Ian Donald believes we must recognise life has a natural end

A time to LET GO?

key points

Pressure for physician-assisted deaths is driven by a culture of individualism and choice, but also by many people's fears of what their last days or weeks of life will be like.

The author, a geriatrician, argues that therapeutic and symptomatic care must go hand-in-hand, and that we must also recognise the onset of natural death. Many deaths in Old Age Medicine departments are uncomplicated and undramatic.

He concludes with the Physician's Prayer, which ends '*from making the cure of the disease more grievous than the endurance of the same, good Lord deliver us*'.

The growing public support for physician-assisted dying is driven by many factors, including a consumer-driven culture of individualism and choice. This is essentially self-centred, and undervalues our interdependence – the essence of a caring and loving society demonstrated by strong intergenerational ties and the commitment to care for the most dependent.

Christians are called to be like Jesus, demonstrating love and compassionate care and travelling with those who approach the end of life, while seeking to minimise their suffering in that journey.

One factor determining the views of so many regarding euthanasia is the fear of what those last days or weeks of life will be like. For many, their view will be formulated by witnessing another's death – family or close friend, or perhaps, for those in healthcare, at work. Paul Badham has written a Christian apology for physician-assisted dying,[1] and his views were shaped by witnessing distressing family deaths. How is it that during the generation that has discovered palliative medicine, in a country that arguably leads the world in palliative care, public clamour for euthanasia has still grown? I believe some of the blame must belong to modern medicine – many now fear that doctors will keep them alive long beyond their natural life, and beyond what they would wish.

Fear of dying badly

It is untrue that medicine is the principal reason for longevity today – it is of course more related to public health and nutrition. Although old age may make little sense to strict 'survival of the fittest' evolutionary theory, we appear to be programmed to live into old age, and a few have always done so. Survival to 65 has changed dramatically in the last 150 years – from 5% to around 90%. The continuing improvement in life expectancy in the UK over the last 50 years of around 2.5 years each decade relates partly to public health changes and partly to better medical care of long term conditions.

The Bible has vivid descriptions of old age – notably that of Solomon in Ecclesiastes 12, where the realities of frailty are even more explicit than Shakespeare's seven ages of man. The biblical view appreciates the wisdom of the aged,[2] and many societies acknowledge the contribution of the elderly to leadership, while in Britain we poke fun at any political leader over 65. The Bible also emphasises our duty to respect older people and support them, either through the family structure or the church – some churches today need to be reminded of this important way we can demonstrate God's love in our community.

Yet for most people it is not the fear of growing old *per se* that worries them – life free of significant disability is also lengthening,[3] witnessed by productive retirement for many. The alternative of a premature death is hardly attractive! Rather it is the prospect of a prolonged period of disability, followed by undignified suffering, culminating in a hospital bed wired up to machines.

In reality, death in the UK through switching off life-support is uncommon. Many more though will experience a hospital admission when we are striving to save life, followed by a period of palliative care. Ideally palliative (or symptomatic) care should go hand-in-hand with therapeutic care, but the impression to the public will often be a sudden switch from a therapeutic to a palliative

approach. Junior doctors naturally find this change difficult, with their strong desire to save and prolong life whenever possible. They will have seen the times when intravenous diuretics or powerful antibiotics have brought someone back to life.

Life's natural end

Patients and their families often know when life is coming to an end. Hospital doctors who know them less well may find this more difficult to recognise. As Christians we want to enable our patients to live their full life, and that includes recognising its natural end.

