tomography after SVR, because we did not systematically acquire that data.

Athanasuleas and colleagues also state that registry data led to “the European Society of Cardiology’s recommendation that SVR be added to CABG if postinfarction left ventricular necrosis is present with left ventricular end-systolic volume index greater than 60 mL/m² in centers with a high level of surgical expertise.” These guidelines actually state that CABG with SVR “may be considered” for such patients, and this is a class IIb recommendation.¹ The updated 2014 European Society of Cardiology guidelines on revascularization are similar but add the comment that CABG with SVR may be considered in such patients “especially if a postoperative LVESV [left ventricular end-systolic volume] index <70 mL/m² can be predictably achieved” (again class IIb).² The requirement for a postoperative left ventricular end-systolic volume index less than 70 mL/m² comes from STICH data.³

We welcome critical appraisal of our findings, but we think that it should come from an accurate and balanced assessment of the data.

Thomas A. Holly, MD^a

Robert O. Bonow, MD, MS^a

Eric J. Velazquez, MD^b

Julio A. Panza, MD^c

^aDivision of Cardiology
Department of Medicine

Northwestern University Feinberg School of Medicine
Chicago, Ill

^bDepartment of Medicine-Cardiology

Duke Clinical Research Institute and Duke University
Medical Center, Durham, NC

^cWestchester Medical Center
Valhalla, NY

References

1. Task Force on Myocardial Revascularization of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS); European Association for Percutaneous Cardiovascular Interventions (EAPCI), Wijns W, Kolh P, Danchin N, Di Mario C, Falk V, Folliquet T, et al. Guidelines on myocardial revascularization. *Eur Heart J*. 2010;31:2501-55.
2. Windecker S, Kolh P, Alfonso F, Collett JP, Cremer J, Falk V, et al. 2014 ESC/EACTS guidelines on myocardial revascularization: The Task Force on Myocardial Revascularization of the European Society of Cardiology (ESC) and the European Association for Cardio-Thoracic Surgery (EACTS). Developed with the special contribution of the European Association of Percutaneous Cardiovascular Interventions (EAPCI). *Eur Heart J*. 2014;35:2541-619.
3. Michler RE, Rouleau JL, Al-Khalidi HR, Bonow RO, Pellikka PA, Pohost GM, et al. Insights from the STICH trial: change in left ventricular size after coronary artery bypass grafting with and without surgical ventricular reconstruction. *J Thorac Cardiovasc Surg*. 2013;146:1139-45.

<http://dx.doi.org/10.1016/j.jtcvs.2015.03.036>

INFANT EUTHANASIA IS MORALLY UNACCEPTABLE

To the Editor:

I read with interest the recent editorial by Udo Schuklenk¹ on the justification of euthanasia for infants with serious anomalies. I offer the following response.

First, Dr Schuklenk is careful with his statistics, because the situation in Europe is not reassuring but rather alarming. His claim that pediatric euthanasia is infrequent reflects, as he admits, replacement of lethal injection by food and water deprivation and an uncertain amount of underreporting. In 2011, Pereira² showed that despite mandatory reporting, 205 to 40% of Dutch and almost 50% of Belgian adult euthanasia cases were unreported. Violations of protocol were statistically more common in unreported cases. Written patient consent was documented in just 12% of unreported cases and in only 72% of reported cases. High-profile cases, such as the euthanasia of Belgian twins who were going blind and the killing of a Dutch woman who declined transfer to a nursing home, underscore the dangerous subjectivity of “unbearable suffering.” Wim Distelmans, one of Belgium’s premier euthanasia providers, also serves as copresident on the Euthanasia Control and Evaluation Committee, which oversees appropriateness of cases,³ and there is evidence that the 2-physician review process in euthanasia consults is pointless.⁴ I hasten to add that although euthanasia for patients older than 12 years became legal in The Netherlands in 2002, Dutch physicians have been openly killing patients since the mid-1980s.⁵ Euthanasia is still technically not legal in The Netherlands for children younger than 12 years.

The slope is already slipping. Physicians have been operating outside the law; protocol violations, underreporting, and conflicts of interest are rampant. Consequently, many Dutch persons fear being pointlessly killed if they are admitted to the hospital.⁶ Extending such an uncontrolled system to children is unconscionable. Only half of Dutch physicians agree that parents should even be involved in the decision to end their child’s life,⁷ and there are concerns regarding the developmental appropriateness of involving children in euthanasia decisions.⁸

Second, consider a congenital repair that is now routine, atrioventricular canal repairs in infants with Down syndrome. In the 1970s, these were not done; standard opinion was that quality of life and surgical risk was too hopeless.⁹ Dr Schuklenk then might have advocated euthanasia for such infants, with the same arguments he made in his 2014 article¹: futility of treatment, suffering, and economic

utility. Today, these patients enjoy a surgical survival that is higher than that for patients unaffected by Down syndrome.¹⁰ This result, unimaginable 4 decades ago, came about only through the efforts of those who refused to identify these patients as “inoperable.” Had we embraced euthanasia at that time, this would have been nearly impossible. Consider further the progress in single-ventricle repairs, arrhythmia treatments, and transplants, treatments unthinkable a few decades ago that have happened only by first rejecting euthanasia as an option for what was once thought “hopeless.”

