

Euthanasia is not medical treatment

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Introduction or background: The public assumes that if euthanasia and assisted suicide were to be legalized they would be carried out by physicians.

Sources of data: In furthering critical analysis, we supplement the discourse in the ethics and palliative care literature with that from medical education and evolving jurisprudence.

Areas of agreement: Both proponents and opponents agree that the values of respect for human life and for individuals' autonomy are relevant to the debate.

Areas of controversy: Advocates of euthanasia and assisted suicide give priority to the right to personal autonomy and avoid discussions of harmful impacts of these practices on medicine, law and society. Opponents give priority to respect for life and identify such harmful effects. These both require euthanasia to remain legally prohibited.

Growing points: Proposals are emerging that if society legalizes euthanasia it should not be mandated to physicians.

Areas timely for developing research: The impact of characterizing euthanasia as 'medical treatment' on physicians' professional identity and on the institutions of medicine and law should be examined in jurisdictions where assisted suicide and euthanasia have been de-criminalized.

Keywords: euthanasia/assisted suicide/palliative care/suffering/healing/medical legislation

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...tha'll nivver feel it, tha'll be out of existence i' two minutes

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Background

Physician-assisted suicide (PAS) and euthanasia are among the most contentious issues faced by the medical profession. Numerous scholars have argued in favor of¹ or against² 'assisted death', as these interventions are euphemistically called. These debates generally take it for granted that the person carrying out euthanasia will be a physician. That assumption has been questioned, most recently, by two ethicists from the Harvard Medical School who propose a limited role for physicians in assisted dying.³ We discuss their proposal shortly. The possibility of deleting the physician from the equation has certainly not been salient in professional discourse.

In this article we will examine factors, highlighting historical contexts and the influence of language, which have helped campaigners who aim to sanitize 'assisted dying' by associating it with medicine. We broach the issue of whether euthanasia can be considered medical treatment by focusing on the irreconcilability of euthanasia with medicine's mandate to heal.

In the remainder of this text, we use the word euthanasia to include PAS, unless the contrary is indicated. We do so in accordance with the fact that both procedures raise the same ethical and legal considerations with respect to many of the issues discussed in this article. In PAS and euthanasia, physicians and society are complicit in helping persons to commit suicide or giving them a lethal injection, respectively. Moreover, whether or not a society will alter its laws to allow 'medically induced death' is a binary decision.

The implication of a medicalized dying process

Are medical doctors, by being responsible for the prolongation of the dying process, blameworthy for the existence of conditions that elicit a desire for hastened death? The profession has indeed created circumstances, through overly aggressive technical interventions, whereby persons' illness narratives have included chapters with alienating, de-personalizing and dehumanizing plots and characters. The following trajectory of a hypothetical patient with amyotrophic lateral sclerosis is all too common: first, non-invasive nocturnal ventilation enters the scenario; next, a wheelchair; then a Dobhof feeding tube, promptly replaced by a jejunostomy; innumerable venous punctures and catheterizations; intervening urinary tract infections; recurrent aspiration pneumonias, followed by invasive ventilation, eventually necessitating a tracheostomy; accompanied by unrelenting despondency; and finally,

progressive somnolence and terminal sepsis. Too many patients find themselves in a sickroom in such a state, one of spent physical resources and suspended hope or even total despair. Some would add that this metaphoric dwelling is also inhabited by a crushed spirituality.

Pro-euthanasia advocates sometimes present such scenarios to support their views that the profession is, in some measure, responsible for the condition in which a patient may conceive of no escape or redress other than self-willed death. A comment such as, 'I'd rather die than slog on with deformity, disfigurement and disability', is not infrequently heard and, when expressed, often denounces a sequence of medical interventions rather than the original illness. In dire situations, one of the few avenues that can seem to offer a sense of comfort is that of personal control. Control, usually packaged in a discursive frame of politico-judicial personal autonomy, can be manifest as a desire to manage the ultimate mode of exit from life, that is, for patients to select the method, place and hour of their death. Moreover, some may want this stance to be legitimized by societal approval and even see it as a heroic act and as furthering a common cause, by promoting shared values and ideologies.⁴

It would, however, be an overstatement to attribute all changes in the nature of death to the health professions. Improvements in general socioeconomic conditions have decreased the incidence of death from catastrophic accidents, trauma and obstetrical mishaps and have lessened the impact of previously deadly infectious diseases. Undeniably, the shift in prevalence from acute and preventable conditions to chronic degenerative diseases, as well as many cancers, is a consequence of a prolongation of life resulting from improvements in public health, universal literacy and preventive interventions. Nonetheless, there is a kernel of truth in the notion, expressed in commentaries dating from Hellenistic to modern times, that physicians have invented 'lingering' death.⁵ We believe that some of the profession's approaches in responding to illness in modern society may have fueled the clamour for radical solutions such as euthanasia.

The process has been abetted by those who espouse so-called 'progressive values', in what are often referred to as the 'culture wars', and who often manifest a pervasive questioning of authority.⁶ A desire for unfettered individual decision-making powers—seeing 'radical autonomy' as always being the overriding value—and the demotion of established religions as influential voices in the public square are also important factors in the rise in demands to legalize euthanasia. We consider euthanasia a misguided solution to a complex socio-cultural transformation. It is reasonable that the medical profession not deny its contributions to the situation; but, it would be perverse if it allows

itself to be co-opted by a perceived need for atonement. It must be vigilant to avoid over-compensating by endorsing society-sanctioned euthanasia.