The experience of dying involves letting go – for the patient and for the family – and clearly it also requires the doctor to let go. We naturally cling to life, and, as doctors, will always seek therapeutic options that might be offered. But there will be many times when we can only relieve symptoms. We must be comfortable with the withdrawing or withholding of treatments which are ineffective, when almost certainly the burdens of treatment clearly outweigh the limited or non-existent benefits. Judging whether the treatment is still offering benefit can be difficult, and requires team working and experience. Recent GMC advice on treatment, including hydration and nutrition towards the end of life, has been very helpful here.[4]

Some doctors may feel uncomfortable judging quality of life – 'Is her life worth saving?' – in determining when they might 'switch' from therapeutic to palliative care. For the non-Christian this may become a very utilitarian judgment, which allows them to be somewhat dispassionate. The Christian doctor will naturally run a mile from this, and may feel that the 'sanctity of life' commits them always to prolong life for as long as possible using whatever means they can. Yet this would be a wrong understanding of the sanctity of life, which principle is better termed *Imago Dei*, made 'in the image of God'. This conveys the unique and special value of each human, treasured by their Maker. We should treasure, honour and respect that life from its beginning to its natural end. We cannot deny that we are mortal. Our respect for that life cannot then be warped into prolonging parts of that person artificially.

A better way

Yet there is a better way, which takes us away from 'playing God'. It is about listening – using all our skills to look for the signs that tell us this person's life is coming to an end. We can embrace this in the same way that Jesus cried 'It is finished'.[5]

Many people know for themselves. Some will 'turn their face to the wall', and we need to learn to distinguish this from clinical depression. We will not always know or be right, but can always give treatment to relieve symptoms. As we listen and give symptomatic relief, we can be honest in where we think the journey is going, yet humble enough to admit we cannot know for sure.

I believe the vast majority wish to live their natural lifespan. They want medicine to try and cure their ailments, and they want to live into old age and see the generations following them. Today the average age at death for women is 82 and still increasing. But people also want a peaceful end when life is over. Death will always be sad regardless of the age when it comes. In old age, many deaths witnessed in Old Age Medicine departments are uncomplicated and undramatic.

Releasing and letting go

So both healthcare staff and family need to understand the importance of releasing and letting go, and handing over to God's sovereignty. Yet this should not lead to pointless waiting – rather it can be a time of continued listening, a time of healing of relationships, as well as a time of preparation for death. 'Show me O Lord, my life's end and the number of my days; let me know how fleeting is my life.'[6]

How often today do we see someone dying 30-50 days after an admission and feel ashamed at how much they have suffered in their last illness? Of course we are right always to give someone a chance, either at their request or acting in their best interests. But we must do so humbly and sensitively, always listening. Our passionate concern for our patient should not blind us to when things are not working out – as if it was our own reputation at stake that the patient should leave the hospital well.

The public remain confused about euthanasia – many will believe that without it, doctors are committed to attaching tubes and sticking in needles right to the last minute of life. Our junior doctors are also confused, with the power of modern medicine deceiving them to believe they must make God-like decisions on who is worth treating. If modern medicine is partly to blame for the clamour for euthanasia, we now must not only strive for the very best in palliative medicine available to all, but also reduce excessive unwanted medical care.

When doctors routinely combine therapeutic and palliative medicine in their dealings with older people, then perhaps we will create the setting where patients can express their wishes more clearly, and death can be discussed more openly. The most heartfelt thank you letters to an elderly care department in the hospital come from bereaved families.

The physician's prayer[7]

From inability to let well alone, from too much zeal for the new, and contempt for what is old, from putting knowledge before wisdom, science before art, and cleverness before common sense, from treating patients as cases and from making the cure of the disease more grievous than the endurance of the same, good Lord deliver us.

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As Christians we want to enable our patients to live their full life, and that includes recognising its natural end

references

1 Badham P. Is there a Christian case for assisted dying? SPCK 2009
2 Job 12:12; Luke 2:25
3 Donald IP *et al*. Trends in disability prevalence over 10 years in older people living in Gloucestershire. *Age and Ageing* 2010;39:337-342
4 Treatment and care towards the end of life: good practice in decision making. General Medical Council, July 2010. *www.gmc-uk.org/guidance/ethical_guidance/6858.asp*
5 John 19:30
6 Psalm 39:4
7 Attributed to Sir Robert Hutchison (1871-1960). *BMJ* 1998; 317 (7174): 1687