The English Speaking Catholic Council

Le conseil catholique d'expression anglaise

BRIEF

SUBMITTED TO THE SELECT COMMITTEE ON DYING WITH DIGNITY

BY THE ENGLISH SPEAKING CATHOLIC COUNCIL

In 1980, a group of individuals who represented various sectors of the English-speaking Catholic community and its organizations met with the idea of consolidating our human and material resources for the development of our community. This led to the formation in 1981 of the English Speaking Catholic Council (ESCC) with a mandate to act as a focal point in coordinating the English-speaking Catholic community of Greater Montreal. Over the years, the ESCC has assumed a higher profile which now extends throughout the Province and beyond.

Inspired by the contemporary Catholic understanding of the role of the laity in the modern world, the English Speaking Catholic Council assists in the promotion of its community's values and advocates those values in the resolution of issues affecting this community. The Board of Directors is made up of women and men from both the private and public sectors, all volunteers, who come together with a commitment to support their community in education, health and social services, community animation, culture and social justice.

The English Speaking Catholic Council acknowledges with deep gratitude the invaluable contribution of the principal authors of this brief: Dr. Ramona Coelho, a family physician who works at CLSC Metro in Montreal. Her training included a focus in palliative care. She spends half of her practice caring for disabled and frail elderly persons who are homebound. And Dr. Philippe Violette, a fourth year urology resident currently completing his training at the McGill University Health Centre and a Director on the Board of the ESCC.

The English Speaking Catholic Council is pleased to submit this Brief to the Select Committee on Dying with Dignity. We would appreciate receiving an invitation to present our Brief at the public hearings.

Clifford Lincoln, President

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2005 St Marc, Montreal, Quebec H3H 2G8 T: (514) 937-2301 F: (514) 907-5010 escc@bellnet.ca

Introduction

In the consultation document, *Dying with Dignity*, euthanasia is defined as an act that consists in deliberately causing the death of another person to put an end to that person's suffering. One might infer from this definition that there is an element of compassion that underlies the act of killing. This is highly debateable. Let us be clear: Euthanasia is giving someone a lethal medication or withholding basic treatment with the *intention* to kill.

It has become more apparent over the past year that many physicians do not understand the difference between letting someone die from natural causes and providing adequate pain control as opposed to actively injecting a person with a lethal substance. This troubling fact shows the lack of knowledge of basic palliative care among our health care professionals. It leaves one wondering what greater societal misconceptions must also exist which fuel and confuse this debate.

Several committees and individuals have recently come forward advocating euthanasia, that is, mercy killing. The argument that holds the greatest traction with many people is that there is a state of intolerable pain for which there is no medical solution. Adding further misunderstanding to the current euthanasia discussion has been the introduction of the phrase "dying with dignity". The general public is being misled by these terms to implicitly understand that without euthanasia, death is undignified. There is a clear bias in all this that is pro-euthanasia and it is a slanted way to start off such an important discussion.

It is true that people have suffered through terrible pain in the past and continue to, where there is a lack of medical resources. However, pain medication and interventions are not very costly in comparison to other common medical interventions. In Quebec, the health care system facilitates a patient's access to pain medication. If pain control remains a problem, it is

due to the lack of expertise and compassion of medical practitioners. Specifically, it is most frequently caused by an inability to recognize or acknowledge pain and ignorance of the principles of palliative care.

Ethical Priorities: Autonomy vs. Protecting the Majority from Harm

Many people feel they are entitled to choose exactly how they live their lives. For the most part, the freedom to make decisions and to self-determination is what allows us to plan, and allows for a sense of control and peace. This right is worth upholding. However, there are reasonable limits to this right to self-determination. For example, if a patient has tuberculosis and refuses treatment, in order to protect the rest of our society, we deem it acceptable to quarantine this infectious patient, even against his/her will. Likewise, with the recent SARS outbreak, people were detained in their homes for up to ten days on the suspicion of having come into contact with an infected individual. Both these examples clearly demonstrate how in many cases, we naturally understand the struggle between the greater good and the autonomy of the individual. When an individual's behaviour puts others at undue risk, his/her autonomy is superseded by the good of society.

With the question of euthanasia, there is a tendency among us to see it as progressive and compassionate. We may want to allow the few people who want to die on their own terms this wish. However, this question must be asked: How will legalizing euthanasia affect the greater good? We will argue that by legalizing euthanasia to satisfy the desire of very few, we would embark on a path that puts the most vulnerable members of our communities at enormous risk.

The dissatisfaction with our current health care system

Recent surveys conducted by the two medical federations (unions) in Quebec among their constituents have made it apparent that many physicians in Quebec do not adequately understand the area of pain control and comfort for the dying (FMOQ, FMSQ surveys).

The problem is twofold: Firstly, most physicians in Quebec do not know basic treatment regimens for common end-of-life symptoms such as pain, nausea, loss of appetite and depression. Secondly, physicians generally remain unaware of the ethical considerations involved in end-of-life decisions.

The dangerous consequence of legalizing euthanasia would be to mandate that a group of people who do not have adequate expertise in pain control be given the right to end life in cases where they deem that the patient is experiencing uncontrollable pain. That is an unsettling proposition.

