Committee on Dying with Dignity

Bruyère Continuing Care, located in Ottawa, provides complex continuing care, palliative care, rehabilitation, care of the elderly, long-term care and family medicine, as well as teaching and research in those programs.

Bruyère Continuing Care is the champion of well-being for aging Canadians and those requiring continuing care helping them become and remain as healthy and independent as possible through innovative and compassionate care, research, education and advocacy.

One of the largest health care centres of its kind in Canada, Bruyère Continuing Care includes: Saint-Vincent Hospital, Élisabeth Bruyère Hospital, Saint-Louis Residence, Élisabeth Bruyère Residence, Bruyère Family Medicine Centre, Primrose Family Medicine Centre, Élisabeth Bruyère Research Institute and Bruyère Foundation.

Élisabeth Bruyère Hospital is also home to the largest academic palliative care unit in Canada and therefore has an important role to play in this discussion.

Attached is a briefing note submitted by Dr. Rene Leiva, Assistant Professor (VPT), Department of Family Medicine, University of Ottawa, Department of Care of Elderly, Bruyère Continuing Care/ The Ottawa Hospital.

SOINS CONTINUS
Bruyère
CONTINUING CARE

Bruyère pour des soins continus.
Bruyère Is Continuing Care.

Hôpital Élisabeth-Bruyère Hospital
43, rue Bruyère St.
Ottawa ON K1N 5C8
Tél./Tel.: 613-562-6262
Téléc./Fax: 613-562-6367

Hôpital Saint-Vincent Hospital
60, avenue Cambridge Ave. N.
Ottawa ON K1R 7A5
Tél./Tel.: 613-562-6262
Téléc./Fax: 613-782-2785

Institut de recherche Élisabeth-Bruyère
Élisabeth Bruyère Research Institute
43, rue Bruyère St.
Ottawa ON K1N 5C8
Tél./Tel.: 613-562-6045
Téléc./Fax: 613-562-4266

Résidence Saint-Louis Residence
879, ch. Hiawatha Park Rd.
Ottawa ON K1C 2Z6
Tél./Tel.: 613-562-6262
Téléc./Fax: 613-683-5001

Résidence Élisabeth-Bruyère Residence
75, rue Bruyère St.
Ottawa ON K1N 5C8
Tél./Tel.: 613-562-6262
Téléc./Fax: 613-562-4223

Centre de médecine familiale Bruyère
Bruyère Family Medicine Centre
75, rue Bruyère St.
Ottawa ON K1N 5C8
Tél./Tel.: 613-241-3344
Téléc./Fax: 613-241-1971

Centre de médecine familiale Primrose
Primrose Family Medicine Centre
35, rue Primrose St.
Ottawa ON K1R 0A1
Tél./Tel.: 613-230-7788
Téléc./Fax: 613-230-7778

Fondation Bruyère Foundation
43, rue Bruyère St.
Ottawa ON K1N 5C8
Tél./Tel.: 613-562-6319
Téléc./Fax: 613-562-6023

Affilié à / Affiliated with

uOttawa

July 16, 2010

National Assembly of Québec
Committees Secretariat
Pamphile-Le May Building
1035 rue des Parlementaires, 3rd floor
Québec, Québec G1A 1A3

Re: General consultation and publics hearings on the issue of dying with dignity (Briefing)

Doctors and society should not be open to euthanasia and assisted suicide as solutions to our patients' suffering.

Behind the fears of existential suffering or becoming a burden to loved ones or feelings of hopelessness and worthlessness, there is a call for help to find meaning even in the midst of such suffering.

When death becomes the answer, we as human beings have lost the opportunity to go beyond our limitations, try harder, and offer hope to these people. Agreeing with assisted suicide is an affirmation that, depending on the circumstances, some lives are not worth living and need to be terminated. At a recent American Psychosocial Oncology Society conference, researchers presented evidence that medical personnel were among some of the most important sources of hope for patients. Mother Teresa used to say that "the feeling of unwantedness, especially from those who are supposed to love and care about us, is the worst threat to our human dignity."[2]

Amid these overwhelming fears, a free, autonomous decision about euthanasia is an illusion. The troubles of human relationships within families become accentuated, and problems of physician error and abuse in an already stressed medical system abound. It would be difficult to ensure that the choice of suicide is freely made and adequately informed.

