Letters to the Editor


MAiD: Medical Assistance in Dying

In response to: MAiD: Medical Assistance in Dying

I read with interest the recent article "MAiD: Medical Assistance in Dying," by Dr. Dasbach (Autumn 2025, pp. 42–45). Dasbach presents a narrative case that captures the moral and ethical tension of MAiD. The ensuing discussion presents a balanced inspection of a central premise of the practice—that under certain circumstances the principle of autonomy allows a patient to request that a physician assist in ending their life. However, the essay gives less attention to a corollary but equally important premise—that under certain circumstances a physician may justifiably and with deliberate intent and foresight bring about the death of a patient.

Legal scholars debate whether the action of a physician who supplies a patient with a lethal dose of medication and instruction in its use is a proximate cause of the ensuing death. However, the fact that this action is a cause in fact of the death is indisputable. But for the act of the lethal prescriber, the death of the patient by ingestion of the overdose of drugs would not occur. For anyone but a physician, acts of similar assistance would likely incur criminal liability. And it is no coincidence that in every US state that authorizes MAiD, the statute provides immunity from a criminal charge of homicide. As Dr. Dasbach observes, such a role is a profound departure from the Hippocratic tradition. The American Medical Association holds that such physician assistance is "fundamentally incompatible with the physician's role as healer." [1]

The discussion also gives only a passing mention to the crucial roles of palliative and hospice care. In a legal ethos wherein unrelieved suffering is the justification for a state-sanctioned hastened death, the fact that palliative and hospice care are effective, available, and significantly underutilized becomes an inconvenient truth.[2]

As MAiD expands in some jurisdictions beyond terminal illness to chronic disease and psychiatric conditions, our profession must confront the reality that the line between relieving suffering and eliminating the sufferer is far less clear than MAiD advocates suggest. Ethical medicine requires firm and protective boundaries precisely because human vulnerability is inherently subject to societal norms.

Instead of normalizing physician-assisted death, we should renew our commitment to palliative and hospice medicine, and to the ancient promise that physicians will accompany patients in their suffering—not end their lives to escape it. Compassion calls us to alleviate pain, affirm dignity, and protect the vulnerable. It should not justify participation in the hastening of death.

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References

1. American Medical Association. Opinion 5.7: Physician-Assisted Suicide. In: American Medical Association. *AMA Code of Medical Ethics.* Chicago (IL): American Medical Association. 2022: pp. 92–93
2. National Consensus Project for Quality Palliative Care. *Clinical Practice Guidelines for Quality Palliative Care,* 4th ed. Richmond (VA): National Coalition for Hospice and Palliative Care; 2018.

The topic of a physician participating in MAiD was thoughtfully presented in your article. I think this topic requires further discussion about concerns.

The issue is not about morality. In fact, the argument can be made that MAiD is in fact a very moral and humane act since it appears to shorten suffering and is a quicker and painless option.

The issues are with medical ethics, which reflect greatly on all physicians, as well as possibly medical-legal issues with malpractice, since mistakes are measurable and prohibitive with deadly consequences.

To review, I think we would agree that MAiD should require, even if not by the listed state of Vermont, that the underlying disease or status:

1. is incurable
2. is beyond any known effective treatment
3. has intolerable suffering
4. has unmitigated suffering
5. has unchanging desire to die
6. has rational desire to die

Generally, these requirements can leave wide discretion and trust to the judgment of the practitioner, therefore risking abuse and mistakes with fatal consequence.

Specifically, real mistakes are possible and measurable. Specific examples and others are in addition to the vulnerable populations listed in the article:

1. "voluntary" decisions by a patient can be distorted by strain, pain, or drug impairment, and therefore may not be rational
2. there can be variability, change of mind, and uncertainty in a patient's decision. How long is the proper "cooling off period" for a fatal decision?
3. the decision can be influenced unintentionally by others, especially family, friends, and professionals, who may be imposing their own beliefs or motives or factors such as burden of care or inheritance
4. advance directives are not informed consent, since the actual facts are not yet present
5. variable level of skill, knowledge, and experience of the medical practitioner, such as wrong diagnosis or options
6. new medical treatments happen in our profession, so timing is a gamble, since we "never know ahead of time"
7. MAiD is attractive to clinically yet temporarily depressed patients so they are often not stable or rational
8. judgment that "a life is not worth living" is subjective
9. we can never be certain of the natural time of death in the future
10. the decision puts an immoral amount of weight on the patient to volunteer.

In summary, the moral attractiveness of MAiD does not take into account the real life risks of fatal mistakes. Any short "necessity" of active euthanasia is far outweighed by the risk of fatal mistakes and possible abuse.

We as physicians should not have a reputation built by this practice. We should leave MAiD to others. Hospice management of what I call the "hastened passive" approach with enhanced comfort methods has always sufficed for my oncology and hospice practice of 35 years. Any decision for suicide should be without our active and direct intentional assistance.

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