ducted and elsewhere, as well as the comprehensive care that Remy and colleagues provide to families grieving after the death of their children.

The study was not designed to test the effectiveness of intensive and comprehensive palliative care consultation for families of ICU patients. Instead, the goal was to learn whether family and patient outcomes might be improved by having structured, supportive conversations that focused on explaining the nature and prognosis of chronic critical illness compared with usual communication provided by intensivists. Palliative care clinicians are trained and frequently consulted to lead discussions of prognosis and goals of care. We asked palliative care clinicians rather than intensivists to conduct the conversations in the study to eliminate the confounder of baseline clinician communication skills.

What does this study add to the science of communication interventions? The findings show that, beyond what is already provided by skilled ICU clinicians, supportive and informative discussions led by other skilled communicators do not by themselves improve the outcomes that were evaluated. As Martin points out, we cannot know from the findings whether this intervention would have any benefit in ICUs where the staff is less skilled or less available to meet with families.

With regard to other factors that may have been associated with outcomes such as family anxiety or stress, we adjusted for the occurrence of patient death by time of family interview and for full formal palliative consultation; neither of these factors explained the lack of differences in the primary outcomes. We do not have data on palliative care or other interactions after hospital discharge or follow-up measurements beyond the 3-month interviews.

The study was not intended to examine the effectiveness of comprehensive palliative care consultation for patients who are critically ill and their families. Its findings should not be interpreted to undermine the evidence showing the benefits of specialty palliative care and comprehensive communication interventions for this population.

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Euthanasia and Physician-Assisted Suicide

To the Editor Dr Emanuel and colleagues, in their article on attitudes and practices of euthanasia and physician-assisted suicide (PAS), documented the failure in Oregon and Washington to track data regarding abuses and complications.[1] With the prescribing physician rarely present when the drugs were taken, how can complications or the rate at which they occurred be determined?

Further complicating the veracity of reports is the inherent conflict of interest of the assisted suicide proponent organization, Compassion & Choices of Oregon. This organization authored Oregon's assisted suicide law and advocates for legalization of assisted suicide in other states.[2] Compassion & Choices of Oregon is associated with 75% of Oregon's assisted suicide deaths.[3]

Despite the authors documenting flawed and inadequate data, the abstract stated "existing data do not indicate widespread abuse of these practices."[1] However, there are many published reports documenting abuses and complications of assisted suicide in Oregon and Washington. Some are documented on the websites of the Disability Rights Education & Defense Fund[4] and the Physicians for Compassionate Care Education Foundation.[5] Among the issues are "physician shopping" to get around safeguards; absence of psychiatric consultation; nurse-assisted suicide (without orders from a physician); assisted suicide in an unconscious patient or without the patient having requested death; and economic pressures and coercion (including Oregon Medicaid patients being denied cancer treatment yet offered coverage for assisted suicide).

Clearly abuses exist, although the rate is unknown. Abuses that do come to light deserve formal investigation. More importantly, the flawed reporting system needs to be fixed so that abuses and complications are reported and addressed appropriately. Patients at the end of life deserve transparency and truly informed consent before making the decision.

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To the Editor The article by Dr Emanuel and colleagues[1] reporting no widespread violation of regulations concerning euthanasia and PAS might suggest that legalizing PAS has no untoward consequences. Because many physicians support PAS but consider euthanasia wrong, an important question is whether legalization of PAS will inevitably lead to euthanasia. As the World Medical Organization and American Medical Association consider whether to withdraw their opposition to legalization of PAS, we argue that the distinction between euthanasia and PAS cannot hold based on 5 reasons.

First, every ethical argument to justify PAS, whether on the basis of respect for patient autonomy or nonabandonment or mercy, also justifies euthanasia.[2] This reason is particularly true for patients who cannot self-administer pills or lack decisional capacity and are ineligible for PAS, such as patients with amyotrophic lateral sclerosis or Alzheimer disease, conditions people imagine justifying PAS. Second, PAS does not give physicians moral distance from the act. Some assert that PAS is different from euthanasia because it puts the ultimate decision in the hands of patients and therefore distances the physician from the act. This claim is spurious. A physician who writes any prescription is morally and legally implicated in its use, although the patient decides on its use. Furthermore, under PAS laws, states charge physicians with vetting whether the patient is eligible, further weakening claims of moral distance.

