that these acts become part of standard end-of-life care. As a nation with a proud tradition of caring for the vulnerable, let us instead choose to ensure that the dying have the choice of palliative care.

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As an expert to the Quebec commission on euthanasia, I wrote a memoir and testified during the public consultations. In response to the *CMAJ* editorial by Flegel and Fletcher,[1] I would like to share facts that are not known by most physicians and patients.

There were 427 presentations to the commission: 99% favoured palliative care; 60% opposed euthanasia (34% favoured); and 2% supported assisted suicide. The resulting recommendation of euthanasia by the commission showed that arguments presented were ignored. As explained in *The Gazette*,[2] the commission's report[3] is a "pro-euthanasia manifesto" that reflects an a priori ideological desire to impose "medical aid in dying," while neglecting worrisome facts.

The commission ignored reports from the Remmelink Commission in the Netherlands that exposed abuse in the euthanasia process in 1990, 1995 and 2003.[4] The commission did not seem concerned that major depression is a valid condition for euthanasia (since 1993), and that 20% of instances of euthanasia are regularly not reported, in violation of the law. In Belgium, the Control Commission is impotent to oversee and effectively assess the validity of euthanasia requests; not a single case has been reported to the Justice Department for review.[5]

Euthanasia lobbyists advocate access for patients with dementia and all minors in Belgium. In the Netherlands, the pro-euthanasia lobby advocates the procedure for all those over 70 and "tired of living." A report from the Netherlands shows about a 73% increase in the number of instances of euthanasia since 2003, and a 50% increase in the number of deaths by terminal sedation.[6] These facts invite further thought before instituting safeguards that have not worked elsewhere.

An in-depth reflection on how to die remains necessary. The notion of dignity needs to be grounded in philosophy, not opinion polls. I suggest that physicians and health care professionals may not want to become agents of homicide (at the State's behest), even if it is labelled "therapeutic." Let's be clear: homicide is never therapeutic.

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Are doctors all-powerful?

In a *CMAJ* editorial, Redelmeier and Stanbrook advocate restricted drivers' licences for seniors starting at an arbitrary age, and propose that seniors could then approach their doctors for assessment — in order to regain the right to drive on fast highways.[1] Really? What makes physicians think that they can determine who is a good driver? Why is it our business anyway? Is it our business to determine who is a good parent, or a safe drunk?

Of course we 80-year-old drivers should be screened — but by the same government that issues our licences. There are brilliant "flight simulators" and "driving simulators," which are capable of quickly and accurately testing night vision, reaction time and visual fields. Just pass a law, put us in the simulator for 20 minutes, and read out the results. Cheap, no staff needed — and no doctors!

By the way, taking drivers off the road who are involved in collisions is not "too late to prevent injuries." It is justice! Why take away a person's freedom who has done nothing wrong? Isn't that called "profiling"?

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***CMAJ* 2012. DOI:10.1503/cmaj.118-2079**

Some letters have been abbreviated for print. See www.cmaj.ca for full versions and competing interests.

Correction

Recommendations on screening for type 2 diabetes in adults

The recommendations from the Canadian Task Force on Preventive Health Care published in the Oct. 16, 2012 issue of *CMAJ* have been updated.[1] The revised recommendations are included in the polywrap of this issue and can be found online at www.cmaj.ca.

Reference

1. Canadian Task Force on Preventive Health Care. Recommendations on screening for type 2 diabetes in adults. *CMAJ* 2012;184:1687-96.

***CMAJ* 2012. DOI:10.1503/cmaj.112-2080**