Physician-Assisted Suicide and Euthanasia

Re: Physician-Assisted Suicide and Euthanasia: can you even imagine teaching medical students how to end their patients' lives? Perm J 2011 Fall;15(4):79-84. DOI: http://dx.doi.org/10.7812/TPP/11-099

Dr Boudreau's Response (Perm J 2012 Spring;16(2):75-7) ignores the main points of my critique: paternalism and reductionism, both serious shortcomings at any time, but worse in the arena of teaching. A valid response should have attempted to justify the peremptory, unconditional "No, of course not …" objection, irrespective of any circumstances, however exceptional; a congealed rhetoric, indeed pejorative as per his words.

Sociologist/theologian J Grand'Maison, referring to desperate agonies he calls "situations-limites," reminded palliativists that: "One cannot at the same time recognize the complexity and the diversity of 'situations-limites' and yet maintain a univocal logic … in each case, one must search for the most humane solution … that is incompatible with rigid views [translation by author]."[1] In the same vein, having described a *situation-limite,* ethicist DJ Roy wrote: "… the doctor would have been utterly justified ethically, in timing that death—upon the patient's request—for a moment of tranquility." Adding: "This is only one story illustrating an *ethically justifiable advancing* of a death" [emphasis added].[2]

Given that in the Benelux countries (Belgium, Netherlands, and Luxembourg) such teaching exists (Joelle Bernheim, MD, PhD; personal communication; 2012 August),[a,3] that Dr Boudreau finds *inappropriate* to compare notes with these colleagues, the problem envisaged is not a pedagogic hurdle but an ideologic choice. This is paternalism: choosing not to expose students and residents—for their own good—to dramatic situations they will surely be exposed to in the future. For, one cannot teach end-of-life/palliative care and not store terminal sedation carefully. So, once one has properly taught palliative care/terminal sedation, there will be no need to teach "how to end patients' lives."

By the time students and residents have been exposed (as they should be) to proper end-of-life care and terminal sedation (well role-modeled), they should know—in the right circumstances—who could benefit from an "utterly ethically justified, requested, advanced death." They already have the necessary skills. As everyone knows, terminal sedation has a hairline frontier with physician-assisted dying. A moral/religious hairline, maturing by the years within students and residents, which cannot be imposed. Anecdotally, a well-known university professor of palliative medicine in Montreal, Canada, told me that 70% of one of his large classes agreed with physician-assisted dying.

The goal of the title of the article is thus unmasked: to simply discourage medical schools from even considering physician-assisted dying, forgetting that no one teaching palliative care will ever have to teach how to end patients lives! The article describes euthanatologists who would come, perform and go, a mere impossibility. That is why euthanatrics appears to be a fiction.

The father of the very notion of suffering,[4] Eric Cassell, MD, wrote: "Assisting a patient in dying is no easy way out … When terminally ill patients request assistance in dying because of their suffering, and their request meets commonly endorsed safeguards, their request should be honored."[5] One feels most uncomfortable at the thought of Dr Boudreau calling Dr Cassell a euthanatologist practicing euthanatrics.

Integral Palliative Care

The first task to address rests on the language. M Desmet, MD, a Belgian Jesuit/palliative care physician submits that: "The choice of words helps define an ethics of accompaniment" (Marc Desmets, MD; personal communication; 2012).[b] If a request for assistance in dying is interpreted as a request to kill rather than as a call for a compassionate advancing of death (as described by Dr Roy), the doctoring and role-modeling will sadly lack in humanity. Dr Desmet mentions some common slopes to avoid: dehumanizing the patient's distress by spiritual/theological overtones; absolutizing physiologic survival; making one's objection a greater problem than the patient's own. Dr Boudreau insists on "not being obliged to act against my convictions" but does not realize that the "No, of course not …" invites students and residents to neglect and overrule their patients' convictions. And when his "ministering to patients with authentic compassion, within a mutually trusting relationship" again becomes a flat "No, of course not …," it is not unfair to entertain suspicion of some feeling of superiority.

Opinions differ, especially when one has not met the researchers from the Benelux countries; yet, it is fair to think along Hon. JL Baudouin's conclusions: "The safeguards implemented in Belgium and the Netherlands to prevent errors function well and, if they exist at all, wrongdoings are rare or inexistent."[6] A statement confirmed by studies that showed that legislation of euthanasia in the Netherlands "did not result in a slippery slope for medical end-of-life practices;"[7] likewise in Belgium.[8]

Ethicist DJ Roy wrote: "… the ultimate challenge of ethics consists in knowing what to do when all the existing rules fail to apply."[2] In the end, this may mean to meet some patients eye to eye to say: "I sense how awful your unrelieved suffering is and I understand your request. It just goes against my deepest values. If you agree, I will ask one of my colleagues who shares your views to join us. He can honor your request. Both of you will need some time to connect. I promise I will stand by you and yours all along."

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Such is the deep meaning of Dr Desmet's *autonomie-en-lien* (bonds in autonomy)—each free, each respectful—somewhat undervalued by Dr Boudreau. This is what he does … it can be taught and role-modeled. It requires some humility. ❖

Marcel Boisvert, MD, retired
Associate Professor of Medicine
McGill University

[a] End-of-Life Chair, End-of-Life Care Research Group, Ghent University and Vrije Universiteit, Brussels, Belgium.

[b] Belgian Jesuit and Palliative Care Physician.

