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.

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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

when we are faced with making an irreversible decision, such as the one facing the parents and doctors in our hypothetical situation? In our case, scenario specialist clinicians concluded that the odds were sufficiently against such developments occurring in a reasonable time frame that they advised the parents to consider euthanasia. I proposed that under such circumstances parents should be the party to make that decision. Doctors remain gatekeepers here. Nobody would force them to euthanize the neonate. We have good reason to trust that medical specialists would not undertake such a course of action for frivolous reasons.

Dr Donahue also thinks that euthanasia ought not to be made available to secure future medical progress. That is an interesting argument. I wonder what parents of such disabled neonates would think about their infants being used as means to further medical progress.

The Hippocratic Oath is mentioned in a throwaway line at the end of Dr Donahue's letter, as the profession's last, best bulwark against euthanasia. It is unclear why 21st century doctors would want to be guided by a 2500-year-old document that was put together by members of a smallish cult, the Pythagoreans. Ironically, modern anti-assisted dying campaigners are often committed Christians, a religious group involved at the time in bitter battles with the Pythagoreans. They even burned down the Pythagoreans' temple.⁴ And yet, when it comes to abortion and euthanasia, they celebrate the Pythagoreans' ethical views on medical practice. Given that Dr Donahue hails from a medical school, I wonder what he thinks of the Hippocratic Oath's prohibition on paying doctors for training future doctors.

The Oath also prohibits surgery. Let's remove those departments from our medical schools, too, just to be consistent. Dr Donahue's appeal to the Hippocratic Oath is nothing more than an appeal to the bits and pieces in the Oath that he agrees with (for reasons unrelated to the Oath's questionable moral authority).

I will let medical ethicist Robert Veatch⁴ have the last word on this: "[T]he Oath is so controversial and so offensive that it can no longer stand alongside religious and secular alternatives. . . . [T]he Hippocratic Oath is unacceptable to any thinking person. It should offend the patient and challenge the health care professional to look elsewhere for moral authority."

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