More on assisted suicide

I agree with Drs. Flegel and Fletcher that we must speak up now regarding assisted suicide and euthanasia.[1]

On July 15, 2012, in the Carter decision, a provincial judge rejected the Supreme Court's Rodriguez precedent and purported to legalize assisted suicide and euthanasia throughout Canada.[2] I am not a lawyer, but a plain reading of the decision reveals questionable assumptions and a lack of understanding of the needs of patients.

The linchpin of the decision is that suicide is not illegal in Canada and is therefore a right.[2] But Canadian laws strive to prevent suicide and even authorize forcible treatment for those who are suicidal. The judge in the Carter case admits that "suicide and attempts at suicide are serious public health problems that governments are trying to address."[2] Thus, the idea that suicide is a right that society must assist with, as long as it is not a crime, is confused.

The judge then declares that the law prohibiting assisted suicide discriminates against people who are too disabled to kill themselves. She also speculates that the law might prompt the plaintiff to commit suicide sooner, while able, which would shorten her life.[2]

This Orwellian reasoning, presuming a right to die based on the right to (unshortened) life, ignores the fact that *anyone,* including the plaintiff, who commits suicide will suffer from a shortened life. How many years of life would Canadians lose if a legal assisted suicide risk lurked constantly in home and hospital?

A friend of mine recently died from a brain tumour. He said that when he first received the diagnosis he might have opted for assisted suicide, had it been available. Two years later, he was an activist against legalization. In the last article he wrote, he states "[Canada's] laws exist to protect me and people like me from abuse when we are at our lowest and most vulnerable."[3]

As a family doctor, I see elder abuse. Sadly, a desire for money or an inheritance is often involved. Worse, the victims protect the predators. An older woman knew that her son was robbing her blind and lied to protect him. Why? Perhaps family loyalty, shame or fear that confronting the abuser would cost love and care.

Predators take their victims to the bank and to the lawyer for a new will. With legal assisted suicide, the next stop could be the doctor's office for a lethal prescription. How are we going to detect victimization? A troubling survey,[4] one of several which uncovers nonconsented euthanasia deaths in foreign jurisdictions, failed to alarm the judge in *Carter* v. *Canada*.[2]

Will Johnston MD
Chair, Euthanasia Prevention Coalition of British Columbia, Vancouver, BC

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***CMAJ* 2012. DOI:10.1503/cmaj.112-2086**

Perspectives on consent

Robert Byrick, president of the College of Physicians and Surgeons of Ontario, wrote a letter to *CMAJ*,[1] titled "Consent requirements for pelvic examinations." In his letter he states that, "express consent of the patient must be obtained (whether the patient is conscious during the examination). The policy also clearly states that if, for any reason, express consent cannot be obtained, the examination cannot be performed." I have 2 questions for Dr. Byrick based on the following scenario: a 23-year-old female patient presents in an emergency department with acute lower abdominal pain, is in shock and unconscious and unable to give consent for a pelvic exam. Is your policy flexible enough to permit a pelvic exam under these circumstances? And if the patient died while the doctor was diligently searching for the next of kin to give consent for the pelvic exam, could the family sue the doctor, and the College of Physicians and Surgeons of Ontario for negligence for exercising "the authority to hold physicians accountable" for a poorly worded or inflexible policy?

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Reference

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***CMAJ* 2012. DOI:10.1503/cmaj.112-2087**

The author responds

The College policy "Professional Responsibilities in Postgraduate Medical Education"[1] relates to examinations performed solely for educational purposes and specifically states that "an examination is defined as 'solely' educational when it is unrelated to or unnecessary for patient care or treatment." For example, if an examination for the purposes of a clinical demonstration was going to be performed while a patient was under sedation, consent would need to be obtained prior to the examination. This does not apply to the scenario posed by Dr. Cameron[2] as the policy does not relate to situations where the examination is necessary for patient care or treatment.

