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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Room for a view

Into that good night

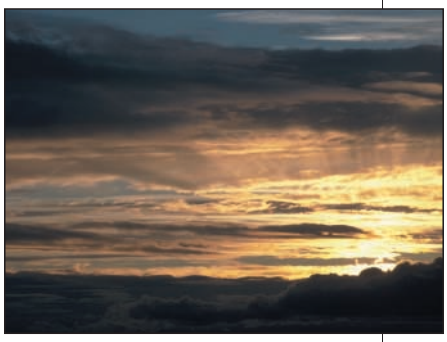
Rage, rage against the dying of the light. — Dylan Thomas

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.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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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