Eventually, society will not be able to defend the most vulnerable from abuse, and doctors will become death dealers instead of healers. Despite assertions from euthanasia supporters to the contrary, countries where euthanasia is legal have suffered from it. Els Borst-Eilers, who served as Health

Minister for the Netherlands from 1994 to 2002 and who is a doctor herself, proposed the country's infamous euthanasia bill. Now, however, she thinks the government acted too soon, to the detriment of palliative care.[3]

Even the United Nations Human Rights Committee is concerned by the extent of euthanasia and assisted suicides in the Netherlands: a physician can terminate a patient's life without any independent review by a judge or magistrate to guarantee that the decision was not the subject of undue influence or misapprehension, second opinions can be obtained from a telephone hot-line, and there is no prior judicial review of physicians' decisions to terminate patients' lives in circumstances in which the patients are not able to make the request themselves.[4]

As palliative care physician John Scott said in his submission to the legislative committee on Bill C-203 on November 19, 1991, said it well:

"As we watch suffering, we too share in the lament. When death approaches, we cry out and at times even cry out for death, but we must reject the temptation to kill. Hear the cry of life at the heart of the lament. Neither physician nor legislator must presumptuously respond to the lament by silencing the one who issues the cry. [5]

In fact, our contention is that a physician who procures euthanasia is falling victim to our current attempts for technological, quick-fix medical responses that have permeated our medical approach. It is no wonder that pagan Greek physicians, who adhered to the Hippocratic tradition, rejected euthanasia. They knew it was the wrong approach. Philosopher Daniel Callahan said, "Euthanasia ... is an act that requires two people to make it possible, and a complicit society to make it acceptable." [6]

People with disabilities are concerned with euthanasia.[7] People do lose their trust in their doctors. Elderly Dutch have fled to Germany because they fear their doctors and even their friends, as reported in the 2008 French government report to the National Assembly.[8] In addition, despite the very poor legal reporting of euthanasia in the Netherlands,[9] it is clear that a large number of people's lives are being terminated without explicit request (i.e., murder).[10] In fact, there are fewer deaths in Canada from cervical cancer than deaths in Holland without explicit request.[11]

From 1997 to 2004, all cases of deliberate euthanasia in newborns concerned babies with non-terminal illness (e.g., spine bifida and hydrocephalus).[12] Even the new law for these cases has failed to set "safe criteria" for who dies and who lives.[13] The past 40 years of euthanasia in Holland proves there is a slippery slope. It has moved from being applied to the very terminally ill to the chronically ill (including those with depression, psychological distress, a "tired of living" mind-set, and dementia) and from a voluntary to non-voluntary (e.g., severely handicapped newborns) capacity. "Suicide counselors" are legal and doctors are expected to provide "reliable information on how to commit suicide."[14–18] . Recently the law has been being challenged to include "time to die" criteria.[19]

In Belgium, the rate of deaths without explicit request is 3 times higher than in Holland,[20,21] and patients can be euthanized in the operating room and donate their organs for transplantation.[22] The Oregon experience is alarming as well, but I will spare you the details with the exception of one illustrative example: In 1998, 25% of patients requesting euthanasia received psychiatric consultation while in 2010 none did. Proper end-of-life care suffers.[23]

"You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die," said Dr Dame Cicely Saunders (1918–2005), founder of modern palliative care.[24]

The real question is how to support "dignity" in the midst of existential suffering. Here lies the challenge. One suggested approach includes creating strategies for developing the right attitude, behaviour, compassion, and dialogue toward our patients.[25] The recent annual conference of the American Psychosocial Oncology Society presented novel and exciting research in this area. Work needs to be done. However, we all have the power to respond to the illness of others with care and solidarity in order to uphold and protect their dignity until the moment of natural death. Ultimately, the final answer resides in the advice from Holocaust survivor Dr Viktor Frankl: '"Love is the only way to grasp another human being in the innermost core of his personality."[26]

We, at Bruyere Contininuing Care, support life affirming choices. Euthanasia takes us in the wrong direction. It distorts patient-doctor relationships, leaves physicians off the hook too easily in challenging situations, violates health professionals' moral autonomy, and dehumanizes physicians as they become executioners. We can do better than euthanasia — we must.

Rene Leiva, MD CM, CCFP (COE/Pall Care)
Assistant Professor (VPT), Department of Family Medicine, University of Ottawa
Department of Care of Elderly, Bruyère Continuing Care/ The Ottawa Hospital
43 Bruyère Street, Ottawa, ON K1N 5C8
Tel: 613-562-6262 ext 1398

