Casting stones and casting aspersions: let’s not lose sight of the main issues in the euthanasia debate

Jose Pereira MD

Downie et al. identified some errors in my article challenging the safeguards that are in place in jurisdictions that have legalized euthanasia and assisted suicide. I humbly accept that there are some errors in the references and subtleties that are regrettable. However, most of what they report to be erroneous and false I would argue is indeed correct, and other issues they raise are meant to cast aspersions and distract readers from the primary issues. The facts and my position remain unscathed; there are too few effective safeguards in place to prevent abuses in the practice of euthanasia and assisted suicide.

Downie et al. clarify that, from the outset, the law allowing euthanasia was not limited to terminally ill people in the Netherlands, but rather dealt with people who experienced unremitting suffering. In the ongoing societal dialogue regarding the issue of legalizing euthanasia in countries such as Canada, it is important to be reminded of that point, because there is a perception by some health professionals and the public that, in jurisdictions that allow euthanasia, the practice is limited to terminally ill people.

Although palliative care services have indeed improved in countries such as Belgium and the Netherlands since the legalization of euthanasia in those countries, the change should by no means be misconstrued as cause and effect. Indeed, palliative care has improved very significantly in several countries that have not legalized euthanasia or assisted suicide. Therefore, legalizing euthanasia is not a prerequisite for improving palliative care services, and poor services should not be used as an argument to legalize euthanasia or assisted suicide. In 2010, the Economist Intelligence Unit published a report about the state of end-of-life care worldwide in which they ranked countries across a number of end-of-life care indicators. Countries such as the United Kingdom, Ireland, Australia, Germany, and France, which have not legalized euthanasia, scored among the top countries in the world on several reported parameters.

My comment regarding euthanasia and discrimination is a concern that has been articulated by some within the disability community. Golden and Zanni summarized this perspective and highlighted concerns that persons with disabilities may be at increased risk in the context of legalized assisted suicide and at increased risk of discrimination. In essence, these people with disabilities have suggested that euthanasia or assisted suicide will victimize them by devaluing their lives.

Downie et al. appropriately identify that the reference regarding lack of psychiatric consultations in the Netherlands is incorrect. However, although the reference may be off, psychiatric consultations are not obligatory in the Netherlands, and the requirement is merely extra caution when a psychiatric condition (or early-stage dementia) is suspected. Oregon requires that the most responsible physician refer the patient for psychiatric counselling if depression or mental illness is suspected. However, the most recent report of the Oregon Health Authority notes that in 2011, of 71 patients seeking death by physician-assisted-suicide, only 1 was referred for a psychiatric or psychological evaluation. That statistic is concerning, given that studies have identified rates of depression syndromes as high as 40.9% and 58.8% in persons requesting euthanasia or assisted suicide.

Downie and colleagues argue that the British Medical Journal citation regarding the Royal Dutch Medical Association did not suggest that being over the age of 70 and “tired of living” should be an acceptable reason for requesting euthanasia. The following quote is taken from that citation: “Doctors can help patients who ask for help to die even though they may not be ill but ‘suffering through living,’ concludes a three year inquiry commissioned by the Royal Dutch Medical Association. The report argues that no reason can be given to exclude situations of such suffering from a doctor’s area of competence.” I assume that Downie et al. are referring to the Royal Dutch Medical Association’s recommendation that guidelines first be established to enable this approach.
Their objection would appear to be semantic, and there should be concern about the direction in which the Royal Dutch Medical Association is heading.

Downie et al. suggest that that there is no statement within the Groningen Protocol that allows for euthanasia of newborns and young children who are expected to have “no hope of a good quality of life.” By way of clarification, I offer the following from comments by Dr. Verhagen: “Finally, there are infants with a hopeless prognosis who experience what parents and medical experts deem to be unbearable suffering. Although it is difficult to define in the abstract, this group includes patients who are not dependent on intensive medical treatment but for whom a very poor quality of life is associated with sustained suffering, is predicted. For example, a child with the most serious form of spina bifida will have an extremely poor quality of life, even after many operations. This group also includes infants who have survived thanks to intensive care but for whom it becomes clear after intensive treatment has been completed that the quality of life will be very poor and for whom there is no hope of improvement.” I would suggest that the facts stand for themselves.

