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Death, suffering, and euthanasia

I am thankful for and welcome this opportunity to respond to Dr Boisvert. It is ironic to see a former palliative care physician accusing those colleagues who oppose euthanasia of "moral harassment" and "pride." There is an obvious failure on his part to realize that any physician would strongly object to an intervention considered bad medicine, whether it be smoking or euthanasia. I would rather turn the tables and argue that embracing euthanasia is a betrayal of our ultimate mandate not to cause harm and it reflects misguided compassion.

As palliative care physician John Scott said in his submission to the legislative committee on Bill C-203 on November 19, 1991,

> As we watch suffering, we too share in the lament. When death approaches, we cry out and at times even cry out for death, but we must reject the temptation to kill. Hear the cry of life at the heart of the lament. Neither physician nor legislator must presumptuously respond to the lament by silencing the one who issues the cry.[1]

I wonder on what evidence those who support euthanasia can claim that assisting with suicide eliminates suffering. We do know that suicide is a symptom of intense suffering, and that the request for euthanasia is mostly the result of existential suffering and not physical pain. It follows then that euthanasia does not truly address the cause of suffering, but rather ignores it. It certainly eliminates the sufferer, whose pain we are not be able to bear. Nobody has ever proven, or ever will, that people undergoing euthanasia do not experience intense existential agony in the last seconds of their death. I think one needs a little bit of humility to realize that there is mystery at the end of life that medicine simply cannot know how to fix. In fact, my contention is that a physician who procures euthanasia is falling victim to our current attempts for technological, quick-fix medical responses that have permeated our medical approach. It is no wonder that pagan Greek physicians, who adhered to the Hippocratic tradition, rejected euthanasia. They knew it was the wrong approach.

Philosopher Daniel Callahan said, "Euthanasia ... is an act that requires two people to make it possible, and a complicit society to make it acceptable."[2]

People with disabilities are concerned with euthanasia.[3] People do lose their trust in their doctors. I am not sure about the survey that Dr Boisvert alludes to, but it certainly does not apply to the elderly Dutch who are fleeing to Germany because they fear their doctors and even their friends, as reported in the 2008 French government report to the National Assembly.[4] Dr Boisvert cannot also ignore the report from the United Nations or the new admissions from the former Dutch Health Minister as mentioned in my previous letter.[5,6] In addition, despite the very poor legal reporting of euthanasia in the Netherlands,[7] it is clear that a large number of people's lives are being terminated without explicit

request (ie, murder).[8] In fact, there are fewer deaths in Canada from cervical cancer than deaths in Holland without explicit request.[8,9]

From 1997 to 2004, all cases of deliberate euthanasia in newborns concerned babies with nonterminal illness (eg, spine bifida and hydrocephalus).[10] Even the new law for these cases has failed to set "safe criteria" for who dies and who lives.[11] The past 40 years of euthanasia in Holland proves there is a slippery slope. It has moved from being applied to the very terminally ill to the chronically ill (including those with depression, psychological distress, a "tired of living" mind-set, and dementia) and from a voluntary to nonvoluntary (eg, severely handicapped newborns) capacity. "Suicide counselors" are legal and doctors are expected to provide "reliable information on how to commit suicide."[12-16] Recently the law has been being challenged to include "time to die" criteria.[17]

In Belgium, the rate of deaths without explicit request is 3 times higher than in Holland,[18,19] and patients can be euthanized in the operating room and donate their organs for transplantation.[20] The Oregon experience is alarming as well, but I will spare you the details with the exception of one illustrative example: In 1998, 25% of patients requesting euthanasia received psychiatric consultation while in 2010 none did. Proper end-of-life care suffers.[21]

"You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die," said Dr Dame Cicely Saunders (1918-2005), founder of modern palliative care.[22]

The real question is how to support "dignity" in the midst of existential suffering. Here lies the challenge. One suggested approach includes creating strategies for developing the right attitude, behaviour, compassion, and dialogue toward our patients.[23] The recent annual conference of the American Psychosocial Oncology Society presented novel and exciting research in this area. Work needs to be done. However, we all have the power to respond to the illness of others with care and solidarity in order to uphold and protect their dignity until the moment of natural death. Ultimately, the final answer resides in the advice from Holocaust survivor Dr Viktor Frankl: '"Love is the only way to grasp another human being in the innermost core of his personality."[24]

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