When and how to die

I am concerned with the statement in the *CMAJ* editorial on "therapeutic homicide," that the euthanasia debate has been theoretical because of the "tacit assumption that doctors do not kill people."[1] This is a less than forceful description of medicine's mandate.

That doctors do not purposefully take lives is far from a tacit thing. This constraint has been an invariant truth for millennia. The *Hippocratic Oath* includes the injunction, "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."[2] An 1826 manuscript states, "How can it be permitted that he who is by law required to preserve life be the originator of, or partner in, its destruction?"[3] Innumerable examples exist where doctors are admonished not to kill. Qualifying this long-standing ethical interdiction as "tacit" saps its intellectual rigour and opens it to questioning. If it is to be disregarded, let it be on the basis of persuasive counter-arguments rather than on the notion that it is not explicit.

I am deeply concerned about potential damage to the medical profession were it to accept assisted suicide as a medical act. I have suggested elsewhere that responsibility for implementing assisted suicide could be mandated to a nonphysician group.[4] This would respond to legislative demands while enabling doctors to fulfill the ancient mandate of healing. Euthanizing and healing are not miscible, nor can they be 2 sides of 1 coin. This is not a tacit assumption; it is the expression of a reverberating imperative.

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I am a cancer doctor in Oregon, where physician-assisted suicide is legal, and I wish to respond to the editorial by Flegel and Fletcher.[1]

In Oregon, the combination of the legalization of assisted suicide and prioritized medical care based on prognosis has created a danger for my patients on the government-run Oregon Health Plan (Medicaid).

The plan limits medical care and treatment for patients with a 5% or less likelihood of 5-year survival.[2] Patients in that category, who may have a good chance of living another 3 years and who want to live, cannot receive surgery, chemotherapy or radiotherapy to obtain that goal.[2] The plan guidelines state that the plan will not cover "chemotherapy or surgical interventions with the primary intent to prolong life or alter disease progression."[2] The plan will cover the cost of the patient's suicide.[2]

Under Oregon law, a patient is not supposed to be eligible for voluntary suicide until he or she is deemed to have 6 months or less to live. In the well-publicized cases of Barbara Wagner[3,4] and Randy Stroup,[5] neither of them had such diagnoses, nor had they asked for suicide. The plan, nonetheless, offered them suicide.

In Oregon, the mere presence of legal assisted suicide steers patients to suicide even when there is not an issue of coverage. One of my patients was adamant she would use the law. I convinced her to be treated. Now 12 years later she is thrilled to be alive.[6] I hope that others can avoid making the same mistake Oregon has.

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In their editorial in *CMAJ*, Flegel and Fletcher asked, "Are we ready to perform therapeutic homicide?"[1]

As the professional body representing more than 300 physicians practising palliative medicine, the Canadian Society of Palliative Care Physicians answers with an emphatic, "No!" Physician-assisted dying is not part of the continuum of end-of-life care, nor has it been part of 2500 years of Hippocratic tradition.

We were encouraged by the *CMAJ* authors' 2 important observations about palliative care, specifically that it "has come of age and is adequate to meet the needs of most dying people," and more important, that "it is underprovided, particularly in remote and rural areas." The Canadian Hospice Palliative Care Association has determined that only 30% of Canadians have access to palliative care.[2,3]

Regarding the call to "speak up now, and with conviction," our 2011 member survey found 83.3% of respondents were against legalization or decriminalization of euthanasia, and 90.6% would not participate in it; 80.6% opposed physician-assisted suicide, and 83.6% would not aid in it.[4] We also applaud the Conservative government's appeal of the British Columbia decision allowing physician-assisted suicide.

We are concerned that liberalizing euthanasia laws in other countries has led to its being performed without appropriate consent — and not always for terminal illness. We oppose any suggestion

that these acts become part of standard end-of-life care. As a nation with a proud tradition of caring for the vulnerable, let us instead choose to ensure that the dying have the choice of palliative care.

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As an expert to the Quebec commission on euthanasia, I wrote a memoir and testified during the public consultations. In response to the *CMAJ* editorial by Flegel and Fletcher,[1] I would like to share facts that are not known by most physicians and patients.

There were 427 presentations to the commission: 99% favoured palliative care; 60% opposed euthanasia (34% favoured); and 2% supported assisted suicide. The resulting recommendation of euthanasia by the commission showed that arguments presented were ignored. As explained in *The Gazette*,[2] the commission's report[3] is a "pro-euthanasia manifesto" that reflects an a priori ideological desire to impose "medical aid in dying," while neglecting worrisome facts.

The commission ignored reports from the Remmelink Commission in the Netherlands that exposed abuse in the euthanasia process in 1990, 1995 and 2003.[4] The commission did not seem concerned that major depression is a valid condition for euthanasia (since 1993), and that 20% of instances of euthanasia are regularly not reported, in violation of the law. In Belgium, the Control Commission is impotent to oversee and effectively assess the validity of euthanasia requests; not a single case has been reported to the Justice Department for review.[5]

Euthanasia lobbyists advocate access for patients with dementia and all minors in Belgium. In the Netherlands, the pro-euthanasia lobby advocates the procedure for all those over 70 and "tired of living." A report from the Netherlands shows about a 73% increase in the number of instances of euthanasia since 2003, and a 50% increase in the number of deaths by terminal sedation.[6] These facts invite further thought before instituting safeguards that have not worked elsewhere.

An in-depth reflection on how to die remains necessary. The notion of dignity needs to be grounded in philosophy, not opinion polls. I suggest that physicians and health care professionals may not want to become agents of homicide (at the State's behest), even if it is labelled "therapeutic." Let's be clear: homicide is never therapeutic.

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Are doctors all-powerful?

In a *CMAJ* editorial, Redelmeier and Stanbrook advocate restricted drivers' licences for seniors starting at an arbitrary age, and propose that seniors could then approach their doctors for assessment — in order to regain the right to drive on fast highways.[1] Really? What makes physicians think that they can determine who is a good driver? Why is it our business anyway? Is it our business to determine who is a good parent, or a safe drunk?

Of course we 80-year-old drivers should be screened — but by the same government that issues our licences. There are brilliant "flight simulators" and "driving simulators," which are capable of quickly and accurately testing night vision, reaction time and visual fields. Just pass a law, put us in the simulator for 20 minutes, and read out the results. Cheap, no staff needed — and no doctors!

By the way, taking drivers off the road who are involved in collisions is not "too late to prevent injuries." It is justice! Why take away a person's freedom who has done nothing wrong? Isn't that called "profiling"?

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Some letters have been abbreviated for print. See www.cmaj.ca for full versions and competing interests.

Correction

Recommendations on screening for type 2 diabetes in adults

The recommendations from the Canadian Task Force on Preventive Health Care published in the Oct. 16, 2012 issue of *CMAJ* have been updated.[1] The revised recommendations are included in the polywrap of this issue and can be found online at www.cmaj.ca.

Reference

1. Canadian Task Force on Preventive Health Care. Recommendations on screening for type 2 diabetes in adults. *CMAJ* 2012;184:1687-96.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2080**