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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.

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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.

Medicalization

The “death with dignity” movement, for all its well-intentioned and laudable passion, is at once a logical reaction to and a pathologic extension of what Ivan Illich referred to 50 years ago as *medicalization*. Simply put, medicalization is the process whereby life's multiple complex processes, dysfunctions, and idiosyncrasies come to be defined as medical problems. Bad breath becomes halitosis; impotence, erectile dysfunction; and senility, dementia.

Death and dying have become medical problems. With its scandalously naïve misunderstanding of anything that might lead to human death as an enemy, medical research, the leading edge of medicalization, has enabled whole generations to outlive their independence. The spectre of the “nursing home” now haunts us all. The banal, if not always benign, loss of function and control formerly known as *dying* is now considered undignified, and even worse somehow if it will soon be over. (“Since she will soon die anyway, how can we let this continue?”) Some dread the perceived indignities that accompany slow, natural dying, while others fear a medicalized death, ensnared in the tentacles of a medicine that cannot seem to let go.

Patients have long had the right to refuse treatment, but with the rise of patient autonomy, and the commodification of medicine, patients (now “clients”) increasingly feel entitled to demand treatment. Must we now further medicalize their deaths by offering physician-assisted suicide or euthanasia as the ultimate procedure, a soothing if paradoxical final solution to medicine's broken promises and too-deep incursion into our lives?

No.

The solution to our medicalized lives and deaths is not another syringe, and not more pills. We must talk openly about the end of life, and be less squeamish about the alarmingly ordinary sights, sounds, and smells of normal dying. Although we must not welcome or glorify suffering, neither should we strive for an artificial, sanitized, and idealized death.

In a cogent criticism of medicine, and of palliative care in particular, Marcia Angell suggests that there now exists in the minds of many a naïve and idealized picture of a “good death.”⁷ Proponents of euthanasia, like some overzealous advocates of palliative care, are chasing a chimeric dream, one that is as constraining as it is illusory. And yet most of us privileged to care for the gravely ill and dying attest to a boundless resilience in our patients and their families. People die as they have lived. Some lean on relationships, others on faith, and most on reserves of previously unknown inner strength.

Some might consider these matters private and personal, especially if we grant them the status of medical procedures. Conversations between physicians and patients are, indeed, sacrosanct. But the collectively


agreed-upon social and legal conventions outlining their respective obligations, what they may and may not do with and to each other (irrespective of consent), are not solely private matters. They concern us all, and are thus everyone's business.

Profound implications

Like war, self-defence, and state-sanctioned executions—the usual exceptions to the prohibition of the deliberate killing of humans—physician-assisted suicide and euthanasia have profound implications not only for active participants, but for loved ones left behind, and for entire communities (especially the disabled and disenfranchised).

Legalization of euthanasia or physician-assisted suicide, far from respecting private interactions between patients and doctors, would require bureaucratic transparency, safeguards, and oversight. With prescient irony Margaret Somerville notes a “logical discrepancy between arguing for what appears to be an absolute right to autonomy in choosing the manner, time, and place of one's death and then limiting access to euthanasia to ‘carefully regulated circumstances.’”¹ Charter challenges and calls for liberalized access are inevitable and will succeed. (Belgium's 2002 law, which prohibited euthanasia under a certain age, recently was amended to decriminalize the mercy killing of children without age restriction.⁸)

British journalist Kevin Yuill, describing what he laments to be substantial momentum in the pro-legalization camp, notes that “[T]he fact that so many have joined movements dedicated to the freedom of so very few should alert us to the fact that the need is not practical but psychological.”⁴ Although we must be merciful, we appear poised to change laws and norms, less to ameliorate the genuine suffering of dying Canadians than to diminish the frustrating but profoundly human impotence of their loved ones and to assuage the angst of a population not fully informed—people dreading a future that might never come, and that once arrived might, as the disabled and dying continue to remind us, be less undignified than predicted.

In late August 2014, as I wrote this paper, British Columbia octogenarian Gillian Bennett swallowed poison rather than face the “indignity” threatened by her progressing dementia. A retired psychotherapist, who presumably had for years coached and challenged people coping with difficulty, she chose suicide. Her post-humously public act demonstrated the ease with which even a frail and failing person can kill herself. No laws need be changed, no guidelines developed, no panels struck. Tragically, it has never been easier. 

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Competing interests
None declared

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CLOSING ARGUMENTS – NO

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- The current obstacles to compassionate physician-patient relationships are immense. 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.
- Death and dying have become medical problems. The loss of function and control formerly known as *dying* is now considered undignified. We must talk openly about the end of life, and be less squeamish about the alarmingly ordinary sights, sounds, and smells of normal dying. Although we must not welcome or glorify suffering, neither should we strive for an artificial, sanitized, and idealized death.
- Legalization of euthanasia or physician-assisted suicide, far from respecting private interactions between patients and doctors, would require bureaucratic transparency, safeguards, and oversight. We appear poised to change laws and norms, less to ameliorate the genuine suffering of dying Canadians than to diminish the frustrating but profoundly human impotence of their loved ones and to assuage the angst of people dreading a future that might never come, and that once arrived might be less undignified than predicted.

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