



Deathbed disputation

Death talk: the case against euthanasia and physician-assisted suicide

Margaret Somerville

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Honesty requires, Margaret Somerville writes in *Death Talk*, that those who engage in the euthanasia debate disclose their position. She is against euthanasia. When I began reading her book, I was for legalizing voluntary euthanasia. Having finished her book, I still am.

The most personal and moving passage in *Death Talk* helped persuade me not to change my mind. Somerville was telephoned in Canada and told that her Australian father had brain metastases and would soon die. She flew to Australia and found him incoherent and in great pain. She insisted that a pain specialist be brought in. His treatment was changed, his pain controlled, and he lived "almost pain free" for another nine months. He told his daughter that "he wanted to live as long as he could — but not if he had to endure such terrible pain" and that he wanted her to do something to help others in the same situation. Somerville adds, in parentheses, "Probably not many of them had daughters who would 'go berserk' as he described me as having done, in order to obtain essential pain-relief treatment."

It isn't hard to believe that when a professor of law who is also the director of the McGill Centre for Medicine, Law and Ethics goes "berserk" in a hospital ward, her father's treatment would improve. But what about the unfortunate 99.999% of patients who do not have such well-qualified and passionate advocates? The sad reality is that many dying patients will continue to endure severe pain. Somerville's father said he would rather die than experience such

pain. Yet his daughter is telling patients in his position that they must live on.

In addition to patients like Somerville's father, who can be helped by better treatment, there are others who experience terrible pain that cannot be relieved, short of being rendered unconscious. Or they may suffer other distressing symptoms such as nausea, weakness and breathlessness. These patients should not be permitted to choose death, according to Somerville.

What argument does *Death Talk* offer in defence of overriding a patient's considered views in this most intimate of decisions? For a thick book, astonishingly little. This can be explained in part by the fact that the book is a collection of essays. Many essays go over ground already covered by preceding essays. For example, the question of how to define euthanasia is discussed, in essentially similar terms, in chapters 3, 5 and 7; the recent upsurge of interest in euthanasia is accounted for in chapters 3 and 6; the decision in the Rodriguez case is analyzed in chapters 3, 4 and 7; and an overlapping set of issues about pain relief are presented in chapters 11, 12 and 13. That a well-known professor should be invited to do so many congresses that she has to give essentially the same paper on several occasions is understandable; that she should compile them in a single volume without eliminating duplication is less excusable.

One would expect a book of more than 400 pages about voluntary euthanasia and physician-assisted suicide to include detailed examinations of the situation in Oregon, where physician-

assisted suicide has been legal since 1997, and the Netherlands, where for 20 years physicians have openly carried out voluntary euthanasia, and where the practice is now legal under specified conditions. But Somerville makes only passing references to Oregon, and her knowledge of the situation in the Netherlands appears shaky. In an exchange with Torsten Nielsen, an advocate of legalized euthanasia, she takes him to task for relying on a 1990 Dutch study that was repeated in 1995 "with different results in relevant and important aspects." Nielsen responds that the results of the 1995 study were not much different from those of the 1990 study. Somerville then claims that the 1995 study "provides evidence of serious abuses of euthanasia" but fails to specify in what way this evidence is different in the later study. (It isn't.) Nor does she tell her readers that much of what she describes here as "serious abuses" is exactly what she describes elsewhere as good medical practice: namely, withholding or withdrawing life support, or giving life-shortening doses of pain-relieving drugs. The only difference is that the more direct and honest Dutch study is prepared to describe such acts as medical decisions that shorten life, whereas Somerville focuses not on what a doctor knows the dose will do, but on what a doctor, in the privacy of his or her conscience, "intends" it to do (supposedly, to relieve pain, not shorten life).

Somerville cites no evidence to support the conclusion that, judged by the criteria used in the Dutch studies, doctors end the lives of more nonconsenting patients in the Netherlands than in any other country where euthanasia is illegal. Indeed, there is considerable evidence from several studies, including one that I carried out with colleagues in Australia, to suggest exactly the opposite: where voluntary euthanasia cannot be discussed openly, doctors end the

lives of more patients without obtaining the informed and considered consent of the patient.^{1,2}

Nor does Somerville ask why, if there is so much serious abuse of euthanasia in the Netherlands, both houses of the Dutch parliament were prepared to vote overwhelmingly, after the publication and widespread discussion of both the 1990 and 1995 studies, to legalize a practice that had, hitherto, merely enjoyed immunity from prosecution. Nor does she consider why the Netherlands' neighbour, Belgium, appears ready to follow the Dutch example and become the next country to legalize voluntary euthanasia.

Perhaps Somerville is not much interested in the facts because her opposition to euthanasia rests on something so vague that facts are scarcely relevant. She wants us to "think in terms of the secular sacred." The "secular sacred" is apparently something that we "have allowed science to obscure," but Somerville doesn't do much to dispel this obscurity. She wants us to develop a new sense of community and to focus on "trust and responsibility" rather than on individual rights. But trust is not an argument against voluntary euthanasia. The Dutch trust their doctors not to leave them to their suffering when they can't bear it any more and want to die. Somerville tells us that we "need to sing 'the song of life: the lyrics of love,'" but she never tells us how these lyrics will help those who, terminally ill and in pain or distress, see no point in enduring another month, week, or day of a life that has sunk forever below the level they consider acceptable. Why should they not be allowed to choose their own song?

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References

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Room for a view

Into that good night

Rage, rage against the dying of the light. — Dylan Thomas

The melancholy smell of burning sweetgrass wafts through the ICU, replacing for a moment the omnipresent odour of sterility. Someone has died. His family crowds around the bed, competing for space with IV poles and beeping machines. His lungs move in ventilator rhythm; his heart beats, as the monitor tells us. Soon his body will follow his mind. His organs will give someone a second chance.

The next day, I notice two Buddhist nuns praying over the body of a young woman. Another body no longer inhabited by a mind.

Here on the unit, the line between life and death is faint. Sometimes it disappears altogether. Is a body supported by dialysis, inotropes and ventilators truly alive? Or, a functioning body without a mind: Is that life? Most patients, of course, come here to live. But sometimes we prolong dying rather than living. Nurses know. They give a resigned shrug on daily rounds, reciting lab values and vital signs without real conviction, until someone finally says, "Stop — it is hopeless."

Where *do* we draw the line? We are trained to attempt everything possible. Even if our reason tells us it is hopeless, our hearts tell us to cling tenaciously to an improving lab value or the slightest change in cognition. We rage against the dying of the light with our mightiest pharmaceutical guns. We fight with technology. But we do not conquer. It is not easy for us to give in to death.

Part of the challenge is to face our own mortality. That 25-year-old motor vehicle accident victim could be me. Or my sister. Or my friend. Here, where we gather the sickest patients together, we face death every day, making decisions that may hasten, or delay, death. This is the core of the medical ivory tower. But the technology does not make the decisions any easier.

I observe those around me, their reactions to death. Black humour pervades. After an unsuccessful code one resident says a quick prayer at the patient's bedside while his colleagues gather outside the room, joking about an unrelated matter. I stand bewildered. I have not figured out a sensible way to react to death. It occurs to me that I didn't know the patient's name. I have a funny feeling in my throat. I swallow hard a couple of times and join the others outside.

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