The profession must not disown its ethical tradition or abandon its basic precepts. The potential harm is not only to individuals, but also to the institutions of medicine and law and the roles they play in society, especially in secular societies, where they are the primary carriers of the value of respect for human life, at the level of both the individual person and society. Ironically, they are more important in this regard now than when religion was the main carrier of the value of respect for life.⁴ Therefore, the degrees of freedom, in terms of legitimate actions and behaviours available to physicians confronted with a dying patient are, and must remain, clearly and strictly limited.

The historical case against physicians assisting suicide

The injunction against physician involvement in hastening death has recurred throughout recorded history, the Hippocratic Oath providing the following emblematic statement: ‘I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect’.⁷ This unambiguous prohibition has oriented medical practice towards specific ends and means and away from certain others for over 2400 years. Its enduring impact was apparent in early-modern Western society. Euthanasia was discussed by the lawyer Casper Questel in a book entitled ‘De pulvinari morientibus non subtrahendo’.⁸ Translated as ‘On the pillow of which the dying should not be deprived’, it described common practices that were thought to hasten death. These popular practices included removing pillows from dying persons so that, with their bodies completely supine, ventilatory capacity would be constricted and death accelerated. Another strategy was to transfer dying persons from their beds to the ground. Perhaps the latter operated through a tacit understanding that the bodily cold thereby induced would bring dying persons closer to their natural demise. Regardless of the underlying pathophysiologic mechanism, it is highly probable that symbolism (for example, facilitating passage of the soul from the shell of the dying body to life eternal) was at play. We note that it was natural death that was sought, not terminating the life of the person.

An intriguing and noteworthy feature of this ancient text is that such practices were popular amongst the general public. They were not acts delegated by society to a particular group and certainly not restricted to medical doctors. Questel was aware of undesirable ramifications if they were practiced by physicians. Physicians risked losing trust should they be discovered to have intentionally shortened the lives of dying

patients. Trust is of paramount importance to a successful doctor–patient encounter and is indispensable to the implicit moral contract between the profession and society.⁹ Maintaining the trust of individual patients and of society is a *sine qua non* for the maintenance of professional status. Participating in euthanasia carries the risk of vitiating trustworthiness.

Constraints on physician complicity in euthanasia are to be found throughout history. An 1826 Latin manuscript by a physician, Carl Friedrich Marx, referred to medical euthanasia as the skillful alleviation of suffering.¹⁰ He absolutely forbade physicians from engaging in any attempt at accelerating death, stating: ‘...and least of all should he be permitted, prompted either by other people’s request or his own sense of mercy, to end the patient’s pitiful condition by purposefully and deliberately hastening death’. Examples of more recent statements of such prohibitions include the defeat in the House of Lords in 1932 of the ‘Voluntary Euthanasia Bill’¹¹ and the Canadian parliament’s clear rejection in 2010, by a vote of 228 to 59, of Bill C-384, a private member’s bill that would have permitted PAS and euthanasia.¹²

Certain jurisdictions, notably the Netherlands and Belgium, have legalized euthanasia. In America, Oregon’s ‘Death with Dignity Act’, which permits PAS, came into force in 1997 and Washington state followed suit in 2008. However, on 6 November 2012, Massachusetts voters defeated a ballot that would have allowed assisted suicide, 51–49%. There have been discussions, debates and proposed legislation in many other American states and other countries in the recent past. Generally, these have reaffirmed the ban on medical assistance in killing (whether in the context of end-of-life or, in the USA, physicians’ involvement in carrying out capital punishment through lethal injections). The Benelux and a few American states represent the exception to the rule. ‘Do not kill’ has been considered a moral absolute for most physicians for millennia, and remains so for physicians even in jurisdictions where the public has looked favorably on legislative change. That medicine has all to do with healing, and nothing to do with the purposeful ending of life, has been a reverberating imperative throughout history.

The medical cloak

The pro-euthanasia lobby derives advantages by aligning itself tightly with medicine and physicians. The history of physician involvement in capital punishment is illustrative of this strategy. Juries in the USA, who had seen horrific footage of convicted murderers being executed in the ‘electric chair’, became reluctant to convict persons accused of

capital offences or to vote for a death sentence for felons convicted of a capital offence. Most physicians and the American Medical Association adamantly opposed medicine's involvement in administering capital punishment by lethal injections. Nevertheless, some physicians participated. By virtue of their involvement and in concocting a method of execution that makes a convicted criminal appear serene during final moments, enhanced acceptability was conferred on the procedure. It has been suggested that 'the law turned to medicine to rescue the death penalty'.¹³

It is germane to point out that the word 'doctor' is linked etymologically to 'teacher'. The Oxford English dictionary's definition is: 'one who gives instruction in some branch of knowledge, or inculcates opinions or principles'.¹⁴ Medical doctors can influence public opinion, much as teachers contribute to the socialization of their pupils. The recruitment of doctors, both as a collectivity and as individuals, to undertake a procedure, can greatly modify the public's view of that procedure.

