

In plain English: No euthanasia please

Why are Downar and colleagues¹ so coy? Why not write in plain English? They come down squarely in favour of physician-assisted death, but don't most physicians already assist in death? The authors,¹ presumably, are promoting physician-administered death. The authors have moved "beyond Yes or No" to advocate euthanasia, but they do not want to admit this. They tell us to forget our well-rehearsed debate: sanctity of life versus patient autonomy, and yet they say they have no clear answer to their question of how to protect the vulnerable or incapable from receiving physician-administered death against their will. Psychiatric indications for physician-administered death by lethal injection could be equally contraindications.

The authors¹ ask, "How can we ensure that physician-assisted death is available equitably to all patients?" Very simply, if amyotrophic lateral sclerosis or metastatic cancer are potential indications for physician-assisted death, then it will have to be offered to all patients with such diseases. A few will accept, many will be frightened and a few will feel obliged. Obviously, there would be a trade-off. The supposed benefit to a few would threaten many more: this is why most doctors oppose euthanasia. Do the authors¹ have any new figures to contradict this? In my 29 years of experience, the vast majority of the frail and ill want to live — and without a medically administered threat hanging over them.

The authors¹ ask, "How can we ensure that physician-assisted death will not be considered a low-cost alternative to palliative care?" There is only one way: do not make killing the patient an alternative. Indeed, the authors do suggest the answer: improve the availability of palliative care and keep physician administered-death illegal.

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Reference

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Premature closure of the debate

Downar and colleagues¹ are premature in their assertion that the "Yes or No" debate about euthanasia and physician-assisted death is over.

As the authors note, last August the Canadian Medical Association (CMA) voted against a change in its policy, which opposes physician-assisted death. The CMA's blog on this issue is running at least two to one against physician-assisted death; an even larger proportion of Downar's palliative care colleagues are opposed.² Whatever the courts may decide, apparently, the majority of Canadian physicians are unwilling to participate in physician-assisted death or euthanasia.

Downar and colleagues¹ provide a comprehensive list of the controversies that may arise should physician-assisted death be legalized in Canada. I wish to respond to 2 of the 13 questions in the list:

"How can we protect the vulnerable?" We can't. It's too short a step from believing that one might choose physician-assisted death to believing that it should be chosen; the vulnerable will inevitably feel a sense of coercion.

"How can we ensure that physician-assisted death will not be considered a low-cost alternative to palliative care?" We can't. Despite the experience in Oregon in this regard, the much larger experience in the Netherlands has been an untoward delay in the development of palliative care services.³ When faced with a difficult palliative case, it's just too easy to say, "Why bother?"

This debate is not over. For the sake of our most vulnerable patients, and for the sake of our colleagues, especially our youngest colleagues, we must persevere.

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The authors respond

Newman¹ and Bright² both express concerns about the messages of our article,³ but neither appears to have understood them correctly.

We did not express support for, or opposition to, legalization of physician-assisted death. We posed questions that we feel should be addressed about the practical aspects of performing legal physician-assisted death in Canada. Newman¹ suggests we are coy in our use of the term "physician-assisted death," but we explicitly defined this term in the first sentence of our article as including both euthanasia and assisted suicide. The term "physician-assisted death" is widely used, including by Justice Smith in the Carter case.⁴

We did not assert that the "Yes or No" debate was "over." We pointed out that the debate will be practically obsolete if physician-assisted death becomes legal by judicial or legislative means, and that physicians have a professional responsibility to prepare for this possibility regardless of whether they support legalization.

We share Newman¹ and Bright's² concern about the potential effects on the vulnerable. But we are reassured by data from the Netherlands that suggest that involuntary euthanasia became less common after legalization of physician-assisted death,⁵ and data from Switzerland⁶ and the United States⁷ that show that vulnerable populations are *less* likely to receive physician-assisted death.

Newman¹ asserts that the only way to safeguard against the use of physician-assisted death as a cost-saving measure is to ban it. This argument seems to imply a lack of commitment by physicians and other health care

professionals to their ethical, legal and professional duties to patients.

Bright² is particularly concerned that physician-assisted death would hinder the development of palliative care, citing a study from the Netherlands.⁸ We respectfully point out that the reference he cites says the opposite: “On the one hand, a legally codified practice of euthanasia has been established. On the other hand, there has been a strong development of palliative care.”

We appreciate the comments and feedback, but please read our article (and your references) more carefully.

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Physician giving consent

This discussion must consider “how” as well as “whether.” One of the questions Downar and colleagues¹ set out for consideration contains the phrase “to consent to physician-assisted death.” This phrase assumes a physician-dominated framework for responding to a suffering

person’s request (even plea). It should be framed as the physician giving consent. The patient’s “complaint” has traditionally been the starting point in the doctor–patient relationship. The patient states the problem; the physician offers medical diagnosis and controls access to possible interventions. When the cure for the “complaint” is futile, one can turn to palliation and acceptance of dying. But when palliation proves futile and help to die is requested, where can a suffering person turn? The means of easy dying are tightly controlled and only in the hands of physicians. Who else could “consent?”

Precipitating death is repugnant to physicians, as to most people, but there are instances in which that act may be the only compassionate and acceptable response to a request for release from suffering.

Questions around the “how” of physician-assisted death must be framed as a response to a request. Framing discussion in terms of “consent” is an insult to a person’s desperate initiative to end suffering.

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1. Downar J, Bailey TM, Kagan J, et al. Physician-assisted death: time to move beyond Yes or No. *CMAJ* 2014; 186: 567-568

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Why physician-assisted death?

I am concerned that Downar and colleagues¹ don’t challenge the assumption that physicians would be the assistants in assisted death. Why assume that doctors could best safeguard and operationalize assisted death?

Causing death has been the antithesis of medicine to this point in history. Physicians have no greater training or particular skill set in this area (e.g., rating existential distress, judging capacity to choose death, living with potential personal distress from causing death) than philosophers, lawyers, soldiers or executioners. Why aren’t we asking whether legalized assisted death

would be best served by a new profession of licensed death assistants?

Allowing natural death, caring always, these are parts of the physician’s role. Add intentionally causing death to that and we risk altering the meaning of medicine and the fundamental trust and relationship between physicians and patients.

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1. Downar J, Bailey TM, Kagan J, et al. Physician-assisted death: time to move beyond Yes or No. *CMAJ* 2014;186:567-8.

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The authors respond

Simon is correct.¹ In fact, we raised this question in our article (in Box 1).² Creating a new profession of “death assistants” would be one way to assuage the moral and ethical concerns of physicians who conscientiously object to assisting a death, or who are concerned that this will undermine the physician–patient relationship. However, we think there are good reasons for the medical profession to be involved, should assisted death become legal.

We note that four countries and five US states have made assisted death legal without creating a new profession. A 2013 Canadian Medical Association poll suggested that 16% to 20% of physicians would be willing to assist a death,³ which would likely be sufficient to meet the anticipated demand. Data from Oregon suggest that physicians who opposed legalization of assisted death were more than twice as likely to have a patient become upset or leave their practice than physicians who supported assisted death.⁴

We must always respect the right of individual physicians to conscientiously object. But assigning assisted death to another profession would be necessary only if physicians unanimously object, which is clearly not the case. Saying no to legal physician-assisted death as a professional body, rather than as individual conscientious objectors, would arguably fail to support the well-being of individual patients who would choose physician-assisted death as the primary ethical consideration.