Intentional euthanasia of infants is morally unacceptable: it advocates selective termination of life on the basis of dangerously subjective definitions, which history has shown impossible to contain. Furthermore, it abandons the hope of medical progress. Both are directly contrary to Hippocratic principles.

Brian S. Donahue, MD, PhD
Division of Pediatric Cardiac Anesthesia
Department of Anesthesiology
Monroe Carell Jr Children's Hospital at Vanderbilt
Vanderbilt University, Nashville, Tenn

References

- Schuklenk U. Physicians can justifiably euthanize certain severely impaired neonates. *J Thorac Cardiovasc Surg*. 2015;149:535-7.
- Pereira J. Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls. *Curr Oncol*. 2011;18:e38-45.
- Hamilton G. ‘Suicide with the approval of society’: Belgian activist warns of slippery slope as euthanasia becomes ‘normal.’ *National Post*. November 24, 2013. Available at: <http://news.nationalpost.com/2013/11/24/suicide-with-the-approval-of-society-belgian-activist-warns-of-slippery-slope-as-euthanasia-becomes-normal/>. Accessed November 24, 2013.
- Cohen J, Van Wesemael Y, Smets T, Bilsen J, Onwuteaka-Philipsen B, Distelmans W, et al. Nationwide survey to evaluate the decision-making process in euthanasia requests in Belgium: do specifically trained 2nd physicians improve quality of consultation? *BMC Health Serv Res*. 2014;14:307.
- Kon AA. Neonatal euthanasia is unsupportable: the Groningen protocol should be abandoned. *Theor Med Bioeth*. 2007;28:453-63.
- Beckford M. Fearful elderly people carry “anti-euthanasia cards” *The Telegraph*. April 21, 2011. Available at: <http://www.telegraph.co.uk/news/health/news/8466996/Fearful-elderly-people-carry-anti-euthanasia-cards.html>.
- Vrakking AM, van der Heide A, Onwuteaka-Philipsen BD, van der Maas PJ, van der Wal G. Regulating physician-assisted dying for minors in the Netherlands: views of paediatricians and other physicians. *Acta Paediatr*. 2007;96:117-21.
- Mendelson D, Haywood I. Minors’ decision-making capacity to refuse life-saving and life-sustaining treatment: legal and psychiatric perspectives. *J Law Med*. 2014;21:762-73.
- Champagne CR, Lewis M, Gilchrist DM. Should we mend their broken hearts? The history of cardiac repairs in children with Down syndrome. *Pediatrics*. 2014;134:1048-50.
- Evans JM, Dharmar M, Meierhenry E, Marciniak JP, Raff GW. Association between Down syndrome and in-hospital death among children undergoing surgery for congenital heart disease: a US population-based study. *Circ Cardiovasc Qual Outcomes*. 2014;7:445-52.

<http://dx.doi.org/10.1016/j.jtcvs.2015.01.010>

THE ETHICAL CASE AGAINST ASSISTED EUTHANASIA HAS NOT BEEN MADE

Reply to the Editor:

Brian S. Donahue was apparently on the lookout for a soapbox from which to agitate against assisted dying. My editorial on the ethics of infanticide involving a particularly severely disabled neonate in a hypothetical scenario served as a hook for his anti-assisted dying diatribe. The interested reader will notice that Dr Donahue barely addressed the substance of my analysis. He did not even question the data I present. Instead, he chose to write a letter about a different subject matter altogether, euthanasia in The Netherlands and Belgium. He is not in favor of it, and he is entitled to his views.

I strongly advise the interested reader of his letter to investigate carefully the references he uses to sustain his case. He claims that many Dutch people worry about being “pointlessly killed” in Dutch hospitals. His evidence? A newspaper article in a conservative British newspaper. He also references an error-ridden commentary by antieuthanasia campaigner Jose Pereira. Pereira’s article was initially published as a peer-reviewed feature article in a small Canadian online publication called *Current Oncology*. Possibly because of its error-ridden nature, the editor of that publication changed its status to a commentary style output. Evidence for the disastrous state of factual affairs in this article can be gleaned from a response by Downie and colleagues.¹ Let us look at just one more of Dr Donahue’s references. He claims that “there is evidence that the 2-physician review process in euthanasia consults is pointless,” when the actual article he cites concluded that “the consultation procedure of another physician by the attending physician is not optimal and can be improved.”² There is a difference between “pointless” and “not optimal,” at least in my limited understanding of the English language.

Dr Donahue thinks that physicians operating outside the law in societies that have decriminalized euthanasia is evidence of a slippery slope.³ If that were the case, incidences of assisted dying that occur in societies that have not decriminalized euthanasia would equally be evidence of the same slippery slope. Dr Donahue confuses correlation with causation. He needs to show more than that events occur in societies that have decriminalized euthanasia that he does not approve of to prove a slippery slope. He fails to show that decriminalization is the cause of these events.

Dr Donahue raises one interesting point. How should we take potential future medical innovation into consideration