

Is physician-assisted death in anyone's best interest?

YES – James Downar MDCM MHSc(Bioethics) FRCPC **NO** – Edward (Ted) St Godard MA MD CCFP

YES I will make 2 arguments to support the idea that assisted death is in the best interests of some patients: death can sometimes be in a patient's best interest; and capable patients are well positioned to determine when death is in their best interests. I will then argue that physicians should have a role in assisted death by reversing the premise of this debate and arguing that nobody's interests are served by denying patients the right to physician-assisted death (PAD).

I speak as a secular North American who supports individual autonomy, subject only to limitations that are justifiable on the basis of empirically provable facts. My arguments are intended for people with a similar moral compass. I respect those who disagree with me on a religious basis, and I recognize that my arguments might not address their concerns.

Death can sometimes be in a patient's best interest

The value of life is great but not infinite. When faced with a dire prognosis, some patients or family members will find strength in an old proverb: "Where there's life, there's hope." But this proverb is best interpreted as a prayer that things will get better rather than a literal statement that anyone with vital signs should be kept alive by any means.

Many religious authorities endorse the vitalist notion that all life is valuable. But these same authorities also believe that it is wrong to prolong a life artificially to no end, and they accept the limitations of life-prolonging treatments.^{1,2} Most accept the principle of double effect, which holds that a patient can receive comfort medications that have the potential to shorten life, so long as shortening life is not the intention. People who accept that lives need not be prolonged indefinitely, or that a life can be "risky" in the interest of comfort, have implicitly accepted that life is not of infinite value. They recognize that compassion can sometimes be shown only through actions that might compromise lifespan.

Death is not an optional experience, and death in Canada is usually a predictable event preceded by a chronic, incurable illness.³ Given the choice, many people try to delay death and some will seek out aggressive means of prolonging life even when faced with a hopeless situation. But other patients have limited life-prolonging options, and although they remain cognitively intact, their quality of life and function deteriorate

below the threshold that they consider acceptable. These patients usually choose comfort-based care and are happy to wait for a "natural" death. But some patients prefer not to wait for a complication to end their suffering; several recent high-profile cases of Canadians with brain cancer,⁴ Alzheimer disease,⁵ and amyotrophic lateral sclerosis⁶ have illustrated this. In either event, the patient is comfortable with the idea that they might be forgoing some period of life in the interest of comfort. They will not avoid death—they might even seek it out—and everyone will feel a degree of relief when it arrives.

There might be a conceptual difference between actively assisting death and passively assisting death by withdrawing or withholding therapies, but both approaches are justified on the same premise: death is in the best interest of the patient. The patient's interests are not affected by whether the outcome is achieved actively or passively.

Capable patients are well positioned to determine when death is in their best interests

Many Canadians die in intensive care units, often as the result of a decision to withhold or withdraw life-sustaining treatments. Ideally, this decision comes from the patient and we are sure that this is what he or she wants. In reality, we usually cannot involve the patient directly in the decision; instead, we rely on substitute decision makers (SDMs), who are supposed to reproduce the decision the patient would have made by considering advance directives or best interests. Substitute decision making is a flawed process. Substitute decision makers are inaccurate predictors of what a patient would want.⁷ Advance directives are uncommon, and they are usually too vague or too specific to be useful for medical decisions.⁸ Substitute decision makers also have numerous potential conflicts of interest. If the patient dies, they might inherit some material wealth, and they will no longer have to bear the emotional and physical burden of caregiving. And if the SDM was ever the victim of sexual, physical, or emotional abuse, the patient might have been the perpetrator.

Despite all of these concerns about substitute decision making, we continue to allow SDMs to decide when patients should be allowed to die. If we are comfortable with this arrangement, then why would we feel less comfortable acting on wishes that are communicated directly by patients, with none of these potential inaccuracies, misinterpretations, or conflicts of interest? Indeed, we are happy to respect capable, terminally

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ill patients' desires to receive palliative care and forgo life-prolonging therapy. We do not insist that they continue chemotherapy until they die a "natural" death. We do not try to convince them that a ventilator will help them find meaning in their life. We respect their ability to know when they have had enough. If patients are allowed to decide when a passive death is in their best interests, why would they not be allowed to decide when an active death would be in their best interests?

Nobody's interests are served by denying patients the right to PAD

If we want to prevent a rational person from pursuing his or her own best interest, we must have a strong justification for doing so. The common arguments used against legalization of PAD are framed as concerns about the effects on vulnerable people, the availability of palliative care services, and physicians as a group. None of these concerns is supported by data.

Data from the United States (US) show that among patients who receive PAD, more than 95% are white, more than 93% are high school graduates, and more than 97% have some form of health insurance.⁹ Data from Switzerland show that the wealthier and better educated are more than twice as likely to receive an assisted death than the poorer and less educated, while people in institutions are less likely to receive an assisted death than those living in private residences.¹⁰ The people who receive PAD are not the vulnerable—they are the privileged.

Palliative care services appeared to have done well in jurisdictions that legalized PAD. Legalization of PAD is often accompanied by a larger strategy and funding to improve end-of-life services, as described in the Netherlands¹¹ and in Australia's Northern Territory¹² (where the law was later overturned by the federal government). In the US, the 3 states that have legalized PAD by statute—Vermont, Oregon, and Washington—are ranked first, sixth, and eighth in the nation, respectively, for the availability of palliative care services in hospitals.¹³ In 2010, the Economist Intelligence Unit ranked the "basic end-of-life healthcare environment" of 40 nations around the globe.¹² Countries in which PAD is legal—Switzerland, the Netherlands, Belgium, Luxembourg, and the US—ranked first, fourth, fifth, seventh, and ninth, respectively. Canada ranked 20th.

