4. Canadian Society of Palliative Care Physicians. *How to improve palliative care in Canada. A call to action for federal, provincial, territorial, regional and local decision-makers.* Surrey, BC: Canadian Society of Palliative Care Physicians; 2016.
5. *Bill C-277.* Ottawa, ON: Parliament of Canada; 2015. Available from: **www.parl.gc.ca/LegisInfo/BillDetails.aspx?billId=8286156**. Accessed 2017 Mar 20.
6. College of Family Physicians of Canada. *CACs in palliative care.* Mississauga, ON: College of Family Physicians of Canada; 2016. Available from: **www.google.ca/maps/d/viewer?mid=1hxx-Kh83m1SSLKGy7I9j4DCGbE8&ll=32.10504412097467%2C-96.63293775&z=3**. Accessed 2017 Mar 20.
7. Kumar SK. Kerala, India: a regional community-based palliative care model. *J Pain Symptom Manage* 2007;33(5):623-7.
8. Saunders C. Living with dying: the management of terminal disease. In: Robertson H. *Meeting death: in hospital, hospice, and at home.* Toronto, ON: McClelland and Stewart; 2000. p. 69.

Choice is led by values

It is disappointing to see *Canadian Family Physician* being used to perpetuate the myth that dying people request medical assistance in dying (MAID) because of inadequate palliative care.[1] This is simply false and misleading. People exercise their right to choose MAID in more than 90% of cases for existential reasons, not for inadequate pain and symptom management. Nor are the 2 options mutually exclusive.

Patients who choose MAID are commonly used to living autonomously according to their own values. These empowered people, when faced with suffering leading to death, choose to exercise control over this aspect of their lives, and in authoring the final chapter of their lives, choose the best death available to them according to their own values. Not what some religious group or palliative care "expert" opines.

They choose to make their own passing as peaceful as possible, and planned according to their values regarding where, when, and who is present.

Yes, they should be aware of and access any and all palliative care options, providing the best pain and symptom management they choose, and every effort should be made to find meaningfulness and closure in their time remaining. That is just proper palliative care—that goes without saying, but it has nothing to do with the reason for the recognition of MAID as a constitutional right by the Supreme Court and its presence as an option to Canadians.

The propaganda against MAID is rooted in falsehoods and religious dogma, none of which should be repeated in any Canadian medical journal in 2017.

—Paul R. Preston MD CCFP
North Bay, Ont

Competing interests
None declared

Reference
1. Collins A, Leier B. Can medical assistance in dying harm rural and remote palliative care in Canada? *Can Fam Physician* 2017;63:186-7, 189-90 (Eng), 195-8 (Fr).

Response

Through the Supreme Court decision, medical assistance in dying (MAID) has become a legal option allowing patients to choose the time and date of their death.[1] Palliative care should be provided to individuals at the end of life, regardless of their legal choice to expedite their death with the assistance of MAID.

Although health care in Canada is universal, there is a difference in resource allocation when it comes to equity versus equality. Palliative care consists of providing holistic care to the individual, treating him or her as a person rather than a medical diagnosis. This can provide comfort to the patient and family at the end of life. Rationales for completing MAID are as unique as the individuals requesting the service. Each case is unique. However, patients should still have access to palliative care—a limited resource without the same access across the country. If you cannot avail yourself of palliative care services at the end of life, what other options are available to you?

—Andrew Collins MD CCFP
—Brendan Leier PhD
Edmonton, Alta

Competing interests
None declared

Reference
1. Collins A, Leier B. Can medical assistance in dying harm rural and remote palliative care in Canada? *Can Fam Physician* 2017;63:186-7, 189-90 (Eng), 195-8 (Fr).

Family physicians' role in hidradenitis suppurativa management

I thank Dr Lee and colleagues for their very interesting review on hidradenitis suppurativa (HS) in the February 2017 issue of *Canadian Family Physician*.[1] It is hoped that family physicians will be more and more acquainted with HS, as I am convinced that the role of family physicians in HS management could be more substantial than it has been in the past.

There are at least 2 reasons for this. First of all, long delays in diagnosis are common, as HS is frequently misdiagnosed as a simple infection.[2] If left untreated, the disease causes substantial morbidity. In 40% to 70% of cases, family physicians are the first health care professionals consulted by patients suffering from HS. Even though patients suffering from HS have consultations with 1 or more dermatologists, family physicians are still the primary caregivers for 15% of patients after an HS diagnosis is received.[3] Therefore, family physicians might speed up a diagnosis and facilitate patients' access to HS-dedicated care if they acquire the skills to recognize and manage HS. Furthermore, HS is a systemic disease with a substantial comorbidity burden[4-7]: cardiometabolic comorbidities (obesity, dyslipidemia, hypertension, diabetes) are not rare, as they are possibly linked to HS through common genetic and