

ASSISTED SUICIDE

The Way For Canada To Go?

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Appeared in the Toronto Star, January 12, 2001

The Netherlands legislature recently passed a law allowing physician assisted suicide, thus becoming the only country in the world with such legislation.

The passage of this Dutch legislation is not surprising. It is the logical next step for a country that, for many years, has allowed euthanasia and physician assisted suicide under purported "strict guidelines" not dissimilar from those now legislated, even though these practices have been technically illegal. Originally based upon the principle of voluntary, repeated, clear requests of competent patients, these guidelines have been extended, over time, to include terminating the lives of incompetent patients, specifically severely disabled newborns, comatose patients, the elderly and those with severe mental illnesses. Studies about these Dutch practices have identified abuses and serious problems, such as the incidence of numerous cases of death without explicit and persistent request, and a climate of fear among the population, especially residents of nursing homes, that their lives may be taken against their wishes (Proceedings of the Senate Special Committee on Euthanasia and Assisted Suicide, 6:49-50). Whether this legislation will prevent these serious abuses and problems remains to be seen.

A recent study published in the New England Journal of Medicine has raised similar fears about the practice of physician assisted suicide in the United States. The study found that only 17 of the 69 people in the State of Michigan who committed suicide with the help of Dr. Jack Kervorkian were terminally ill. Dr. Donna Cohen of the University of South Florida, one of the authors of the report, has been quoted as saying that "Kervorkian attracted a group of people who were desperate and depressed and didn't have the support systems to deal with their suffering." (Globe & Mail, Dec. 7, 2000)

Do we want a society that faces these human dilemmas with a sense of community and hope, struggling together to give meaning to what often seems meaningless? Or do we envision a society that seeks what is comfortable, denies the reality of suffering and death, and tries to ignore or eliminate what threatens our desire for control?

Is physician assisted suicide the way for Canada to go? A debate about whether strict guidelines regulating the practice would be effective in preventing abuses in Canada is not the issue. The real issue, rather, is the more fundamental question about our values as individuals and about the type of society we want to create. What vision and values do we want to be fostered and lived in our families and communities?

What meaning do we give to suffering, dying and death? Do we want a society that faces these human dilemmas with a sense of community and hope, struggling together to give meaning to what often seems meaningless? Or do we envision a society that seeks what is comfortable, denies the reality of suffering and death, and tries to ignore or eliminate what threatens our desire for control?

A genuine vision for our country, in my opinion, would promote those values that affirm life, respect human dignity, build communities committed to the common good, and foster compassion, hope and the willingness to give of oneself for others. Such a vision expresses the wisdom of the world's faith traditions which tells us that while mastery and control, self-sufficiency and competence are desirable qualities in many areas of our lives, unless they are balanced by an ability to let go, to be dependent and vulnerable, we reject the most profound dimensions of our human wholeness. Seen in this light, suffering and dying are regarded as an essential part of living. Concerted efforts must be taken to alleviate sickness and suffering, while seeking, at the same time, to discern meaning in these experiences. Guided by such a vision, compassionate and quality end-of-life care would be priority goals for our society and an integral part of our health care system for all Canadians.

Does such a vision include assisted suicide? The intent of assisted suicide is to kill the patient afflicted by excruciating pain and suffering. It is an admission that continued living

no longer has meaning, that living through suffering has no meaning, and that our resources of human compassion and love have become ineffective. It is an act of despair and an admission of failure - failure on the part of the community to provide the necessary human support when it is most needed. Assisted suicide does not give a message of hope and meaning to family, friends and the larger society. For some, assisted suicide may represent an act of ultimate control over life and death, but such a need for control can also be the barrier that prevents a person from discovering the deeper meaning of life that is experienced only through surrender. Condoning assisted suicide would undermine society's commitment to the more difficult, but infinitely more rewarding, task of meeting a person's real human needs.

We live in a society of many contradictions. The cry for assisted suicide is growing at the same time that medical science and pharmacology have developed pain management to a level never before attained. Pain is one of the most feared aspects of the dying process and profoundly affects a person's physical, social and spiritual well-being. Why are so many people

dying in pain? There are a number of reasons that could be cited: some care providers fear that the use of pain relieving drugs will become addictive; others confuse pain relief with euthanasia; people who are dying and who complain about pain often are not believed; and, finally, most clinicians learn only basic pain management interventions while in medical school.

Ira Byrock, author of *Dying Well*, and a specialist for the past twenty years in care for the dying, distinguishes between the physical pain of disease and the emotional and psychological suffering that comes as people face losing all they have been and all they have imagined they will be. He notes that suffering persists when a person's physical pain is ignored or judged uncontrollable, or when a person's emotional anguish is not understood or is dismissed. He writes that the personal, internal sufferings can be far more intense than physical pain and require even more skillful interventions. Such personal distress or suffering is both a natural and necessary part of being human. When faced with the compassionate support of others it can be an opening up to self-knowledge, a

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time of growth, reconciliation and resolution. (Dying Well: The Prospect for Growth at the End of Life. New York: Riverhead Books, 1997, p. 59)

Byrock maintains that physical pain exists because doctors lack the will, not the means, to treat pain aggressively. He writes:

Eighteen years of clinical hospice experience has taught me that physical distress among the dying can always be alleviated. The word "always" in this context may sound facile, but I use it deliberately. Pain is only "uncontrollable" until it is controlled. Pain and physical symptoms caused by advanced disease usually yield to relatively simple treatment. This is not to say that symptom management is routinely easy. Effective therapy may require the efforts of a physician skilled in palliative medicine and a team of hospice-trained nurses, consultant pharmacists, and others... sometimes pain is so severe and so resistant to customary medicine and therapies that a patient is forced to accept sedation at the cost of comfort.

Byrock says that over a period of ten years, in helping to care for hundreds of hospice patients, he had to resort to full sedation using an infusion of barbiturates only

once. (Dying Well, p. 159)

The recent report, Quality End-of-Life Care: The Right of Every Canadian, of the Senate Subcommittee to Update Of Life and Death, confirms Byrock's concern about the lack of adequate pain management. The subcommittee was struck to examine to what extent the unanimous recommendations of the 1995 Special Senate Committee on Euthanasia and Assisted Suicide had been implemented. The message given from numerous experts in the field is that little has been done. There is no national strategy on palliative or end-of-life care, and no provinces have made palliative care a top priority. There is still little curriculum in medical schools for pain and symptom relief or for palliative care. A minority of nursing, social work, pharmacy, psychology, and other health care programs offer palliative care training. In other words, the knowledge and expertise is available if we want to use it. What is lacking is the will of the medical profession and of politicians to make end-of-life care a national priority.

Is assisted suicide the way for Canada to go? I believe that Canada does not need such legislation. I believe that we must act on the recommendations of the Senate subcommittee by giving priority to the expansion and improvement of palliative care for the terminally ill. This means more government funding

for palliative care services, a changed attitude among physicians toward pain control and dying, curriculum changes in medical schools, and funding for research.

Assisted suicide will not foster quality end-of-life care nor will it help us to become a more caring society that values and supports human life at its most vulnerable moments. In fact, to legalize assisted suicide would likely inhibit these values and be a deterrent to the expansion of palliative care services in Canada. It is not surprising that, in Holland, palliative care services have been neglected. When death becomes the accepted way to deal with terminal illness, little energy or resources are directed to palliative care for dying persons. Is that the type of vision that we wish for our society?

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