Language is critically important in not only reflecting, but also creating reality. For example, the field testing conducted prior to the passage of the Oregon Death with Dignity Act demonstrated that when the intervention was described as 'suicide' or 'euthanasia', popular support declined by 10–12%.¹⁵ The phrase 'death with dignity', by avoiding the negative connotations of suicide, was perceived as less alarming. It was able to create a halo of benignity and to generate greater support for and muted opposition to the proposed law. For similar reasons, the euphemism 'physician assistance in a dignified death' is reassuring. It would be rare indeed for an individual to wish explicitly for a gruesome death or want to banish a benevolent healer from the sickroom. Research shows that emotions,¹⁶ which we would qualify as 'examined emotions', and we would add, moral intuition, are important in making good ethical decisions. Choice of language affects both these human ways of knowing what is morally right and morally wrong.¹⁷

Jill Dierterle, a member of the Department of History and Philosophy at Eastern Michigan University, denigrates the validity and power of words in order to claim that none of the anti-PAS arguments hold merit and concludes that 'we have no reason not to legalize it'.¹⁸ She turns a blind eye to any potential harm and conveniently overlooks the lacuna in current data-gathering procedures or impact assessments. This stance flies in the face of the golden rule of medicine: *primum non nocere*. Hence, it is anathema to the vast majority of practicing physicians. Few of us, presented with a new and relatively untested therapeutic instrument, would conclude, 'we have no reason to doubt its safety; let's forge ahead'. Her nonchalant dismissal borders on the offensive. Note how

she handles an important deontological argument against PAS: ‘...if PAS is wrong, its wrongness cannot be constituted by its conflict with the Hippocratic Oath. After all, the Hippocratic Oath itself is just a bunch of words’.¹⁸ With the phrase ‘just a bunch of words’ Diertele implies that the oath is hollow and meaningless. But ethical precepts and laws are also just a ‘bunch of words’, yet they establish our metaphysical reality—what can be called our metaphysical ecosystem—which, depending on its nature, determines whether or not we have a society in which reasonable people would want to live.

It is critical to the euthanasia debate to consider what role, if any, physicians may, should or must not play. It is not a ‘given’ that, were euthanasia to be legalized, it would be inextricable from the medical mandate. We propose that it is in the best interests of individuals and society to remove the medical cloak from euthanasia in order to lay bare fundamental arguments against it. The stakes are too high to have the veneer of doctoring obscure the essential core of what is involved and its potential harms and risks.

Collaborators in euthanasia

The commentary previously mentioned, ‘Redefining Physicians’ Role in Assisted Dying’, suggests that a non-physician group could be made responsible for the ‘active’ role in euthanasia.³ The label ‘thanatologist’ has been suggested for such a group.¹¹ The possibility that a new discipline might emerge raises a set of intriguing questions: What would be the scope of practice of thanatologists? Where would one draw the line between ‘active’ and ‘passive’ roles? Of what might their education consist? We want to make it clear that we believe euthanasia is inherently wrong and, therefore, should never be undertaken, but, it is important to consider what such a proposal could involve if it were put into practice.

It is reasonable to speculate that the training could be offered in a program at a technical level and that the duration of training period would be modest. The act of terminating someone’s life is thought to be fairly straightforward—at least, the execution of it is not overly complicated. The experience in the UK of recruiting and training hangmen can provide useful clues.¹⁹ Executioners were trained in the late 19th to mid-20th century with a 5-day course that included lectures, a practical component—‘applicants to pass pinioning in the presence of the Governor’—and ended with a written examination that included simple algebra—the applicant was required to calculate the length of drop (i.e. stretch of the rope) for men of varying weights. Given the complexity of drug-based protocols used in euthanasia,

5 days of instruction would likely be insufficient. A program in the order of 24 weeks, as is the case for cadet training in many police academies, might allow for core objectives to be adequately covered and relevant abilities to be tested and credentialed.

A provocative essay on the topic suggests that lawyers could be trained in euthanasia, practicing a new specialty called *legistrothanastry*.²⁰ Although admittedly implausible, the proposal serves to foreground pragmatic issues relevant to the debate. It rests on two fundamental assumptions: (i) that lawyers are trained to interpret laws and regulations accurately, to apply them strictly and to act on the basis of implementing patients' values and (ii) that carrying out the required tasks does not require sophisticated technical expertise. The authors state, 'Attorneys who wish to provide this service would require only a small amount of additional training'.²⁰ An appropriate educational blueprint could include the following cognitive base: the physiology of dying, basic pharmacology and an overview of the historical, ethical and legal aspects of natural and requested/assisted death. The toolkit of required skills would likely include: communication, verification of decision-making capacity and informed consent, securing of intravenous access, supplying and/or administering of lethal drugs, management of complications, accurate recognition of death and completion of death certificates. The desired attitudinal substrate would include: personal resolve (that is, stick-with-it-ness), respect for individuals' rights to autonomy and self-determination, and, ideally, a calm demeanour.