Robert Byrick MD
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2. Cameron IA. Perspectives on consent [letter]. *CMAJ* 2011;184:2018.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2088**

We at the Canadian Medical Protective Association (CMPA) read with interest the *CMAJ* article, "Informed consent for clinical treatment."[1] We were disap-

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pointed that this article was authored exclusively by American physicians and relied almost entirely on American case law and literature and, as such, did not address some of the important legal principles of informed consent that are unique to Canada.

The CMPA is a leader in Canada in the area of medicolegal risk management and has extensive experience with topics such as informed consent. The CMPA would have welcomed the opportunity to submit an article to *CMAJ* on this important medicolegal concept. Indeed, the CMPA has published numerous articles on the subject of informed consent, including a comprehensive booklet for its members entitled, *Consent: A Guide for Canadian Physicians*.[2]

The CMPA appreciates that the authors of this article acknowledge that "it is important for clinicians to determine the precise standard used in their jurisdiction and to adapt their practice accordingly. The Canadian Medical Protective Association provides detailed information on Canadian standards (www.cmpa-acpm.ca)."[1] However, the article should have more clearly emphasized at the outset that the information is based on American legal principles and does not specifically address well-established Canadian legal principles, most notably "material risk."

Given the significance of this Canadian legal concept, *CMAJ* may wish to consider clarifying that Canadian physicians should discuss "material risks" when obtaining informed consent from their patients. The determination of what constitutes a "material risk" requires consideration of what a reasonable person in the circumstances of the particular patient would want to know.

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***CMAJ* 2012. DOI:10.1503/cmaj.112-2089**

With regard to the *CMAJ* article by Hall and colleagues,[1] informed consent is a redundancy, because being properly informed is a precondition of consent. Without being properly informed, a patient or client cannot give any legitimate, binding consent. Therefore, that all professionals withhold any request for agreement or signatures until after all information and questions have been fully addressed is imperative.

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1. Hall DE, Prochazka AV, Fink AS. Informed consent for clinical treatment. *CMAJ* 2012;184:533-40.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2090**

The authors respond

We thank Dr. Gray for his comments regarding the Canadian legal tradition of informed consent and the concept of "material risk."[1] Our article notes the need for "clinicians to determine the precise standard used in their jurisdiction and to adapt their practice accordingly."[2] Because we were recruited to write for an international audience, further discussion of these points seemed beyond the scope of our review. Indeed, given our charge, we deliberately avoided detailed comparisons of distinctly national legal traditions. Instead, we sought to emphasize how the ethics of informed consent have come to guide medical practice internationally, in a way that goes above and beyond the requirements of unique local laws.

Although the specific legal precedent and lineage of "material risk" is important in Canada, we fail to appreciate how it is substantively different from the "reasonable patient standard," which we mentioned in our article and which is used in the United States and throughout the world. The difference between the two terms is likely more relevant to lawyers trying to defend cases rather than to clinicians trying to avoid trouble. Whether in the US, Canada or elsewhere, physicians should always explicitly discuss risks that patients would likely want to know about.

That our review reflects a bias toward US law merely reflects that we chose to write about the context we know best. It also reflects that the legal and ethical concepts of informed consent emerged out of the US. Indeed, the still-emerging discipline of bioethics has been increasingly criticized for its latent, often unrecognized, chauvinism that reflects distinctly American philosophical assumptions.[3] If our review is perceived to contribute to such cultural bias, we sincerely apologize. That said, we believe that our review provides a balanced summary of the broadest consensus regarding informed consent — one that can guide the practice of physicians in a wide range of legal contexts.

We also agree with Dr. Mann's comment[4] that any robust understanding of consent demands that the patient has been informed about the decision at hand. Yet there is a legal and philosophical distinction between "simple" consent, by which a patient explicitly authorizes an intervention, and the higher bar of "informed" consent. As our review outlines, unfortunately a multitude of forces limit the capacity of clinicians and patients to achieve "ideal" informed consent. These limitations in no way abrogate the need to continually strive for excellent clinical communication. Rather, we contend that excellent informed consent requires clinicians to recognize these limitations so they can develop pragmatic approaches to mitigate their effects.

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***CMAJ* 2012. DOI:10.1503/cmaj.112-2091**

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