Physician-Assisted Suicide and Euthanasia

Dear Editors:

Re: Boudreau JD. 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.

Considering that physician-assisted suicide and euthanasia is a sensitive and controversial topic, the reductionism and the lack of objectivity of the question asked and of its discussion are intriguing. It is clear that the author and advisers wished no answer but their own. It is not usual for scholars to be reluctant to confront their views with others.

Surprising it is, that of those with the most experience in the field, none were consulted, namely from the Netherlands, Belgium, and the State of Oregon. Their comments would have broadened the horizon for the readership and rectified some lexical vagaries. It is generally understood that kill and murder are acts perpetrated on nonconsenting victims. Thus, the absolute moral value of “not to kill” does not apply to requested euthanasia, and “self-murder” is an oxymoron.

The experts from overseas would have insisted that euthanasia cannot be reduced to the “teaching of an act intended to hasten death”; and that what can very well be role-modeled is a humanism paving the way toward the “presence and accompanying,” hailed by Dr Boudreau, which is the essence of the Belgian Integral Palliative Care: high-quality palliative care, open to the “act” of advancing death, when terminally ill patients request assistance in dying because of their suffering, and their request meets commonly endorsed safeguards, their request should be honored.

In that perspective, bright and sensitive medical students, learn to develop a rich “autonomie-en-lien” (bonds in autonomy), an obbligato tandem between patient and physician, wherein both remain free, yet tied by the bonds of humanity (Marc Desmets, MD; personal communication; 2012). The morality of an act resting on its justification and its benevolence—as per philosopher Tom Beauchamp, MD—is in the realm of the physician; benevolence, as the answer to suffering, affirmed solely by the patient. “Only the patients know how awful their own suffering is,” wrote Cassell.

In the above context, to entertain nightmares of “Moules of euthanasia,” taught by certified “euthanatrians” teaching evidence-based medicine, which may well be irrelevant when “The One and Only Mrs Jones” will face death, all belong to fiction. Curricula, textbooks, research, hence journals, on end-of-life and palliative care abound and have been on the rise, more so where regulated physician-assisted dying has been enacted. Palliative care, including medically assisted dying are already taught in the Netherlands and in Belgium by qualified medical educators. Palliative care education fits very well with the aims and agenda of general medical education, helping to correct the imbalance between knowledge, skills and attitudes. In 2007, the Flemish Palliative Care Federation stated: “No dual track in end-of-life care by which palliative care practice and teaching on the one hand and euthanasia on the other would develop in separation” … “Each patient’s choice must be respected.” What is needed then is a continued expansion of those activities by mentors respectful of patients’ autonomy and for whom the faculty’s agenda is aligned with, and subordinated to, the patient’s own. Paternalism is no longer a virtue but an oppressive tyranny (vide infra). “The first duty of the physician is no longer to save life at all costs, but to respect his patient’s choices,” affirmed the Hon Baudouin. Dr Cicely Saunders reminded all that: “Whatever our own beliefs, we should never impose them on another person, least of all on any individual who is dependent upon us.”

Should a ludicrous specialty of “euthanatriasts” ever be considered necessary, one for “terminalists” or “sedationists” is then urgently needed to administer terminal sedation, for both euthanasia and terminal sedation end in death. The instigated inadequacies regarding “death talk,” diagnosing depression, and pain management are still being raised. To be noted, even in reputed palliative care units, terminal sedation can last more than 15 days (in 10% of cases) and even more than 20 days (in 3.4% of cases). The longer it lasts, the more knowledge, skills and humanism are necessary to cope with the wide spectrum of physical, psychosocial and spiritual problems that develop.

Response to Dr Boisvert:

By qualifying it as “fiction” it seems to have escaped Dr Boisvert that my commentary was rhetorical—intended to persuade the reader towards a particular perspective. Although the word rhetoric has acquired a pejorative connotation it arises out of an honored tradition. The question, “Can you even imagine teaching medical students how to end their patient’s lives” is rhetorical affirmation. “Can you even imagine” is meant to be received as, “No, of course not—one should not contemplate such a scenario.” With this goal in mind it would have been inappropriate to consult pro-euthanasia lobbyists.

