

Moving on from euthanasia

It is time to move on from the euthanasia debate.¹ Let's also move on from "physician-assisted suicide."

Rationally, if a society legalizes the killing of sick people, it should use the group that is most efficient, legal, trained and, at times, paid to kill: the Armed Forces. Want to die? Fill out a chit, and the sniper takes you out from 100 yards. No pain; indeed, you will never even hear the shot. Still in the hospital? Perhaps nerve gas in the oxygen line. Very effective. Some options are a bit messy, and therein lies the rub. The hypocrites want everything all "nice" and sanitized.

The Armed Forces will kick and scream about killing the population they are sworn to serve. So please, tell me why physicians should do it instead.

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What a mindless comment. Flegel and Hébert's editorial directs that "As physicians, we should ... avoid further polarization of this important debate with our own values and ideologies."¹ Flegel and Hébert don't seem to realize that they have just injected their own values into the debate by insisting that, in their personal opinion, only impersonal values have merit! Of course, this is central to the very issue being discussed; whether a specific value happens to be one's own is clearly separate from its relative merit.

Most of us share the authors' desire for honest dialogue, education and engagement. However, trying to muzzle physicians from anything beyond the physiology and basic science of dying, as the authors seem to imply, is an affront to the whole of medicine. Clinical care benefits from continual investi-

gation, testing and discussion by physicians across the whole range of human experience. Those who spout paternalistic injunctions against personal values and ideologies artificially close discussion and polarize with values and ideologies all their own.

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Legislation protects the vulnerable?

Chambaere and colleagues describe a decrease in the rate of life-ending acts without explicit request (LAWER) and an increase in the rate of euthanasia since legalization of euthanasia in Belgium.¹ Given this coincidental rise and fall, I propose that legalization has converted instances that would previously have been life-ending acts without explicit request into euthanasia. Instead of performing life-ending acts without explicit request while believing their patients wanted euthanasia, physicians now feel able to explicitly discuss the issue without fear of prosecution.

The data presented by Chambaere and colleagues support this hypothesis. As the authors mention, in 2007, the characteristics of patients receiving life-ending acts without explicit request were dissimilar to those of euthanasia patients: the former were older (53% over the age of 80), nearer the end of their lives and less likely to have cancer (34%). However, data collected in 2001, before legalization of euthanasia, did not show this clear separation of characteristics between the two groups of patients (e.g., only 24% of patients receiving life-ending acts without explicit request were over age 80, and 52% had cancer). This supports the idea that before legalization, some patients

who may have wanted euthanasia were receiving life-ending acts without explicit request because communication between physician and patient was not explicit. If this is true, it's an example of a protective function of regulation.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/182/9/895#523111

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Assisted death without consent?

The recent article by Inghelbrecht and colleagues¹ has led to startling interpretations in the media of unethical practice by Belgian nurses involved in palliative care. Assisted death without patient consent, runs the theme.

The study shows that medical decisions were made without the patient's explicit request, but it is vague on the role of the decision-makers choosing for the patient. The appendices to the article are only suggestive: Why does the flow chart not show the response to question 10.7 (i.e., whether discussion with relatives had occurred)? Also, the article shows in tabular form that, of the "unexplicitly requested" assisted deaths, nurses discussed the patient's or relatives' wishes in 41% of cases when they were involved in decision-making. Why is this not mentioned in the text? In the other cases, was the physician involved? Or others? The nurse answering the questionnaire may not have known, but the interpretation seems to be that no discussion was held.

The article makes several important supported claims that describe evasion or overlooking of the law and policy, but the most startling suggestion — that

half the cases of assisted death are without consent — is the least supported. The evidence clearly does not permit such an interpretation.

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In our article, the finding that half of cases of assisted death are performed without the patient's explicit request is very much supported by the data. There was patient consent or a patient's wish in some of these cases, but for the administration of life-ending drugs, this is legally not sufficient. A request or wish from relatives acting as surrogate decision-makers is also insufficient to justify such an act. But ethical and legal criteria aside, it is true that most decisions to administer life-ending drugs without explicit patient request are discussed between physicians and nurses as well as relatives.

In another study, also set in Belgium but surveying physicians instead of nurses, Chambaere and colleagues found that in only 6.5% of such cases, the physician had made the decision without consulting others.¹ The relatives were involved in 79.4% of cases, and other professional caregivers (colleague physicians or nurses) were consulted in 71%. Given these figures, it is safe to assume that a decision to administer life-ending drugs without explicit patient request is rarely made without some form of consent or agreement, be it from the patient, relatives or colleague caregivers. However, consent (even from the patient) does not constitute sufficient legal grounds to perform this act.

Our article focused explicitly on the role of nurses in decision-making and the preparation and administration of life-ending drugs in cases of assisted death with and without explicit patient request. Our questionnaire asked whether there was discussion between the nurse and the relatives in those

cases — which happened in 68.9% of cases. We did not include this finding in the article because involving the relatives, especially in the case of patient incompetence, is ultimately the responsibility of the physician, as is the decision itself, with input from relatives and nurses.

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Increasing rates of flu vaccination in primary care staff

We recently reported on a randomized trial of a program to increase staff influenza vaccination in primary care clinics.¹

As mentioned in the review by Lam and colleagues,² previous studies were in hospital and long-term care settings, and only one study had an arm in primary care (with an unsuccessful campaign). The difference between inpatient settings (hospitals and institutions) and outpatient settings (primary care clinics) is obvious but often ignored in the literature. The authors should have been more careful about generalizing analysis of data from staff in nursing homes to “nonhospital settings,” which erroneously suggests that the conclusions also refer to primary care.

Our study showed that a promotional and educational intervention program can be highly effective in increasing the rates of influenza vaccination among staff. The campaign included local vaccination “champions,” whose effectiveness was recently demonstrated in a hospital setting.³

Although we performed an intervention to increase rates of vaccination among staff, we think that the evidence

about the benefits of such an intervention is weak. Lam and colleagues base the recommendation that all health care personnel should be vaccinated on a 2006 Cochrane review.⁴ However, the Cochrane review concluded that there was no credible evidence of the benefit to elderly patients of vaccinating nursing home personnel.

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Ontario immunization rate for polio

The editorial about the polio outbreak in Tajikistan incorrectly states that immunization rates for polio in Ontario are between 70% and 80%.¹

The most recent data from Ontario's Immunization Record Information System shows that 83% of 7-year-old children and 94% of 17-year-old adolescents are immunized against polio. Although immunization coverage rates for 7-year-olds have been relatively stable over the last decade, the rates have improved steadily by 17 years of age.

Under the Immunization of School Pupils Act, medical officers of health are required to maintain vaccination records of all school students for designated diseases. A written vaccination record or proof of vaccination is required by law for diphtheria, tetanus, polio, measles, mumps and rubella unless there is a valid written exemp-