Although the tone of the previous discussion may be—and should be—rather 'chilling', the substance it addresses has clearly gained a foothold in the current medical literature. A description of procedures for successful euthanasia has been published; one is entitled 'Euthanasia: medications and medical procedures'.²¹ It includes protocols for dealing with terminal dyspnea or agitation in the terminal phase, euthanasia, and the induction of 'controlled sedation'. Controlled sedation is placed in inverted commas by the author, presumably because he feels that it needs qualification; in his opinion, it represent a hypocritical response to suffering and is undertaken with the aim of muzzling the patient while he dies. We note, but will not discuss here, the ethical issues raised by 'palliative sedation', sometimes called 'terminal sedation', in which the dying patient is sedated in order to relieve otherwise unrelievable suffering. We suggest that the former term should be used when sedation is the only reasonable, medically indicated, way to relieve the patient's suffering (when it is *not* euthanasia); the latter term is appropriate when those conditions are not fulfilled and the doctor's intention is to hasten the patient's death (when it *is* euthanasia).

The epigram to the euthanasia guidelines cited above is fascinating. It states: ‘One summer evening, Mr J-M L, suffering from Charcot’s Disease, passed away peacefully after having asked for and obtained the assistance of a physician. Upon leaving the home, the latter did not ponder: ‘What did I do?’ but rather, ‘Did I do it well?’ (Translation by author JDB)²¹ This formulation reveals a unique mindset. The affective and moral stance expressed in that quote is closely aligned to a technical perspective, one where the emphasis is on accomplishing tasks with self-efficacy as opposed to one embellished with critical reflection. Meta-reflection is an important aspect of doctoring. What we do and the conversations we routinely engage in forge who we become; they become a habitus. Even the clothing we wear can influence our thought processes. For example, a recent article documents the impacts on cognition of donning a lab coat.²² If the simple habitual act of wearing a white lab coat can affect thinking and action, one can easily imagine the harmful impacts of regular discussions of euthanasia as they insinuate themselves into the ethos of medical care.

‘The Executioner’s Bible’, a story of England’s executioners in the 20th century, describes the work of the hangman as a ‘cold, clinical operation’.¹⁹ The epigram we have chosen for our essay, extracted from that textbook, is a quote from James Billington, the UK’s Chief Executioner from 1891 to 1901. It is intended to evoke calculated efficiency. The author of ‘Euthanasia: medications and medical procedures’ is similarly categorical, prescriptive and unrestrained by self-doubt. For example, he advises the physician not to propose suicide without medical assistance; to do so is considered incompatible with the role of the physician. He warns the physician against using ‘violent options’ (such as injecting potassium chloride) as this is considered contrary to medical ethics. Leaving aside a disregard for the value of respect for life, the punctilious euthanizer can be seen as behaving with professional dignity and serenity, within *a priori* defined limits. As the Home Office stated in 1926, when describing the work of hangman William Willis, ‘...even an executioner can remain humane and decorous’.¹⁹ Our purpose in making this historical link is not to denigrate advocates of euthanasia. Rather, through this analogy we are endeavoring to focus on the act itself and not just the actor. The latter is often well meaning.

Thanatologists, given the narrow focus of their field of expertise would, over time, almost certainly develop clinical practice guidelines; these might be tailored to different illness categories, for instance, neurodegenerative diseases and the various cancers with poor prognosis. This process seems to be well underway. For example, a recent paper explores euthanasia requests and practices in a highly particularized context, namely, patients in Belgium dying of lung cancer.²³ If euthanasia is

accepted as integral to ‘medical care’, this sort of disease-specific focus will surely expand. One can envisage the emergence of guidelines delineating the complementary roles of physicians and thanatologists. Most physicians (we hope) would eschew any involvement in euthanasia and confine themselves to traditional roles such as diagnosing, estimating prognosis and providing supportive care and symptom control, that is, excellent palliative care—which does not include euthanasia, as some advocates argue it should.

The extent to which principled opponents of euthanasia would be legally ‘excused’ from participating in the steps leading up to fulfilling a patient’s request for assisted death is a contentious aspect of the debate. How would the profession balance the requirement for individual physicians to fulfill specific social roles and the need to respect the freedom of conscience of those who, on moral grounds, reject certain options? Physician–philosopher Edmund Pellegrino argues that physicians can refrain from entering into professional relationships that have the potential to erode their moral integrity; he offers strategies to assist the physician in navigating potential conflicts.²⁴

Psychiatrists and medical ethicists who do not reject euthanasia would be expected to focus on soliciting patient perspectives, exploring options and assessing comprehension, competence and voluntariness—that in making her decision, the patient is free from coercion, duress or undue influence, assuming this is possible. The profession has begun to equip itself with tools to deal with this incipient new clinical reality in jurisdictions which allow euthanasia. Physicians in the USA have been provided with an eight-step algorithm to assist them in discussing assisted suicide with patients who request it.²⁵ These guidelines were developed immediately after the legalization of PAS in Oregon. It is reasonable to expect that additional decision-making tools will emerge should the practice gain wider societal acceptance. Also, the possible consequences on undergraduate medical education, should it have to include protocols for ending patients’ lives, have been explored.²⁶

Again, we note that the above discussion is included for the sake of comprehensive coverage of the issue of physicians’ involvement in euthanasia, were it to be legalized, and whether it could be ethically acceptable ‘medical treatment’ or even ‘therapy’. It is not meant to signal that we see euthanasia as ethically acceptable.

