

## **A Response to Euthanasia & Assisted Suicide**

By Dr. Julia Bright

*This was the presentation that family physician Dr. Julia Bright gave at the Chilliwack Pro-Life Society's Banquet Dinner on March 11, 2016.*

If you're anything like me, you have found the recent news regarding the legalization of physician-assisted suicide in Canada overwhelming. It is easy to feel discouraged and distraught by these changes, and so I want to focus my reflections on something positive. Staying positive is what I believe is the best antidote to this negative force entering our country. In order to stay positive in the face of these changes, we need to:

1. Acknowledge and think about our own mortality
2. Support those among us who are dying or nearing death by helping them to achieve peace and live out their last days well
3. Support the palliative care movement

We need to remember that there *is* an alternative choice to suicide—a natural death in the context of a caring community.

I speak to you from the perspective of a family physician involved in palliative care, but also as a person who faces her own mortality when thinking about these issues. And that is key when trying to accompany people on the journey of dying. We must acknowledge that one day *we* will be the one dying.

That being said, I am no expert on this, because I haven't died yet. In fact, I haven't even faced a serious illness yet in my life. So my reflections are based on what I've learned through my work and from other doctors. I would like to reference Dr. Kuhl, who wrote the book **What Dying People Want** and Dr. Gallagher, who is a palliative care physician in Vancouver who has written multiple articles in Canadian medical journals.

At this point, I want to tell you a story. It is about a patient of mine who died recently at a relatively young age from cancer. He went through multiple medical treatments in an attempt to overcome this illness, but ultimately after facing more and more problems at home and hospital, he moved to hospice for his final weeks. During one of my visits there, he was lying in bed watching a home renovation show on TV. I asked him how he was doing and while we talked, he pointed out to me a small wooden box on the table at the end of his bed. It was an urn that his neighbor had made for him. He was planning to be cremated and that box would one day soon hold his remains. He hoped that in the future his wife and their pet dog would also join him in this resting place. So, he was lying in his bed, with this reminder of his mortality directly in front of him. What really impressed me about this was his acceptance of what was happening. I thought to myself—am I brave enough to calmly

acknowledge that one day I will die? Will I be able to maintain that bravery when my death is imminent? And an even harder question-can I accept that my loved ones will one day die?

Personally, I hope I can get to that place of peace. And when I am taking care of a dying patient, that is my goal for them-to create enough freedom from physical and emotional suffering so they can obtain peace and acceptance.

Is it possible to have a good death? I believe it is because I have seen it. People who are comfortable, surrounded by loved ones, well looked after by experienced nurses. People who have said their goodbyes. Dying is not all negative. As I heard a priest say once, happiness is not dependent on health. Some of the most content, calm people I know are physically unwell.

Cultural movements like physician-assisted suicide usually arise as a misguided response to a real problem. People in Canada have died in pain and have faced obstacles to obtaining care that maintains their dignity. Their families have suffered watching this happen. The answer to physician-assisted suicide is not to wish that things could just go back to the way they always were. It is to use this as an opportunity to create a better solution. We cannot be afraid to talk to people about the end of life. Even if they bring up suicide. There are many reasons a dying person might bring up the idea of hastening death by suicide. We need to explore and respond to these.

I want to summarize what is meant by palliative care. Because the knowledge and application of this model of care can prevent the desire for hastened death.

First of all, who are the dying? In a sense, we all are. Some of us will die suddenly, without going through the journey I'm talking about tonight. But when considering this movement towards physician-assisted suicide, those who need our special attention are those with incurable cancer, those with more than one organ failing like heart failure or kidney failure, those with progressive neurological diseases-like ALS, those with dementia, and the frail elderly. I'm sure we all have people around us in at least one of these categories. While respecting their need for rest and privacy, I recommend getting to know them better. Most people fear abandonment more than pain, so our presence in their lives can make a difference. And we can learn from them what it's like to be at that stage of life. What are their memories, their desires, their difficulties?