http://www.bruyere.org/bins/index.asp

References

1. Boisvert M. Should physicians be open to euthanasia? Yes. *Can Fam Physician* 2010;56:320, 322. (Eng),**[Free Full Text]**
2. Langford J. *Mother Teresa's secret fire.* Huntington, IN: Our Sunday Visitor; 2008.
3. Caldwell S. Now the Dutch turn against legalised mercy killing. *Daily Mail* 2009;(Dec). Available from: **www.dailymail.co.uk/news/article-1234295/Now-Dutch-turn-legalised-mercy-killing.html#ixzz0lj4ZGChX**. Accessed 2010 May 11.
4. Human Rights Committee. Human Rights Committee concludes ninety-sixth session [news release], New York, NY: United Nations; 2009;(Jul). Available from: **www.unhchr.ch/huricane/huricane.nsf/0/1E96D3DB91309495C12576040053E5DE?opendocument** . Accessed 2010 May 7.
5. Campaign Life Coalition. *Euthanasia briefing book.* Ottawa, ON: National Public Affairs Office; 2002. Available from: **www.campaignlifecoalition.com/documents/Euthanasia_Briefing_Book.pdf**. Accessed 2010 May 10.
6. Kuhse H, Singer P. When self-determination runs amok. *Bioethics. An anthology.* 2nd ed ed. Malden, MA: Blackwell Publishing; 2006. p. 381–5.
7. Coleman D. Not dead yet. In: Foley KM, Hendin H, editors. *The case against assisted suicide: for the right to end-of-life care.* Baltimore, MD: Hopkins Fulfillment Service; 2004. p. 213–37.
8. Leonetti J. *Rapport d'information fait au nom de la mission d'évaluation de la loi N° 2005-370 du 22 avril 2005 relative aux droits des malades et à la fin de vie [Tome 1].* Paris, Fr: Assemblée nationale française; 2008. Report No. 1287. Available from: **www.assemblee-nationale.fr/13/rap-info/i1287-t1.asp**. Accessed 2010 May 11.
9. Onwuteaka-Philipsen BD, van der Heide A, Koper D, Keij-Deerenberg I, Rietjens JA, Rurup ML, et al. Euthanasia and other end-of-life decisions in the Netherlands in 1990, 1995, and 2001. *Lancet* 2003;362(9381):395–9.**[Medline]**
10. Van der Heide A, Onwuteaka-Philipsen BD, Rurup ML, Buiting HM, van Delden JJ, Hanssen-de Wolf JE, et al. End-of-life practices in the Netherlands under the Euthanasia Act. *N Engl J Med* 2007;356(19):1957–65.**[Abstract/Free Full Text]**
11. Canadian Cancer Society, National Cancer Institute of Canada, Statistics Canada, Provincial/Territorial Cancer Registries, Public Health Agency of Canada. *Canadian cancer statistics 2005.* Toronto, ON: Canadian Cancer Society; 2005.
12. Verhagen AA, Sol JJ, Brouwer OF, Sauer PJ. Deliberate termination of life in newborns in the Netherlands; review of all 22 reported cases between 1997 and 2004 [article in Dutch]. *Ned Tijdschr Geneeskd* 2005;149(4):183–8.**[Medline]**
13. Sheldon T. Dutch law leads to confusion over when to use life ending treatment in suffering newborns. *BMJ* 2009;339:b5474.**[Free Full Text]**
14. Hendin H. The Dutch experience. *Issues Law Med* 2002;17(3):223–46.**[Medline]**
15. Sheldon T. Dutch approve euthanasia for a patient with Alzheimer's disease. *BMJ* 2005;330(7499):1041.**[Free Full Text]**
16. Sheldon T. The Netherlands regulates ending the lives of severely ill neonates. *BMJ* 2005;331(7529):1357.**[Free Full Text]**
17. Sheldon T. Dutch court acquits suicide counsellor of breaking the law. *BMJ* 2007;334(7587):228–9.**[Free Full Text]**
18. Sheldon T. Dutch doctors publish guide to "careful suicide." *BMJ* 2008;336(7658):1394–5.**[Free Full Text]**
19. Sheldon T. Dutch politicians are under pressure to hold "time to die" debate. *BMJ* 2010;340:c1045. DOI: 10.1136/bmj.c1045
20. Van den Block L, Deschepper R, Bilsen J, Bossuyt N, Van Casteren V, Deliens L. Euthanasia and other end of life decisions and care provided in final three months of life: nationwide retrospective study in Belgium. *BMJ* 2009;339:b2772.**[Abstract/Free Full Text]**
21. Van den Block L, Deschepper R, Bilsen J, Bossuyt N, Van Casteren V, Deliens L. Euthanasia and other end-of-life decisions: a mortality follow-back study in Belgium. *BMC Public Health* 2009;9:79.**[Medline]**

22. Ysebaert D, Van Beeumen G, De Greef K, Squifflet JP, Detry O, De Roover A, et al. Organ procurement after euthanasia: Belgian experience. *Transplant Proc* 2009;41(2):585–6.**[Medline]**
23. Hendin H, Foley K. Physician-assisted suicide in Oregon: a medical perspective. *Mich Law Rev* 2008;106(8):1613–40.**[Medline]**
24. Saunders C. Care of the dying—1. The problem of euthanasia. *Nurs Times* 1976;72(26):1003–5.**[Medline]**
25. Chochinov HM. Dignity and the essence of medicine: the A, B, C, and D of dignity conserving care. *BMJ* 2007;335(7612):184–7.**[Free Full Text]**
26. Frankl VE. *Man's search for meaning.* Gift edition ed. Boston, MA: Beacon Press; 2000.