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### The author responds

The points raised by Juurlink<sup>1</sup> in response to our article<sup>2</sup> are worthy of consideration. The release kinetics of the drugs as given in the COGENT trial may have attenuated the potential for a drug–drug interaction. However, in the absence of any further randomized clinical trial of concomitant omeprazole and clopidogrel, extrapolation from the COGENT dataset may be the best evaluation we have of whether there is a real interaction. The observational data are mixed and cannot provide the same level of evidence as a randomized trial. The pharmacokinetic and pharmacodynamic data are fairly consistent, though the relationship with clinical outcomes is uncertain and controversial. Nevertheless, if all proton pump inhibitor options are easily available and similarly priced, to initiate therapy with a proton pump inhibitor that does not have this potential interaction seems prudent.

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### The quality of mercy

In their *CMAJ* commentary, Cook and colleagues<sup>1</sup> point out deficiencies in end-of-life care in Canada, in particular that many people receive unwanted life support, and are cared for in institutions when they would prefer to die at home.

Unfortunately, the authors do not

mention the obvious corollary to avoidance of unwanted life support, namely ending a life that is becoming more intolerable with each passing day. The lack of such an option in Canada must be a fundamental component of any discussion of end-of-life care.

It may be that skilled nursing and appropriate medication in a modern palliative care setting can alleviate most physical suffering. However, for some people, the chief misery at the end of life may not be from physical suffering, but from the loss of privacy, dignity, purpose and independence.

Even though suicide is a legal act, helping someone end his or her life remains a criminal offence. In spite of polls indicating that a majority of Canadians believe such assistance should be available if requested, the present federal government is clear that it will not change the law; the Canadian Medical Association also seems to prefer the status quo.

In the end, it all comes down to one simple question, “Whose decision should it be?” The answer can be found in another question, “Whose life is it?”

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### Independent research needed to inform end-of-life policy choices

In their *CMAJ* editorial, Flegel and Fletcher<sup>1</sup> call for a national dialogue on end-of-life care, arguing that policy change should not be the result of a single court decision.<sup>1</sup> In Canada, different medical end-of-life practices, such as treatment withdrawal, use of medication justified by symptom management and use of lethal drugs are being debated.<sup>2-4</sup> Concerns about the effects of policies are central to the Canadian debate, and international evidence is quoted by proponents and opponents of legislative reforms.

We recently conducted a scoping

review of international evidence on medical end-of-life practices, with a focus on the use of lethal drugs by physicians.<sup>5</sup> Key findings from this review are currently relevant to public debate. We found no empirical study on the use of lethal drugs by physicians in Canada, which is surprising given frequent claims that “assisted suicide,” “euthanasia” or “medical aid in dying” are being practised illegally in Canada.

Policy-makers should therefore be careful in drawing conclusions about what is known, and not known, about the likely effects of policies.

Scientific evidence alone cannot provide simple answers to complex end-of-life care dilemmas. However, having robust knowledge publicly available is a precondition for informed democratic deliberation on end-of-life care in Canada.

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