With respect to the statement “In 2006, legislators in Belgium announced their intention to change the euthanasia law to include infants, teenagers, and people with dementia or Alzheimer disease” in my original paper, the reference is a report about the ongoing debate in that society regarding that issue. Perhaps a better choice of reference, but one that makes the identical point, is attributable to Cohen–Almagor, who reported the following: “In Belgian society, quality of life is important. Euthanasia is what the people want and now politicians are studying the situation before they decide to introduce further changes. Laterre and Deliens said that the government did not think there was a problem with the practice of euthanasia. Its wish was to have quiet, to remove the subject from the public agenda (personal communication; interviews with Laterre and Deliens, 16–17 February 2005). Wim Distelmans (personal communication, 2 July 2007), on the other hand, does not think that the debate is over). On the contrary, he said that the extension of the law to minors and adults affected by damaged brain function (as in cerebral metastases or dementia) is debatable. At present, the debate revolves around euthanasia of children and young people as well as of mentally ill and demented patients (personal communication, Jean-Louis Vincent, 10 December 2008).”

With respect to the data on the intensive care unit in Belgium, Downie et al. are correct in saying that the 3.5 days refers to the average length of stay on the unit. Belgian law requires a waiting period of at least 1 month from the time of written request to when euthanasia is performed when a patient is not considered terminally ill. A report by Cohen–Almagor states that the medical director of an intensive care unit in Belgium informed him that the law is difficult to apply in the intensive care setting and that he (the intensivist) and his staff do not wait for 1 month as the law requires. The intensivist is quoted by Cohen–Almagor as stating that when “doctors see that there is no help available, they put patients to sleep. Beneficence is the guiding rule.”

Downie and colleagues appropriately bring to my and the readers’ attention that the reference to support the quote “We don’t need palliative medicine, we practice euthanasia,” allegedly attributed to a Dutch physician, is incorrect. The source of that error lies in the original paper by Harris et al. in which I had found the statement and reference: the reference in that paper was incorrect. On the issue of the need for a consultation by a second physician, there is evidence from the Netherlands and Belgium, in the context of unreported cases, that a second consultation is not universally done. Downie et al. highlight that, in Oregon, the physicians do not need to be independent. To this author, that circumstance highlights a major flaw in the process, because it seems to protect the physician more than the person requesting physician-assisted suicide. Unfortunately, compared with the Netherlands and Belgium, Oregon has published few data related to lack of adherence to the guidelines and laws, and so this important question cannot be addressed.

With respect to the comment that, in Oregon, a physician member of a pro-assisted-suicide lobby group provided the consultation in 58 of 61 consecutive cases of patients receiving physician-assisted suicide, the correct data is that 57 of 59 assisted suicide deaths were facilitated by a pro-assisted suicide lobby group in 2009. Those data cast doubt on the objectiveness of the assessments. The author of the report containing the above data writes that “Oregon Health Department officials expressed concern in 2009 regarding the ‘worrisome trend’ over the years in the decline in requests for formal psychiatric evaluation.” They state: ‘The decline in formal evaluation raises concerns that depression remains undiagnosed in some patients who request and receive a prescription under the DWDA’ (Death with Dignity Act).’ Again, although Downie et al. may take issue with the reference, the facts remain concerning.

Downie et al. clarify that, in the study Chambers et al., “predominantly among patients ...” applies only to the use of life-ending drugs without explicit patient request, not to euthanasia. The fact that patients are having their lives deliberately ended in the absence of their explicit consent underscores the concern that safeguards are not being adhered to; such use should not be occurring, and yet it continues to occur despite legalization of euthanasia. Clearly there are different ways of interpreting the study.