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Response to Dr Boisvert

Euthanizing is not a healing proposition

Dr Boisvert attempts to convince the reader that physician assisted-suicide (PAS) and euthanasia are moral and merciful acts undertaken in intolerable situations. He tries to cajole us with euphemisms such as "ethically justifiable advancing of a death" into embracing PAS.

In my initial article, the purpose was to explore consequences on pedagogy should assisted-suicide become a medical act. The scope of the dialogue has expanded. I am grateful to *The Permanente Journal* for giving me the opportunity to respond. I am opposed to PAS and euthanasia—irrefragably so. Although there is a range of opinions on these practices—with books in favor[1] and against[2]—I am convinced that the vast majority of physicians harbor profound reservations. Surveys show that of all separately identified groups in societies comparable to Canada, physicians are among the most opposed to PAS and euthanasia.

Dr Boisvert provides anecdotal evidence referring to "the opinions of large classes of students." I will respond in kind. In a recent opinion piece in Canada's national newspaper I argued that in the event of society deciding to accept assisted-suicide it must appreciate its incompatibility with medicine's traditional healing mission.[3] Numerous replies from colleagues suggest the silent majority's opinion is that euthanizing is not a healing proposition and it should not become part of medical practice. Most physicians studiously abide by it in their quotidian practices. Two ethicists from the Harvard Medical School made a similar case recently, arguing for a group of nonphysician practitioners to carry out assisted suicide.[4]

I suggest the "reductionism" Dr Boisvert attributes to me should be more appropriately worn by him. Reductionism "assumes that a system can be considered a hierarchical classification of objects in which the objects at each level are complex structures of the objects comprising the next lower level."[5] Reductionist approaches look down (eg, from organ to atom). Those of us who consider the dying process as involving the possibility of a transformative or transcendental movement towards wholeness are looking in the opposite direction. I am not evoking God or the heavens here. Rather, I am conceiving of a focus away from molecules—one towards meaning-making. Dr Boisvert implies that those who are anti-euthanasia are "absolutizing physiological survival." He is absolutely wrong. Death is a natural process. I am not a vitalist, one who believes that life should be extended at all costs. But implementing that approach is different from and does not require euthanasia. Nor do I view the dying body as a spent mechanical force. I see the patient as always a person, a unique embodied self and a complex fellow human being embedded in a social community. I disagree with the moral philosopher who has stated, "If a patient is mentally competent and wants to die, his body itself constitutes unwarranted life-support unfairly prolonging his or her mental life."[6] If one examines closely the arguments of PAS advocates, extreme Cartesian philosophy is often apparent.

Dr Boisvert takes comfort in studies that appear to vitiate the slippery slope argument. He expresses satisfaction with the administrative safeguards in place in Europe. But their record is far from untarnished. A current review of practices in the Netherlands exposes ethical concerns.[7] For example, physicians failed to report assisted-suicide in 20% of cases and frequently misclassified euthanasia as palliative sedation. In a 2010 study of physicians in Flanders, 32% of the deaths involving the use of life-ending drugs occurred in cases where patients had not made explicit requests; these tended to be elderly patients without cancer.[8] Even if the bureaucratic cogs and wheels functioned as expected (possibly providing euthanalogists with some empirical arguments) the fact remains that this debate cannot be divorced from moral considerations. Physician involvement in requested death casts a menacing shadow on the entire profession

and can permeate the physician-patient relationship in its broadest sense. Even Dr Cassell, a proponent of PAS, and repeatedly cited by Dr Boisvert, cautions: "I do not believe that palliative care or hospice programs should publicly support assisted death … ."[1]

Dr Boisvert suggests that there are situations where "existing rules fail to apply." It is unclear what he means but he may be referring to moral limits rather than legislative constraints. In the next sentence he conflates it with therapeutic strategies. His logic is confusing and I suggest confused. If by *rules* he means ethical lines in the sand, the appropriate response is that there *are* accepted absolutes. Edmund Pellegrino has stated, "Physicians must never kill. Nothing is more fundamental or uncompromising as this moral absolute. It is by definition a denial of the first end of medicine—acting for the good of the patient."[9] He is not the only physician or philosopher to have proclaimed it. That prohibition has been "on the books" since the Hippocratic Oath. It has been a reverberating imperative of professional healers for over 2400 years! We cannot allow it to be diminished or deformed by relativism and constructivism. If, by "existing rules" he was referring to protocols for relief of suffering, I would simply ask Dr Boisvert to consider why so many of his colleagues do not share his despair and therapeutic nihilism.

Clearly, Dr Boisvert and I have irreconcilable perspectives. However, the claim that those who question the morality of assisted suicide are lacking in humility must be repudiated. Hubris comes in many guises and disguises. There is an old saying in human rights that is often cited: "Nowhere are human rights more threatened than when we purport to do only good." That is true, because our desire to do good blinds us to the harm that may be entailed in doing it. In other words, the greatest damage is sometimes done by those who purport to do only good. I have no doubt that Dr Boisvert aspires to do only good, but I believe he is seriously mistaken about the harm that will be perpetrated, in particular to the profession of medicine, if euthanasia were to be legalized. ❖

J Donald Boudreau, MD
Arnold P Gold Foundation Associate Professor of Medicine; Associate Professor, Department of Medicine; and Core Member, Centre for Medical Education
Faculty of Medicine at McGill University
Montreal, Canada

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