (October 14, 2022) Honoring Long-Lived Cultural Beliefs for End-of-Life Care: Are We Prepared in the Modern Western Society? . *Cureus* 14(10): e30313. doi:10.7759/cureus.30313

**Reply 1: The historical focus of the article was on Medieval Britain whose population was not the diverse, multicultural society as is the modern UK. In Medieval times, culture was predominantly Christian plus some influences from Islamic and Jewish culture and these are discussed within this narrative review (lines 237, 279). We agree that the modern-day UK context, is culturally diverse.**

**Changes in the text 1: We have added the suggested Wong et al., reference (line 196, page 8) to a statement acknowledging the complexity of caring for diverse patients with differing cultural, religious or spiritual needs.**

Comment 2: The authors have talked mostly about the UK health system. If they want to keep the article restricted to the UK, it would be good to see the statistics of the national health system about end-of-life care during COVID-19 times, which the authors' main concern is.

**Reply 2: We agree that this contextual information would be useful to the reader.**

**Changes in the text: Line 211 to 216, page 9, additional information and an additional reference has been added. APPG. The Lasting Impact of COVID-19 on Death, Dying and Bereavement. London, UK: APPG; 2023 March 2023.**

Comment 3: It would be good to elaborate how some of the learning points from the medieval times that would be appropriate to apply in the current UK health system.

**Reply 3: In section 2.3 Can history inform modern practice in end-of -life care and 3. Conclusions: the way forward, we discuss what can be learnt for medieval history. Key points made include: the need for an understanding of death as an integral part of life. (line 429), a need to re-familiarize our society with death and dying and this understanding should be implemented from an early age (line 430) and a training requirement for health professionals in better understanding the individuality of spiritual and existential needs during end-of-life care, which will vary widely according to individual choice, culture, societal group, religion, and belief (line 438).**