The emotional tone evoked in Dr Boisvert’s letter is surprising to me. We are urged to conceive of end-of-life talk and actions as a sublime, stylized, mutually enriching, and obligatory pas-de-deux between suffering patient and benevolent physician, choreographed under bonds of autonomy. This is problematic on several levels. First, I believe that autonomy is inadequate as an ethical framework to understand the fiduciary duties of physicians. The ethicist Alfred Taubner has outlined the limitations of our rights-based politicojudicial and commercial culture where an atomistic interpretation of autonomy obscures the moral identity of the physician. His essay entitled “Sick Autonomy” is critical to the euthanasia debate. Second, the notion of a linked autonomy may very well be internally flawed and indefensible. If I, in my role as physician, am to enjoy inviolate personal autonomy and exercise interdependent autonomous acts along with my patient how could I be obliged to act against my convictions? This notion merits judicial reflection. Third, although the term obbligato tandem is a lovely one and it may capture the ideal relationship between physician and patient, in the context of end-of-life care I fear that it borders on unwarranted Panglossism. It is at odds with my own clinical practice and that of most physicians called to the bedside of dying patients. I am convinced that Dr Boisvert would be in agreement with the depiction of death as invariably painful and alienating. It is often experienced, at least initially, as a disorienting catastrophe. It is uncommonly wished for, rarely unfolds at convenient times and is endowed with few redeeming features. As such, I have reservations with the dance metaphor; this does not negate the desirability of a tight interpersonal bond implied by the eloquent phrase obbligato tandem.

Dr Boisvert reports that physicians in the Netherlands are highly trustworthy and opines that this status may be tied to their willingness to look favorably upon requests to be euthanized. The article by Kmieciowicz, cited to support his claim, is hardly compelling. The authors themselves offer this disclaimer: “Our straw poll would never receive awards for being scientifically robust ….” There is no

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for both staff and families. Not rarely, experienced palliativists at times do poorly in such situations, as heard personally in workshops on “prolonged terminal sedations.”

**Humanism and Values**

Such “deep-seated personal convictions about one’s obligation to others—especially those in need” (humanism as defined in the commentary) has made the physicians in the Netherlands the most trustworthy physicians in the seven countries in the *British Medical Journal* inquiry, which included the United Kingdom (UK) and the US, whereas Belgium is second only to the UK for its palliative care activities. And contrary to unsubstantiated fears, there is no evidence of a slippery slope, no evidence that “vulnerable” persons have suffered any abuses and that requests for death are not less numerous from patients followed in palliative care rather than receiving standard care.25

Dr Boudreau is right, this question is not “exclusively axiologic,” nor is it exclusively humanistic, yet, it is nearly so for both these terms. The Hon Baudouin also declared: “One’s opinion (about euthanasia) and personal sentiments, depend, above all, on one’s own moral and religious convictions,” (emphasis added; translation by author). That represents a cunning slope towards paternalism, “a tyranny sincerely exercised for the good of its victims may be the most oppressive …” wrote CS Lewis: “... those who torment us for our own good will torment us without end for they do so with the approval of their conscience.”21

As well, humanism is unevenly displayed by physicians. It has also been displaced by science and technology, premedicated marks gaining in importance at admission time. Obvious to all, knowledge and skills are so much more easily taught than are personal values influenced or attitudes changed. Students soon learn to appreciate—and rate—the great and the less great humanists, all doing their best. Some cases will overwhelm the very best end-of-life care. Humility is not humiliating. In the end, students will learn that euthanasia is not a choice between life and death but a personal choice about a personal death, which should be honored.

William Osler would wonder what “Whole Person Medicine” is all about. Did the faculty ever have any other goal? Likewise, euthanasia modules and euthanatricians can only result from a misguided hypercompartamentalization, which might have suited Descartes but surely not Spinoza.26

Profoundly humanist mentors CAN teach compassion and respect, from birth till, and including, death.