Some physicians argue that legalizing PAD would compromise the physician-patient relationship. This is a difficult argument to sustain in a country where PAD is supported by 84% of the population.¹⁴ Data from Oregon show that patients are more likely to become upset by physicians who oppose PAD than by physicians who support it.¹⁵ Furthermore, the Canadian Medical Association essentially rejected this argument at its recent annual general meeting, where 90% of members voted to support "the right of all physicians,

within the bonds of existing legislation, to follow their conscience when deciding whether to provide so-called medical aid in dying."¹⁶

Some have expressed concern that PAD would be a violation of the Hippocratic oath, and suggested that a new profession of euthanasia practitioners should be created. We should remember that the Hippocratic oath has been modified extensively over the years to reflect changes in laws and sensibilities. Specifically, the prohibition on abortion and the implication that only men should be trained in medicine have both been removed from the original version.¹⁷ Laws, policies, and codes of ethics change over time. Certainly, many physicians now believe that providing PAD would be an extension of their duty of care, when other means of treating end-of-life suffering have failed. And physicians can offer a range of therapies beyond PAD, allowing an opportunity to relieve suffering through other means, right up until the last moment. What other options could a euthanasia practitioner offer?

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Competing interests

Dr Downar is Co-Chair of the Physicians Advisory Council of Dying with Dignity Canada, a not-for-profit organization that advocates for improved end-of-life care and the right to an assisted death.

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CLOSING ARGUMENTS – YES

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- Some patients have limited life-prolonging options, and although they remain cognitively intact, their quality of life and function deteriorate below the threshold that they consider acceptable. These patients usually choose comfort-based care and are happy to wait for a "natural" death. But some patients prefer not to wait for a complication to end their suffering. In either event, the patient is comfortable with the idea that they might be forgoing some period of life in the interest of comfort.
- We respect substitute decision makers' decisions to effectively end a life by withdrawing or withholding life support, despite the known inaccuracies and conflicts of interest inherent in substitute decision making. Why are we less comfortable respecting patients' own requests to end their lives, which have none of those inaccuracies and conflicts of interest?
- The common arguments used against legalization of physician-assisted death are framed as concerns about the effects on vulnerable people, the availability of palliative care services, and physicians as a group. None of these concerns is supported by data.

The parties in these debates refute each other's arguments in rebuttals available at www.cfp.ca. Join the discussion by clicking on Rapid Responses at www.cfp.ca.

NO The issue of physician-assisted death is complex and emotional, and we must not allow truth to become a casualty. Medical professionals and laypersons alike struggle to understand distinctions between euthanasia and physician-assisted suicide, and many more fail to distinguish either act from simple refusal or authorized withdrawal of treatment.¹ We must demand and demonstrate a courageous and respectful clarity.

The expression *physician-assisted death* is what is kindly known as a euphemism. *Euphemism* is defined as "the substitution of a mild, indirect, or vague expression for one thought to be offensive, harsh, or blunt."² Writing recently in *The New Yorker*, Adam Gopnik noted:

[E]uphemism is a moral problem, not a cognitive one. When Dick Cheney calls torture "enhanced

interrogation," it doesn't make us understand torture in a different way; it's just a means for those who know they're doing something wrong to find a phrase that doesn't immediately acknowledge the wrongdoing.³

The substitution of *physician-assisted death*, or the ubiquitous *medical aid in dying* (something I provide daily), for the more accurate if somehow distasteful *euthanasia* (itself a euphemism) or *physician-assisted suicide*, represents at best a misplaced attempt at decorum or delicacy,⁴ and often a deliberate obfuscation. That our journal, like the Canadian Medical Association, has stooped to using this language is regrettable and, frankly, embarrassing. It is not just semantics.

Compassion

The question with which Canadians must grapple is whether it is in *everyone's* best interests that the Supreme Court of Canada appears to have legally sanctioned doctors, under loosely and ambiguously defined circumstances, to kill, or assist with the suicide of, a small number (so far) of consenting (for now) patients.

I strongly believe it is not.

I agree wholeheartedly with Dr James Downar when he states that "there are types of suffering that we do not have the ability to treat"⁵; it would be hubris to suggest otherwise. Suffering, sadness, and pain are part of the human condition.

However, as Margaret Somerville eloquently notes, the issue at hand concerns not only

our rightful, profound sympathy for people experiencing serious suffering ..., but also whether allowing physicians to intervene with a primary intention of inflicting death is inherently acceptable as a foundational principle and basic value.¹

I strongly believe it is not.

Before cure eclipsed care, at the heart of medicine was a relationship between a doctor and her patient. The possessive pronoun is important: *my* doctor, *my* patient. Caring for patients is a compassionate endeavour. *Compassion* is derived from the Latin *compati*⁶: to suffer together. The current obstacles to compassionate physician-patient relationships are immense: an aging population; increased medical specialization; overcrowded hospitals and care facilities; and health care providers who often appear strained and distracted.

But surely we should not offer to kill patients to compensate for the fact that we have become too busy to care? As subspecialists too often appear to abandon patients once there is "nothing left to be done," so does a society that legalizes and normalizes euthanasia and physician-assisted suicide risk abandoning its most vulnerable members.