In Quebec, there is also the issue of a frustrated and overworked hospital staff and increasing costs in health care. The authors have seen many patients who have horror stories about their hospital experiences. They feel ignored and put away in a room where they have to fight for attention. Within the hospital system, there are many competing factors that already limit the care and compassion we give to patients. Despite the heroic examples of some health care workers, there are an un-numbered proportion who are just managing to do their job and do not have extra time or energy to address the more human aspects of suffering. The reality is that our healthcare system is not meeting basic standards of care of these medical problems.

We would like to share two recent cases that one of the authors, Dr. Coelho, recently experienced to illustrate this point. They are told from her perspective:

1. Amy[1] is a healthy 84 year old woman who suffers from osteoporosis (poor bone integrity). She was scheduled to have an elective hip surgery but unfortunately had a fall and broke her wrist. During her convalescence she developed diarrhea secondary to C.difficile and on her way to the bathroom, fell and broke her hip. On returning to the hospital, the house staff (including physicians, nurses and aids) clearly perceived Amy`s quality of life as poor and gave her little attention. When I came to visit her, this was painfully clear to me. They were surprised she knew someone as young as I was and told me it was a shame that her quality of life was what it was. In fact, Amy's quality of life was anything but poor. She had been a volunteer at a hospital in Montreal for over twenty years, she is the former principal of an excellent school in Westmount and she has an active social life. Unfortunately, the house staff made assumptions about Amy's life based on her acute illness and current deteriorated state. One day, I called Amy to talk after she was admitted, only to find her short of breath and in terrible pain. I rushed to the hospital to find her acutely dying. The nurse had taken her vital signs but had not alerted anyone to her condition and had not given Amy any pain medication. After an hour of arguing with the nurse, calling the resident and talking to the internal medicine staff on call, Amy was taken to the operating room for a surgery that saved her life. She is now recovering and planning for her elective hip surgery, still has a dynamic social life and is very happy to be alive. The house staff clearly had misjudged her quality of life and her potential for recovery. If euthanasia were legal, it is doubtful that people like Amy would have survived. That is, she might not simply have been neglected, but they may have decided to euthanize her to rid her of her pain and poor quality of life.

[1] Names have been changed to protect the individuals.

2) Tom is a 44 year old patient whom I visit at home. He has myotonic dystrophy and he is disfigured from his disease (he has little muscle mass). Physicians, like others, don't like to see this kind of deterioration, especially when we have no effective treatment. However, despite his appearance, Tom himself is happy to be alive and constantly says he would like to live as long as possible. He speaks to his family daily although they are in Ontario, and his mental capabilities are normal. Recently, Tom had increasing weight loss so I sent him to the hospital for an evaluation. He spent a long time in the emergency room (ER) despite my multiple attempts to discuss his case with the staff physician in the ER and having personally asked my husband (a physician at that hospital) to intervene. In short, no one wanted to admit Tom. Not that he did not deserve or want investigations. Put bluntly, beds are tight and he looked like a long admission. In the end, Tom signed out of the ER because he felt he was treated as a non-entity. This kind of callous attitude is commonplace in our hospital system. Tom tells me that he would rather die than go back to the hospital. But his reason for "preferring to die" is not because of his health or pain, but because of the lack of humanity and compassion he experienced at the hospital.

The fear inspired in patients by our healthcare system is real. Wanting euthanasia is not a solution but a fatal symptom of the inhumanity of our hospital system. There is a tremendous amount of work that needs to be put into our hospitals and healthcare to create an atmosphere that is welcoming and caring. If we truly value each citizen of our nation, if mercy and compassion are the primary goals, this is where our efforts should be spent rather than the promotion of death by euthanasia. In effect, euthanasia would simply be a furthering of the already present inhumanity and malaise in our healthcare system, rather than a compassionate reform.

Previous examples of legalizing euthanasia: The potential for abuse

Examples of how legalized euthanasia has functioned in other counties show that the most often cited reason to choose euthanasia by the patient is the fear of what is to come, not uncontrollable pain (Ganzini et al, 2009). It is known that healthy people often underestimate the quality of life of sick people. Most individuals, at the moment when they realize their prognosis is poor and death is close at hand, are likely to be ambivalent or scared and to request euthanasia to prevent future suffering. However, countless examples show that if they are helped and supported through that initial phase, they often are happy to have lived and feel more closure towards the end of their lives (Hendin and Foley, 1997). This is truly dying with dignity rather than choosing death out of fear.

Possibly the greatest argument against legalization of euthanasia is the abuse that will ensue. There are frequent clearly documented cases in the Netherlands of families, nurses and doctors being the ones who suggest euthanasia, not the patient. This creates an enormous burden on the patient who might already be depressed, scared and concerned about being a burden. Abuse of the elderly is not uncommon in our society and euthanasia opens up the doors to a furthering of such abuse *with* the participation and blessing of the treating physician. Another example from the Netherlands is that of an elderly man who did not have a terminal illness and who was terrified of being placed in a nursing home. His wife found him a burden to care for and gave him two options: euthanasia or a nursing home. He chose euthanasia. Clearly this example shows the potential for abuse (Hendin 2002).