Respectfully,

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* Belgian Jesuit and Palliative Care Physician.

**References**


How Do Adolescents Access Health Information?

Dear Editors:


As a Pediatric and Adolescent Gynecologist I have struggled with the fact that the electronic medical record (EMR) cannot be accessed by adolescents. I worked at the Kaiser Permanente Los Angeles Medical Center for 14 years and am now at Group Health in Washington State using the Epic EMR. I am quite frustrated by the fact that my teenage patients cannot exchange e-mails with me regarding their care.

I assume that federal law prohibits teenagers ages 12 to 18 (and their parents) from accessing their results and using the e-mail function of the EMR because it applies in both California and Washington. I am sure this was a well-intentioned idea to protect adolescents and help keep their parents in the loop, but restricting electronic access to physicians only adds a barrier to access of high-quality medical care and advice. I have to resort to playing phone tag via cell phone with all of my teenage patients—or worse, texting—this is inefficient and inadequate.

I agree that teenagers should speak with their parents first and keep them in the loop regarding health matters, but the reality is that some teenagers are not comfortable doing this. Then where do they turn? I think most parents, myself included, would prefer that their teenage sons and daughters get advice from a responsible adult who can be trusted to protect their best interests, ie, their physician, rather than seeking advice from the Internet, their friends, or on the “street.”

It is my hope that the laws regarding adolescent access to their own physician via EMR e-mail will be reevaluated and changed so that this important and vulnerable group of patients can communicate in a manner we know they are comfortable using with a responsible adult who can be trusted to give appropriate advice and care in health-related matters: their physician.

Respectfully,

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Erratum


In the article listed above, an error occurred in the order of the figures in the “Lunate Dislocation” section. Figure 4 should have been labeled Figure 6; Figure 5 should have been labeled Figure 4; and Figure 6 should have been labeled Figure 5. The corrected article may be viewed at: www.thepermanentejournal.org/issues/2012/winter/4261-image-diagnosis-perilunate-and-lunate-dislocations.html. We regret this error.

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autonomy, rely on different scripts of logic for slippery slope arguments, hold different conceptions as to the scope of a life worth living and subscribe to differing priorities with regards to personal responsibilities. The clash of values is undeniable. But, the argument advanced by Dr Boisvert that ministering to patients with authentic compassion, within a mutually trusting relationship, is an example of medical arrogance must be repudiated. It is offensive to conclude that the refusal of a physician to assist in a patient’s suicide is tantamount to oppression and paternalism.

Dr Boisvert invokes William Osler as a role model for contemporary physicians. Although this is totally conjectural, I consider it highly unlikely that Osler would have allied himself with the pro-euthanasia lobby or would have signed up for duty on the mobile euthanasia clinics. He practiced whole person care (even though he did not use that phrase) and enjoined the profession to spirituality. In an article entitled “The faith that heals,” he stated, “The angel of Bethesda is at the pool—it behooves us [the profession] to jump in.”11 A worsening of this nature seems incongruent with a physician placing a lethal dose of medication in someone’s mouth, vein, or … hand.

It was pointed out in a recent report by the British House of Lords that the greater the experience with end-of-life care, the less sure professionals are about the prospect of a change in the law in favor of euthanasia.11 Dame Cicely Saunders, founder of the modern hospice movement, was opposed to euthanasia. Ballour Mount, who coined the term palliative care and founded the McGill Programs in Whole Person Care, is opposed to euthanasia. Opposition by physicians to euthanasia is generally strongest amongst palliative care experts.12 Notwithstanding the recent endorsement by the College of Physicians of Quebec for Belgian-style euthanasia there are other developments, such as the recent vote taken by the Massachusetts Medical Society, confirming that we have not all gone soft on our values.13 We should not accept anything that might dampen the reflex to comfort at all times and for all times. Vigilance is called for. “Euthanatrics” can beguile even the most well-intentioned and sensitive “palliativist.”

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References