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

Bright[2] 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.

James Downar MDCM MHSc (Bioethics), Tracey M. Bailey BA LLB, Jennifer Kagan MD
Divisions of Critical Care and Palliative Care (Downar), Department of Medicine, University of Toronto, Toronto, Ont.; John Dossetor Health Ethics Centre and Department of Psychiatry (Bailey), Faculty of Medicine and Dentistry, University of Alberta, Edmonton, Alta.; Division of Palliative Care (Kagan), Department of Family and Community Medicine, University of Toronto, Toronto, Ont.

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Physician giving consent

This discussion must consider "how" as well as "whether." One of the questions Downar and colleagues[1] 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.

Paul Henteleff MD
Founding president, Canadian Hospice Palliative Care Association, Ottawa, Ont.

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Why *physician*-assisted death?

I am concerned that Downar and colleagues[1] 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.

Jessica Simon MD
Palliative physician, Faculty of Medicine, University of Calgary, Calgary, Alta.

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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.

James Downar MDCM MHSc (Bioethics), Tracey M. Bailey BA LLB, Jennifer Kagan MD
Divisions of Critical Care and Palliative Care (Downar), Department of Medicine, University of Toronto, Toronto, Ont.; John Dossetor Health Ethics Centre and Department of Psychiatry (Bailey), Faculty of Medicine and Dentistry, University of Alberta, Edmonton, Alta.; Division of Palliative Care (Kagan), Department of Family and Community Medicine, University of Toronto, Toronto, Ont.

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Correcting the record

The conclusions in "The increasing inefficiency of private health insurance in Canada"[1] about the trends in medical loss expense ratios for insured supplemental health benefit plans are incorrect and ultimately misleading.

The data used in this article[1] are aggregate-level data for group and individual benefits in Canada. The data includes a disparate set of coverages that have different market drivers. The loss ratios vary greatly for each set of coverages, as do their historical trends.

Broadly, the group benefits business can be broken into two areas: supplemental health insurance plans (e.g., drugs, dental, travel, paramedical, vision, hospital rooms) and income replacement (i.e., short and long-term disability) and other nonmedical coverages (e.g., creditors disability insurance, critical illness).

Loss ratios for specific coverages can vary substantially from year to year. I can confirm that the average medical loss ratio for insured supplemental health insurance plans between 1997 and 2012 was 85%, with the medical loss ratio coming in at 82% in 2012. The medical loss ratio for supplemental health benefit plans over this period has been relatively flat.

The negative trend in the aggregate-level data that is highlighted in the article[1] is being driven by the income replacement and other nonmedical expense coverages. Income replacement coverages (the largest component) have experienced a decreasing loss ratio over this period. These benefits are paid over many years and are funded by premiums collected and investment income earned on the assets purchased with the premium. The decreasing loss ratio is in part due to an increasingly larger portion of the benefit being funded by premium rather than investment income as a result of the falling and sustained low-interest rate environment in Canada over that period.

The private health insurance industry is highly competitive, with over 25 insurers providing group health benefits. Should a client feel that a proposed premium adjustment is unwarranted at his plan's renewal date, the client can negotiate with the insurer or transfer his business to a new insurer.

Stephen Frank MPhil (Finance)
Vice President, Policy Development and Health, Canadian Life and Health Insurance Association, Toronto, Ont.

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The authors respond

Frank[1] claims to "correct the record" by providing an estimate for the medical loss ratio for supplemental health insurance plans in 2012, and an average of this ratio from 1997 to 2012. Of note, Frank[1] excluded disability coverage and similar benefits from his calculations. In contrast, we used statistics for the entire for-profit health insurance market, because the Canadian Life and Health Insurance Association does not publicly release disaggregated data.

The important question is whether these new data lead to different conclusions regarding the efficiency of private health insurance. We made two major arguments: first, compared to the public sector, the medical loss ratios in private plans are low; second, the medical loss ratios in both the group insured and individual insured markets have decreased over time.[2] Private insurance is less productively efficient than public insurance and has become less productively efficient over time.

On the first point, the data Frank[1] provides actually support our argument: the figure he provides for the private health insurance medical loss ratio — 82% — is much lower than those of Canadian public health insurance programs.[3]

Our second point was that medical loss ratios have decreased from 1991 to 2011.[2] Frank[1] counters that this was not the case for supplemental health insurance (i.e., excluding disability coverage and similar benefits), at least from 1997 to 2012. There are two problems with his claim. Notably, data omit 1991 to 1996, when overall medical loss ratios were comparably high. Second, Frank[1] claims that the trend is "relatively flat" without disclosing data for each year.

Frank's[1] additional data support our first major conclusion, and do not undermine our second. Further, the selective disclosure of additional data supports our argument that more effective regulation of private health insurers — including requirements for greater transparency — would benefit Canadians.

Michael Law PhD, Jillian Kratzer MSc, Irfan Dhalla MD MSc
Centre for Health Services and Policy Research, School of Population and Public Health, Faculty of Medicine (Law, Kratzer), The University of British Columbia, Vancouver, BC; Department of Medicine, University of Toronto, Toronto, Ont.; Li Ka Shing Knowledge Institute, St. Michael's Hospital; Institute for Clinical Evaluative Sciences (Dhalla), Toronto, Ont.

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