Also, there is the argument for the potential abuse of euthanasia purely based on economics. It has been documented that on refusing to fund certain chemotherapies for patients, insurance companies in Oregon will send an information letter suggesting assisted suicide (Somerville 2010). There are also cases of doctors admitting they are more likely to suggest euthanasia if they need the bed for another patient. In the Netherlands, where there are many reports of

abuses of euthanasia, many of the elderly are fleeing to German nursing homes to avoid being euthanized involuntarily should they get sick. Also, there is an emerging trend from the Netherlands placing the onus on the patient to make it clear in writing while they are still competent that they *do not* want euthanasia (Hendin, 2002). This implies that euthanasia is a standard treatment which one must opt out of, and demonstrates the inevitable assault on individual freedom that acceptance of euthanasia by a society creates.

Euthanasia, once accepted, quickly progresses from a novel idea intended to occur under rare circumstances to a commonly occurring cultural norm. Most societies that legalised euthanasia initially had the intention of using it only for terminal cases-- for patients in terrible pain with no possible cure. It had to be voluntary and there needed to be a second opinion from another doctor. After three decades of acceptance of euthanasia in the Netherlands, it has become common there to perform involuntary euthanasia (where the patient is not consulted), as well as euthanasia in non-terminal cases for chronic diseases and without a second opinion (Sheldon). Today, there are patients who are not physically sick, but because of social reasons say they "can't go on" and are being euthanized because they claim they want it (Hendin, 2002). These people, under any other medical regime, would be admitted to the hospital for depression and for their suicidal thoughts. The risks cannot be underestimated. Once a society learns to view death as just another choice for the living, it becomes easy to justify almost any kind of medical killing. Instead, we should strive to form a society that protects and upholds life, that gives the weak and hopeless strength and hope, and that cares for our dying, allowing them to live to the end of their lives in peace and comfort.

Protecting our most vulnerable: The depressed

The risk of changing societal perceptions of suicide and thus abusing yet another vulnerable group is self-evident. At present, suicidal thoughts are viewed as a clinical sign of depression. People who commit suicide devastate the lives of people who knew them. The rate for suicide and depression increases among those contacts left behind. Most commonly the cry to end one's life is really a cry for help that needs immediate attention. If our society were to view the request for death as normal, as would inevitably be the consequence of legalizing euthanasia, what would happen to these cries for help? In the Netherlands, many of these cries are not understood correctly, and the patient is euthanized (Hendin, 2002).

We have excellent palliative care methods and a well-established psychiatric approach to depression. People asking for death are truly in need of proper palliative or psychiatric interventions, not a lethal injection. We have seen from the example of other countries, that often palliative care diminishes and psychiatry is consulted less if the request for death is seen *as normal*. This does a great disservice to the majority of our vulnerable who need someone to help alleviate their mental suffering and those who loved them and who are left behind.

Catholic Perspective

We, the English Speaking Catholic Council, strive to advance principles and policies on human life that are both consistent with the teachings of the Catholic Church and the greater common good. The core principles which inform our thinking include the following convictions: Human life is invaluable; everyone is equal; everyone deserves to be respected, affirmed and loved. Respect for the intrinsic dignity of every person is the center of our ethical approach and this dignity does not depend on our physical or our mental ability. When one is incapacitated by illness or near death, their inviolable dignity remains unchanged.

Respecting this dignity creates obligations for society as a whole. How we organize our society, specifically regarding euthanasia, will directly affect our perception of human dignity. Euthanasia will necessarily corrupt our view of the value of human life and will lead our society to conclude that life is optional. The obligation to "love our neighbour" has an individual dimension, but it also requires a broader social commitment. That commitment is to treat our most vulnerable members well through improved access to palliative care services and psychosocial support.

Conclusion

1 - Our medical system is under significant stress. This stress has likely been the catalyst behind opening up the discussion to legalize euthanasia. Patients' pain is not being controlled and needs are not being addressed by our medical system. However, euthanasia would actually not be a solution as it ignores the inherent problems in our medical system and even furthers them. We have excellent palliative care techniques and the question of uncontrollable pain should not be an issue in our society. Our true societal problem is the lack of emphasis and priority given to humanity and compassion within the health care system. We can control pain and help people but *we* are failing. Euthanasia is not the solution, it enhances the problem. The discussion of its legalization is a symptom of deeper issues in our health system. It might appear like an easy way to help certain suffering individuals but the consequences for society are grave and irreversible.

2 -Recently and even in this hearing, the term "dignity" keeps resurfacing. People want to die with dignity, and it seems that some equate this with having total control. Control over all functions of our life is impossible. In the case of dying, we are not in control, and we need to ask whether the illusion of control that euthanasia offers is worth the risk that it poses for the

many. The control we do have is pain control, support, love and acceptance. These lead to a death with more closure and peace than euthanasia could ever offer.

3 - Euthanasia gives the wrong message to those who suffer. It ignores a true cry for help and misses a chance to intervene positively.

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2005 St Marc, Montreal, Quebec H3H 2G8 T: (514) 937-2301 F: (514) 907-5010 escc@bellnet.ca