Third, permitting PAS without euthanasia is discriminatory. If PAS is justified for some patients, it is discriminatory not to provide equivalent access to death for patients with paralysis, dementia, or other neuropsychological conditions. Fourth, legal arguments will be made to permit euthanasia for these patients on the basis of due process and equal protection. This is exactly the reasoning used by the Supreme Courts of British Columbia[3] (affirmed by the Canadian Supreme Court) to argue that access to PAS requires access to euthanasia. Fifth, from a practical perspective, euthanasia is more efficient. Some patients cannot afford barbiturates. Others are unable to consume all the pills, prone to vomit them, or are underdosed and require active assistance (euthanasia).

For these reasons, most nations that have formally legalized physician-assisted death have legalized both PAS and euthanasia; 99% of all such deaths in these countries are by euthanasia, not PAS.[1] As medical societies and legislative bodies consider the legalization of PAS, they should be aware that the distinction between PAS and euthanasia is likely unsustainable.

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In Reply Drs Stevens and Toffler raise concerns about the lack of data on complications and abuse with the performance of PAS in Oregon and Washington. We agree there is a dearth of data, and we advocated for more research on problems and complications of euthanasia and PAS. Two types of research studies should be conducted. One would enhance official reporting forms requiring information on specific types of complications, such as vomiting of medications, prolonged time to death (>1 hour), and regaining consciousness. It is true that in completing these forms, physicians would be reporting on their own practices and may be reluctant to disclose complications. However, they may still be willing to provide information about unanticipated problems, and such reporting provides a minimum frequency of complications. All jurisdictions also should routinely conduct death certificate studies in which death certificates are randomly selected and the signing physicians contacted to complete a survey about the circumstances of the death. Such surveys have been performed in Belgium[1,2] and the Netherlands.[3] Although rarely used, surveys of bereaved family members identified from death certificates could also uncover practices that physicians might not know about or disclose.[4]

Stevens and Toffler suggest existing data provide proof of abuse in a number of individual cases. Individual cases are worrisome, but they are anecdotes and not data and do not provide support for the notion that abuse is common. Our conclusion based on existing studies is that there is "no evidence of widespread abuse." It does not suggest there is no abuse nor that the abuse is not widespread, only that existing studies suggest that the majority of cases of euthanasia and PAS accord with the legal prescriptions and that the administration of lethal drugs without explicit patient consent did not increase but rather decreased after legalization.

We agree with Dr Sulmasy and colleagues that the justifications invoked for legalizing PAS apply equally well to euthanasia. It may be, as they claim, that physicians are just as morally entangled in PAS as they are in euthanasia. However, they are psychologically less connected to PAS. At least in the United States, physicians tend not to be present when patients ingest medications, and the psychological burden of writing a prescription for PAS is likely much less than that of actively injecting patients with muscle relaxants to end their lives. Although psychology is not morality, it does play an important role in how people think about the acceptability of legalizing PAS and euthanasia.

We are not lawyers and cannot judge whether Sulmasy and colleagues' prediction—that in the United States, legal cases

will inevitably require legalizing euthanasia—is correct. Five states in the United States and Switzerland are the only jurisdictions that have legalized only PAS. As noted in the article, in polling in the United States, paradoxically the public supports legalizing euthanasia significantly more frequently than legalizing PAS, yet only PAS has been legalized. The data support the claims by Sulmasy and colleagues that in most jurisdictions that have legalized PAS and euthanasia, euthanasia is by far the more common practice, and there are more complications with PAS.

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CORRECTION

Data Error in Figure: In the Original Investigation entitled "Temporal Trends in Late Preterm and Early Term Birth Rates in 6 High-Income Countries in North America and Europe and Association With Clinician-Initiated Obstetric Interventions," published in the September 12, 2016, issue of *JAMA*,[1] the data for the Norwegian labor inductions and prelabor cesarean deliveries were incorrect due to a copy and paste error in creating the Figure from the raw data. This article was corrected online.

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