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EDITORIAL

THE DEATH MENU
How would you like to die sir?

BY

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We are all used to the head waiter in a restaurant standing by the side of a table offering a food menu and asking what would you like to eat sir ?. But we are not-yet-used to a doctor standing by the bed side of a patient and asking how would you like to die sir ?. This is what is almost happening in some countries now, Holland is a good example. But how did they get there?. Let us get the story from the beginning.

If you are not of the lucky few who will die suddenly or die during sleep, then you are more likely than not to end dying in an intensive care unit (I.c.u.) of a hospital, with half a dozen of wires connecting you to a monitor above your head where everyone can see it except you, as if it's not your business. Moreover you will have quite a few tubes inserted down you and up you. One down the throat to your lungs and another down the nose to your stomach, a third through your neck to the heart and a fourth up your urethra to reach the urinary bladder. And these are only the basic set, other tubes may be inserted to different parts of your body according to your needs as perceived by the doctors in charge.

An alert patient in an I.c.u. does not enjoy a moment of privacy. There will always be a few persons around your bed pushing medications through you but gazing, all the time, at the monitors as if you do not exist. Of this crowd none is a relative or a friend, no familiar face, those are kept outside because it's not visiting hours and when it is your condition is probably critical and cannot accommodate visitation . You may have liked to say goodbye to the loved ones in a more comfortable and less hostile environment, but no way, modern medicine has certainly prolonged our lives but at the same time has prolonged our dying and has made a spectacle of the last moments of life.

In the face of this oft-repeated situation euthanasia was summoned to the medical field. Hesitantly and shyly at the beginning , but soon as an option in certain indications.

Euthanasia was the first step down a slippery slope. A classical indication at the beginning was the patient with widespread malignant tumor not responding to any treatment , progressive and causing the patient severe pains. The patient is begging the family and the doctors in charge to get on with it and end his life or at least let him alone to die sooner. He does not want to stay hanging in the rope down the cliff. He is simply saying if you doctors cannot pull me up, then please cut the rope.

If you think euthanasia is reasonable in such a condition, then just wait to see what followed.

Gradually but quickly, it was argued - and rightly so- that malignant disease is not the only incurable disease and is not the only painful disease. And by applying logic of the first order the indication for euthanasia should extend to cover all identical or closely similar conditions. It was also argued that there are -apart from pain-other undesirable symptoms as distressful as pain. It was further argued that pain is not only of somatic origin. In fact psychiatrists say that depression is the most painful disease in medicine, and certain types of depression are incurable.

So the indications of euthanasia extended to many other conditions and expanded to include persons who are-believe it or not- tired of living or who think that their life is not worth living, purely subjective indications. To me tired of life or that life is not worth living is a kind of life and a life style problem of social and environmental nature, maybe with a certain psychological background. It is certainly not a medical condition that justifies termination of life. Who of us did not feel,at one time or another,that he is tired of living or that life is not worth living?. Let us remember that of those who survive a trial of suicide only 10 % try again.

Added to all of the above is the western understanding of the concept of autonomy which is considered there to include the right of the person to do whatever he likes to himself or with himself provided that his actions do not extend to someone else. A debatable concept since every person is a member of a family, group or society and any drastic action affecting him will- at least indirectly- affect others. But this indirect effect was ignored and any personal action limited to one's body is considered an autonomous right. And in countries where suicide is not a crime and autonomy supports this , suicide became a right for each individual. If this individual would like to exercise his right but cannot because he does not know how or he is physically not capable, he logically has the right to ask for help. Such help is usually asked from a medical practitioner, and the request is usually supported by a sham medical reason for the doctor to use as an excuse. And this way assisted suicide was introduced in medical practice in these countries.

On the death menu also are other items that usually come from the patient's prior request as advance directives to the medical care providers, such as : No c.p.r. , meaning do not resuscitate if my heart stops. No ventilation, meaning do not put me on a mechanical ventilator if I stop breathing. No artificial nutrition,meaning do not feed me artificially if I cannot eat naturally.

So , the death menu is now quite rich:

----- Euthanasia:

Voluntary
Non voluntary
By guidance only
By actual help
By lethal drug
By suffocation

----- Assisted suicide:

By guidance only
By actual help
By lethal drug
By other methods

----- Advance directives:

No c.p.r.
No ventilation
No artificial feeding

All of these methods that are meant to expedite death, are based on the assumption that a suffering person will stop suffering after death; an assumption that has never been proven scientifically and is not accepted by many religions.

If I am not happy with the way people die in an I.c.u.- which is the fate of most of us - eventually- where they die in spite of medical care; and I am not happy with euthanasia and assisted suicide where people die with the help of medical personnel, what is the alternative then?.

The alternative is palliative care that includes besides control of symptoms, psychological support and social help that may need be extended to close members of the family. The classical protocols of management applicable to the regular patient should be modified to suit the terminally ill. Since the objective is palliative care, symptomatic treatment should be liberal and intensive. We may have to cross the line of the standard or even the safe dose but stop at a good distance from the lethal dose. Liberal visiting hours should be arranged for the inpatient and whenever possible palliative care at home is preferable.

Palliative care specialists should work harder to develop this practice into a medical speciality. As neonatology was developed to look after us at the beginning of our life, palliative care should develop to look after us at the end of our life. We deserve it.

Our job as doctors is to care and cure, to preserve life not to end it. When a patient dies he should die in spite of our maximum efforts, not to die with our help to save our efforts. We should never be death agents. Those who insist to die should find for themselves another arena but the medical arena which is for help to cure and not for assistance to die.

We should not,at any time, be in a situation where we stand by the bed side of a patient offering him a death menu and asking him how would you like to die sir?.

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