Downie et al. write that the University Hospitals of Geneva asserts the lack of a relationship between the staffing of community-based palliative care...
services and the taking of a position by the organization on the provision of assisted suicide within its walls, and that the number of physician full-time equivalents in palliative care increased from 3 to 3.5. The positions used to calculate those figures, and their function within the hospital (hospital team versus the palliative care unit), are not clear. Nevertheless, having had at the time been recruited to an academic appointment at the University of Geneva and having had a clinical and academic leadership appointment at the University of Lausanne in Switzerland, I clearly recall being asked by the clinical palliative care leadership at the University of Geneva to assist in opposing the reduction of the physician full-time equivalents in the palliative care unit, according to that request, and noting the hospital’s response (advising that the request could unfortunately not be met and proposing that I seek funding from an alternative source—which was also unable to assist). The timing of the cutbacks and the closure of the community palliative care program at the time was unfortunate, but the recent increase in palliative care physician positions at that hospital and unit is welcome.

Downie and colleagues take issue with my comment that the “United Nations has found that the euthanasia law in the Netherlands is in violation of its Universal Declaration of Human Rights because of the risk it poses to the rights of safety and integrity for every person’s life.” They state that the United Nations has not made any such pronouncement. Although the United Nations has not condemned the law, a committee of the United Nations, the UN Human Rights Committee, has raised several concerns about the Netherlands euthanasia practice. Their focus on these technicalities would appear to be meant to obfuscate the primary issue. In a 2001 report by the British Broadcasting Corporation, the rapporteur of the committee is quoted: “The main worry is not only the actual practice, but also the fact that this new law could create precedents that dilute the importance and trivialise this act,” he said. “The practitioner could become practically insensitive and the act trivialized.” More recently (August 2009), DutchNews.nl reported that the “Dutch policy on euthanasia should include judicial approval before a life is terminated, according to the latest report by the United Nations’ Human Rights Committee, reports Saturday’s Volkskrant. The Netherlands says its euthanasia procedures are safeguarded by the fact that a second—indeed—doctor must agree to the termination of life but the UN committee does not agree that this is sufficient the paper says.” The Dutch Section of the International Commission of Jurists refers to that publication at their Web site and reports: “The committee [United Nations Human Rights Committee] expressed concern about the current euthanasia procedure, because it does not include a pre hoc, but only a post hoc procedure and the fact that the decision is made by doctors. The committee would prefer a decision by a judge prior to the euthanasia to prevent possible mistreatment of this legislation.”

My concern about the training of LEIF (Life End Information Forum) physicians, the physicians who essentially serve in Belgium as gatekeepers of euthanasia, is that even 30 hours of training in palliative care does not make them specialists in that field. If euthanasia and assisted suicide are to be last-resort options, then surely persons requesting them should be assessed not by physicians who have received basic training in palliative care, but rather by highly specialized individuals in the field. In countries such as the United Kingdom, Australia, Ireland, and the United States, 3–4 years of training are required, not just 30 hours.

All perspectives should be heard, and the focus should be on the substantial points that I made, the occasional—unfortunate—reference error notwithstanding. The casting of stones and casting of aspersions speaks to the emotional nature of this discussion. There are different perspectives on this debate. These different perspectives are important if, as a society, we are to proceed with a dialogue on this complex issue. Despite the attempt by Downie et al. to discredit and divert attention away from the primary position, the notion that euthanasia and assisted suicide are, or can be, regulated within effective safeguards is a fallacy. For that, there are references aplenty.

CONFLICT OF INTEREST DISCLOSURES

The author has no financial conflicts of interest.

REFERENCES


**Correspondence to:** Jose Pereira, 43 Bruyère Street, Ottawa, Ontario K1N 5C8.
**E-mail:** jpereira@bruyere.org