Healing and euthanasia

It has been repeatedly found that of all separately identified groups in Western societies, physicians are among the most opposed to involvement in euthanasia. There is substantial indirect evidence to support

this claim, even in jurisdictions in which doctor-assisted death is legal. For example, in Oregon, there is a suggestion that some patients have to resort to ‘doctor shopping’ to obtain their lethal medications. The Oregon Public Health Division’s annual report for 2011 shows that one physician was responsible for 14 of the requisite prescriptions out of a total of 114 that year.²⁷ Also, the Netherlands recently approved the launching of mobile euthanasia clinics. A stated reason for this development was that patients’ goals in self-determination were being thwarted by physician resistance to providing euthanasia. Not all physicians, including many Dutch colleagues, are on-side with having euthanasia become a medical act.

A questionnaire-based study comparing the opinions of the Dutch general public with that of physicians revealed some marked differences. With respect to the active ending of life for patients with dementia, the level of acceptance was 63% for the public and 6% for physicians.²⁸ With respect to terminally ill cancer patients, the figures were much higher and less divergent; this may be a consequence of the prolonged experience of euthanasia in cases of terminal illness in the Netherlands. Or, it might be that often survey questions are phrased as, ‘If a person is in terrible pain, should they be given access to euthanasia?’ The respondent must choose between leaving the person in pain and euthanizing them. But this choice is wrongly constructed. The person should be able to choose fully adequate pain management—that is, the ‘death’ of the pain—without having to endorse the intentional infliction of death on the patient.²⁹ Despite high levels of acceptance by physicians of euthanasia for cancer patients in the Netherlands, recent reports reveal persistent ethical concerns.³⁰ It is also noteworthy that physicians involved in palliative care, including in Britain, appear to be particularly concerned about legalizing euthanasia.³¹

What underlies the medical profession’s reluctance to accept euthanasia? There are multiple explanations. Aside from ethical, moral and religious beliefs, one of the most salient and compelling has to do with one’s conception of the medical mandate, especially as it relates to healing. Healing is a challenging term to define. Many in our institution (the Faculty of Medicine, McGill University) consider it to be ‘a relational process involving movement towards an experience of integrity and wholeness’.³² It has been operationally defined as ‘the personal experience of the transcendence of suffering’.³³ A feature of healing important to our thesis is the notion that healing does not require biological integrity. Although it may seem counter intuitive at first glance, it has been pointed out that if a sick person is able to construct new meaning and is able to achieve a greater sense of wholeness, that individual may ‘die healed’.³² It is undeniably a vastly different concept

than curing, although they are not in opposition one to the other. Most physicians accept the healer role as a fundamental and enduring characteristic of the profession.³⁴ In our undergraduate medical program, this concept is taught using the term ‘physicianship’; it refers to the dual and complementary roles of the physician—the physician as healer and professional.³⁵ It could be argued that one can remain ‘professional’ even while serving as a collaborator in requested death. On the contrary, many commentators—the American Medical Association is a prime example³⁶—believe that it is impossible to do so as a ‘healer’, one who is focused on accompanying the patient on a transformational journey towards personal integrity that transcends the embodied self.

The process of healing in the doctor–patient relationship is poorly understood. We do not have a complete picture of how it is initiated or which clinical skills or abilities are essential in fostering a healing relationship. The literature suggests that healing resides in the quality of interpersonal connections and that it requires a deep respect for the agency of the physician in the therapeutic process.³⁷ An appreciation of the placebo effect, or in more poetic terms, the ‘doctor as the medicine’, is required.^{38,39} It is almost certainly linked to the phenomena of transference and counter-transference and it may utilize the power differential for salutary purposes, even if these phenomena operate largely at a covert level.

The patient–doctor relationship is marked by intense ambivalence. Any physician who has initiated a discussion with a patient on the issue of resuscitation or desired level of technical intervention will realize how easily it can be misinterpreted, how quickly it can catalyze existential angst and how thoroughly it can overwhelm hopeful sentiments. Affective turmoil and cognitive dissonance can rapidly ensue. These sorts of cross-purpose exchanges would surely be magnified in the context of discussions regarding euthanasia. Although there may be a productive ‘meeting of the minds’ in any specific doctor–patient dyad, the risks of emotional derailment, self-effacing dependency and irreparable miscommunication should not be minimized. It is inconceivable to us that deep layers of existential suffering would not be activated and exposed by such a discussion. A healing space that can support patients would be unnecessarily deflated. Admittedly, this belief is based on incomplete understandings of the clinical encounter, yet the axiomatic foundation of that encounter is anchored in a 2400-year old tradition. We must consider why we have so jealously guarded that tradition. We could always have abandoned it by accepting euthanasia. Unlike many other current medical–ethical dilemmas, neither death nor euthanasia is a novel issue presented by new technoscience.