I heard a sermon recently and the priest said he used to dread his visits to the nursing home. Each time he left he hoped he would never end up there. But one day it struck him that he *would* end up there. And since then, he can't wait to go and try to enhance the lives of the people there. Imagine how different it would be if healthy people everywhere created nursing homes with their future selves in mind. What improvements could we make? My dream would be for hospitals, hospices, and nursing homes to be places we look forward to going to. Somewhere beautiful

where you get a little bit spoiled. I think we've done a better job of this with children's hospitals and places like Canuck Place or our own Cascade hospice. More attention is given to the physical surroundings and the individual wishes of each patient.

There is a movement now in medicine to use a palliative approach earlier on in someone's illness rather than waiting until the very end. This means paying attention to comfort even while treatments for the disease are happening. For example, giving someone with heart failure morphine when they feel short of breath along with all of the medications the cardiologist uses to treat heart failure. It also means bringing up the topic of planning for the end of life earlier. One of the hardest things I see is when a patient moves through the medical system and the doctors and nurses know that his disease is not curable, but the patient doesn't know. This can happen unintentionally when the focus is on trying to reverse the problem at hand, but not talking about the big picture.

Palliative care involves being honest about prognosis. This doesn't mean taking away someone's hope, but rather giving them information to make choices about their treatment and how they spend their time. It has to be done properly and with compassion. This can be difficult when we don't know the exact timeline. For example, it is easier to predict how much time a patient with metastatic cancer has than someone with bad heart disease. Cancer usually causes a gradual decline, whereas heart disease can cause a series of life threatening events and the person gets a little worse after each one. I find the other barrier to giving information about the big picture well is time pressure. Our medical system is busy and I know as a doctor I rarely have as much time as I would like to spend with people. But for some discussions, we need to make time.

Giving people the information to make choices about their treatment helps them maintain a sense of control. This should include the choice to withdraw from treatment if it isn't working or if it's becoming too uncomfortable.

The purpose of palliative care is to use medical expertise and compassion to ease pain and other symptoms associated with the dying process, like nausea, shortness of breath, or delirium-which is when someone gets disoriented or agitated because of his illness. It requires a team of people including doctors, nurses, social workers, volunteers, chaplains, and family members. It takes time and energy. I think we have to be careful when we say 'dying people are not a burden'. I wouldn't want any dying patient to feel we would be better off not having to look after him, but it is important to acknowledge the effort that caregiving takes. I would say it *can* be burdensome, but it doesn't mean the burden is unwelcome. In fact, where would we be without these burdens in life? We might have more time for ourselves, but it would be less meaningful.

Everyone on the team needs to be willing to suffer with the dying patient. We will never be able to eliminate all suffering. Dying involves grief, letting go, and loss of

function. Unresolved issues from the past often need to be worked out-like family conflicts or spiritual battles. Friendship and support can help a dying person to turn these difficult moments into “opportunities for personal growth.”<sup>1</sup>

Our system is imperfect and despite our best intentions, dying people often suffer more because of waiting, poor communication, or just complications of their disease that are hard to manage. It takes creativity and commitment to overcome these barriers to good palliative care.

To conclude, I have three thoughts. First, I would encourage us all to acknowledge our own mortality. Picture the urn at the end of your bed. I think it helps us to live better and to prepare to die well.

Second is to remember that the decisions we make at the end of our lives don't just affect us. We live in a community and we die in a community. Choosing physician-assisted suicide is not a private decision, affecting only the dying person. It affects the freedom of doctors and nurses everywhere. It most definitely affects the doctors and nurses directly involved. And it will affect families. When I see depressed patients, one of the important questions to ask is if they have been pondering suicide. They often respond that it's crossed their mind, but they could never do that to their families. We intuitively know that it will be hard for our family if we die by suicide. This applies at the end of life as well. Conversely, a good death can have a positive impact on those around us. It is a huge consolation for family members to know that they did their best to help their dying family member and to know that person reached acceptance.

Finally, to give you some hope-remember that physician-assisted suicide was not introduced to this country by doctors. The majority of Canadian doctors are committed to curing illness, and when they can't, to help their patients die a natural death. There is no doubt that palliative care can be improved-and I know many good people who are working tirelessly on that. We will not give up.

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<sup>1</sup> Dr. Romyne Gallagher, “Doctor, can we get this over with?” *BC Medical Journal*, Vol. 58, No. 1, January, February 2016