Recent developments

Many proponents of euthanasia like to claim that opponents rely on two types of unsound arguments: one based on empirical data and the other anchored in axiology. In the first instance, they allege that the outcomes data available from jurisdictions where euthanasia or assisted suicide has been legalized, suggest that our fears of potential abuse are groundless. They deny that there is a ‘logical’ slippery slope—that the situations in which euthanasia will be available will expand over time—or a ‘practical’ slippery slope—that euthanasia will be used abusively. Pro-euthanasia advocates claim that evolving legislation does not pose a threat to persons with a disability, does not lead to euthanasia without consent, does not invite extension of the practice to vulnerable populations—in short, that it has not become a ‘run-away train’. They usually express satisfaction with individual clinicians’ professional restraint and integrity as well as with administrative safe guards. Some suggest that the acceptance of euthanasia results in improvements in traditional palliative care. This belief that it represents a positive force for changing prevailing clinical practices is not based on robust evidence. Moreover, the evidence for the existence of a practical slippery slope is very convincing. This was very recently affirmed by the High Court of Ireland, in a judgment we discuss shortly, in deciding whether prohibiting assisted suicide contravened the Irish Constitution, which it held it did not.⁴⁰

A recent dramatic example of the logical slope’s gravitational pull is the euthanizing, in December 2012, of 45-year-old twins in Belgium. Deaf since childhood, Marc and Eddy Verbessem were facing the additional disability of blindness. Accepting that they were irremediably suffering, their physician euthanized them.⁴¹ Euthanizing patients with non-terminal conditions, even though it can be legal in Belgium, will surely meet with the disapproval of most physicians. Even within the pro-euthanasia movement, this development may be considered an aberration. Nonetheless, there are increasing numbers of commentators who subscribe to the following philosophy: ‘If a patient is mentally competent and wants to die, his body itself constitutes unwarranted life-support unfairly prolonging his or her mental life’.⁴²

There are two arguments, both warranting careful scrutiny, frequently advanced in support of physician involvement in euthanasia. The first is that physicians have privileged access to information about their patients’ unique perspectives and circumstances, including personal resources and frailties, as well as complex family dynamics. That argument has been undermined by evolving practices. The ‘Oregon Public Health Divisions’ report for 2011 reveals that the median length of the

doctor–patient relationship for those who died by PAS was merely 12 weeks (with a range of 1–1379 weeks).²⁷ It is highly unlikely that a physician would have acquired a sophisticated understanding of a person's values, hopes and fears in the matter of a few weeks. It is even less plausible in the case of the mobile euthanasia units currently being deployed in the Netherlands. The second argument is that physicians are inclined, by temperament and experience, to accompany their patients throughout the illness trajectory, including death. That too is not defensible on the known facts. For example, in Oregon, in the first 3 years of the administration of Oregon's 'Death with Dignity Act', physicians were present at approximately half of assisted deaths. By 2005, it was 23%. In 2011, it was a mere 9%.²⁷ The behaviour of these prescribing physicians is not congruent with the image of physicians represented in that iconic painting by Sir Luke Fildes, bearing the title 'The Doctor', and often used to portray empathic witnessing. Pro-euthanasia advocates can come across as rather intrepid in their defense of personal autonomy. Autonomy is the overriding principle that is used to buttress arguments in favor of euthanasia; indeed, it generally runs roughshod over all other considerations. Many pro-euthanasia commentators are disposed to brush off concerns about the impact of accepting 'radical autonomy' as always being the overriding value—especially concerns about the risks and harms to vulnerable people and to important shared values, in particular, respect for life at the societal level. A 2012 case in British Columbia manifests all these issues; it involved vulnerable persons, values conflicts and shows the preferencing by the court of the value of individual autonomy in relation to euthanasia. The case originates in a challenge to the Canadian *Criminal Code*'s current prohibition of assisted suicide.⁴³

Gloria Taylor, a plaintiff in the case, *Carter v Canada (Attorney General)*⁴⁴, was a person with ALS who requested assisted suicide arguing that as her illness progressed she would be incapable of committing suicide, unaided, due to her physical disability. The judge, Justice Lynn Smith, ruled in the plaintiff's favour on the basis that the prohibition was unconstitutional on the grounds that it contravened both Ms Taylor's constitutional 'right to life, liberty and security of the person' (under section 7 of the *Canadian Charter of Rights and Freedoms*)⁴⁵ and her right not to be discriminated against as a physically disabled person (under section 15 of the *Charter*); and that the prohibition could not be saved (under section 1 of the *Charter*), as a reasonable limit on constitutionally protected rights. Consequently, the judge held that the law prohibiting assistance in suicide was not applicable with respect to preventing Ms Taylor and other people in similar circumstances from having such assistance. The judgment is very long

and legally complex and is now on appeal. Read as a whole, it strongly supports legalizing PAS and euthanasia.

Criticisms of the judgment include that it gives undue weight to the evidence of expert witnesses who favour legalizing euthanasia, while overly devaluing that of those who oppose it. The High Court of Ireland, in a case with similar facts to the *Carter* case, in that the plaintiff had an advanced debilitating neurological disease and, likewise, was seeking to have the prohibition on assisted suicide struck down, summed up this aspect of the *Carter* case as follows:

In that case, the Canadian court reviewed the available evidence from other jurisdictions with liberalised legislation and concluded that there was no evidence of abuse. This Court also reviewed the same evidence and has drawn exactly the opposite conclusions. The medical literature documents specific examples of abuse which, even if exceptional, are nonetheless deeply disturbing. Moreover, contrary to the views of the Canadian court, there is evidence from this literature that certain groups (such as disabled neonates and disabled or demented elderly persons) are vulnerable to abuse. Above all, the fact that the number of LAWER ('life-ending acts without explicit request') cases remains strikingly high in jurisdictions which have liberalised their law on assisted suicide (Switzerland, Netherlands and Belgium) – ranging from 0.4% to over 1% of all deaths in these jurisdictions according to the latest figures – without any obvious official response speaks for itself as to the risks involved'.⁴⁰

One can also question Justice Smith's conclusions that PAS is not inherently unethical; that individuals' right to autonomy takes priority over the value of respect for life; that sanctity of life is only a religious value; that there is no relevant ethical or moral difference between refusals of life-support treatment that result in the death of the patient and euthanasia; and, that the availability of legalized PAS is necessary 'medical treatment' for some.

Is euthanasia medical treatment?

Justice Smith's justification for allowing euthanasia is largely based on a selective application of *Canadian Charter of Rights and Freedoms* jurisprudence⁴⁵ and depends upon her being able to distinguish the binding precedent set by the Supreme Court of Canada in the *Rodriguez* case.⁴⁶ The latter held, in a four to three split among the judges, that the Canadian *Criminal Code*'s prohibition on assisted suicide⁴³ was constitutionally valid.

Invoking the *Canadian Charter of Rights and Freedoms*, Justice Smith ruled that Ms Taylor's right to life was infringed by the

prohibition of assisted suicide because she might conclude that ‘she needs to take her own life while physically able to do so, at an earlier date than she would find necessary if she could be assisted’.⁴⁴ We believe that this would strike many as a straw man argument. It is to convert a right to life to a right to assisted suicide, by accepting as a breach of a right to life that a person will commit suicide sooner, if not given access to assisted suicide. But validating assistance in committing suicide hardly upholds a right to life.

Like everybody else, Ms Taylor has a right to refuse treatment even if that means she will die sooner than she otherwise would. Justice Smith accepts the plaintiffs’ argument that there is no ethical or moral difference between euthanasia and refusals of life-support treatment that result in death and, therefore, both should be legal. But a right to refuse treatment is based in a right to inviolability—a right not to be touched, including by treatment, without one’s informed consent. It is not a right to die or a right to be killed. At most, people have a negative content right to be allowed to die, not any right to positive assistance to achieve that outcome. A person with Ms Taylor’s illness trajectory will surely die—even more precipitously if they decline many of the interventions described in the hypothetical patient with ALS we introduced earlier on. (Subsequent to the judgment, Ms Taylor died a natural death from an infection). It is also important to underline that current medical practices enable physicians to attenuate much of the suffering that may accompany the progressive loss of function and well-being in advanced ALS.

The judge appears also to accept the argument that legalizing euthanasia enhances palliative care. This goes some way towards treating euthanasia, as some have termed it, ‘the last act of good palliative care’.⁴⁷ It is also consistent with the ‘no-difference-between-them approach’ to a spectrum of end-of-life medical interventions. Euthanasia is confused with interventions, such as pain management and rights to refuse treatment, which are ethically and legally acceptable, and an argument is thus set up that, if we are to act consistently, euthanasia must also be ethically and legally acceptable. It is tantamount to legalizing euthanasia through confusion.⁴⁸

Justice Smith turns to the British Columbia Prosecutorial policy on assisted suicide for definitional assistance with respect to whether PAS is medical treatment. Here’s what she says:

In the policy, ‘palliative care’ is defined as ‘a qualified medical practitioner, or a person acting under the general supervision of a qualified medical practitioner, administering medication or other treatment to a terminally ill patient with the intention of relieving pain or suffering, even though this may hasten death’. The policy states that that conduct,

‘when provided or administered according to accepted ethical medical standards, is not subject to criminal prosecution’.⁴⁴

In other words, the policy’s definition of palliative care can be expansively interpreted to place euthanasia in same category as other end-of-life interventions which may hasten death.

For the sake of exploration of the issue, let us assume momentarily that euthanasia is medical treatment. What might flow from this?

Classifying euthanasia as medical treatment would affect the scope of disclosure of information necessary to obtain informed consent. A physician must disclose to the patient all reasonably indicated medical treatments as well as their risks and benefits. It would now have to include euthanasia. Even most pro-euthanasia advocates regard it as unethical for a physician to introduce the possibility of euthanasia. Currently, it is generally accepted that any discussion of it must be initiated by the patient.

It would also mean that to obtain informed consent to euthanasia, all reasonably indicated treatments would need to be offered and they would certainly include all necessary palliative care, in particular, fully adequate pain management. Many of those advocating for euthanasia posit euthanasia and palliative care as alternatives, but informed consent to euthanasia could not be obtained unless good palliative care was available. This is not available to a majority of people who die in Canada; it has been estimated that less than 30% have access to even the most minimal form of palliative care.⁴⁹

As well, Canadian psychiatrist Dr Harvey Max Chochinov, who specializes in psychiatric treatment for dying people, has shown that there are significant fluctuations in the will to live, even as death is imminent.⁵⁰ The impact of these findings, as well as conditions such as depression, on the possibility of obtaining valid informed consent to euthanasia would need to be fully addressed.

Another crucially important issue is that, if PAS and euthanasia are ‘medical treatment’, then surrogate decision-makers have the authority to consent to them for the patient. Their decisions must be based on either their knowledge of what the patient would have wanted or, if those wishes are unknown, their belief that these interventions are in the ‘best interests’ of the patient. Would mentally incompetent people and those with dementia or disabled newborn babies, as is now the case in the Netherlands under the Groningen protocol, be eligible for ‘therapeutic homicide’?⁵¹

Yet another issue is what would be the indications for euthanasia as medical treatment and who could access it if were legalized? Justice Smith, citing an expert witness for the plaintiffs, refers to ‘the end-of-life population’.⁴⁴ This is a term used in the Royal Society of

Canada Expert Panel Report on *End of Life Decision-Making*.⁵² In the report, this population is defined as those persons on a continuum beginning with any serious diagnosis or injury. This represents an expansion of a term, ‘end-of-life’, traditionally used for those inevitably in the last days of life, to all people with serious chronic conditions, resulting from illness or injury, that may be fatal in the course of time. And, of course, it is notoriously difficult to predict with any certainty the timing of even obviously terminal illnesses. It is precisely the type of ‘slippery slope’ that we fear emerging from the ‘limited’ exception, as defined by Justice Smith. It will likely culminate in more decisions similar to that taken in the case of the Verbessem brothers in Belgium.

It is also pertinent to point out that Canada continues to fund and promote programs that aim to prevent suicide. If suicide is conferred the status of a right or is held to be acceptable medical treatment it would be difficult to reconcile this situation with the presence of programs that aim to actively thwart it. Some resolve this dilemma by trying to banish the word ‘suicide’ from the debate, in favor of the phrase ‘assisted dying’. Marcia Angell, erstwhile editor of the *NEJM* and a fervent proponent of PAS, endorses the notion that ‘assisted dying’ can be distinguished from ‘typical suicide’. The latter is described as being undertaken by someone with a normal life expectancy, whereas the former is carried out in someone ‘who is near death from natural causes anyway’.⁵³ They are going to die anyway, so what does it matter?! We believe that this reasoning is rather disingenuous and that it can result in a dishonouring of that segment remaining in someone’s life, whether this is measured in minutes or months, and could deprive them of something as ephemeral as dreams and hopes. It certainly negates the idea of dying as our last great act of living.⁵⁴

Finally, a decision classifying euthanasia as medical treatment could have impact far outside the context of issues directly related to death and dying. For example, in Canada, the federal and provincial governments’ respective powers are allocated under the Canadian Constitution. The criminal law power belongs to the federal parliament and the power to govern health and social services to the provincial legislatures. If euthanasia was defined as medical treatment, the federal parliament’s prohibition of it in the *Criminal Code* could be invalid by reason of its trespassing on the provincial jurisdiction to govern health and social services. That is one reason that the Quebec College of Physicians and Surgeons, which supports legalizing euthanasia, argues that it is medical treatment. Likewise, the Quebec Legislative Assembly committee, which issued a report, ‘Dying with Dignity’,⁵⁵ adopts the same argument. From past experience, we expect that Quebec might challenge the constitutional validity of the *Criminal Code* prohibition on this basis. However, a legal committee, set up by the Quebec

government, has proposed another approach. It has just reported on how Quebec could operationalize giving doctors legal immunity for carrying out euthanasia, including by the Attorney General of Quebec instructing Crown Prosecutors not to prosecute them under the *Criminal Code* for doing so, provided they comply with certain guidelines.⁵⁶ In either case we could see Quebec becoming ‘separate’ from the rest of Canada on this critically important issue.

Conclusion

In pondering medicine’s possible involvement in euthanasia, we must foreground those aspects of the medical mandate that are immutable and eternally relevant. We believe these to be the constant nature of ‘illness’, changeless across time, place and culture, and the resultant obligations of the healer. It is important to appreciate how illness affects persons in all spheres of their lives. Patients become intensely vulnerable, impressionable and open to abuse. Pellegrino has summarized the nature of the clinical encounter eloquently as ‘a peculiar constellation of urgency, intimacy, unavailability, unpredictability and extraordinary vulnerability within which trust must be given’.⁵⁷ This vulnerability sets up an intense and enduring obligation of physicians; they must respond to the wounded person with authenticity, compassion and moral agency. The latter demands that physicians harness and deploy their unique influences and persuasive powers in a particular manner. The essential nature of physicianship has evolved over time in a direction that recognizes the extraordinary vulnerability of patients and guards ferociously against their exploitation. In part, this has been achieved by imposing inviolable limits on the physician’s terrain of action. Moreover, we believe that, even if one accepted that euthanasia was ethically acceptable—which we do not—it opens up too many doors for abuse.

The medical profession has arrived at a crossroad; it must choose whether to embrace euthanasia as medical treatment, as a logical extension of end-of-life care, or it can reject the redefinition of its healing mandate that this would entail. We believe, that looking back in the future, the euthanasia events of the present time will be seen as a turning point, not only for the profession of medicine, but also for societies. Crossing the line in the sand articulated by Hippocrates, that as a physician ‘I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect’, would result in the ‘doctor as healer’ becoming the ‘doctor as executioner’. In short, healing and euthanizing are simply not miscible and euthanasia can never be considered ‘medical treatment’.

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