Learning to touch the patient's soul: a difficult lesson from the Netherlands

To the Editor In his article,[1] Carlo Leget, a Dutch researcher and humanist, Chair of the European Association for Palliative Care (EAPC) Taskforce on Spiritual Care in Palliative Care, discusses the cultural and value-oriented aspects of Dutch mentality that have led to the introduction of euthanasia and physician-assisted suicide as legal procedures. At first glance, the reader may get an impression that this is only a Dutch "problem"; however, on closer look, it is not. Especially the second part of the article, which focuses on the relation between euthanasia and spirituality, reveals a universal message for contemporary medicine.

Why spirituality? First of all, it needs to be underlined that spirituality is widely defined as a dimension in which a human being relates himself or herself to the transcendence and existential values. Broadly speaking, this involves a personal relation to the search for the sense of living, dying, and suffering; to own dignity, autonomy, and hope; to oneself and others; and to the question of "who I am". Religiousness, being part of spirituality, has been recognized as an important factor preventing the development of euthanasia legislation. Thus, the steady increase in officially reported cases of euthanasia and physician-assisted suicide can be related to some extent to the process of secularization. However, we still need to deal with the question why the dominant motives for the wish to hastened death in the United States, Canada, and European countries are the loss of autonomy (eg, to be dependent on others and not to be able to decide/control one's own life), loss of dignity (eg, to be disrespected), being a burden to others, and being less able to enjoy life's activities, which may be either already experienced by an individual or anticipated in the future.[2,3]

Studies on a geriatric population who felt that "life is completed and no longer worth living"[4] or asked for spousal self-euthanasia[5] raised the questions about a close association between death wishes and depression and pointed to the sense of aching loneliness, pain of not mattering, growing emptiness of life, inability to express oneself, multidimensional tiredness, and the sense of aversion towards feared dependence as the reasons for such requests. Interestingly, all countries in which euthanasia or physician-assisted suicide is permitted have a very well-developed system of care for elderly people and palliative care available not only for cancer but also for noncancer patients.

Why do people prefer to be killed rather than to be cared for by the loved ones and by professional caregivers? Why do they not trust the health care system? Why do they feel offended and disrespected while becoming more vulnerable? Leget wrote about the visible and nonvisible pressure exerted by the culture of control both on patients and on medical professionals, which leads to decisions to "do rather than undergo", thus paradoxically compromising the patient's autonomy.[1] That is why, the message "there is nothing more to cure or modify the disease" is even likely to evoke a sense of abandonment (felt not only by the patient[6] but also by the doctor, who may feel that by not offering any curative treatment he or she abandons the patient).[7] In modern medicine, "caring for" is still much less valued (also in financial terms) than "curing". Clinicians who administer chemotherapy or perform even a minor surgery are much more esteemed than those who spend the whole day taking care of a patient with advanced dementia. However, this "doing something" approach in clinical practice may take us too far away from what really matters to the patient.

The concept of whole-person care in contemporary medicine, promoted especially by the George Washington Institute for Spirituality and Health, emphasizes the necessity of a holistic approach to the patient's needs with spiritual care as an integral part of the health care system.[8] This means implementation of substantial changes into the education and practice in all branches of medicine (not only end-of-life care) so that the health care personnel learns how to be with the patient (even for 10 minutes of a consultation) as if the patient was the only person in the world; how to truly listen to patients as they reveal their inner selves; how to show respect as for somebody who is unique, also, or rather above all, in little things; and finally, how to ask patients about their will, wish, or preferences, especially when the patients gradually lose their independence. It

does not make our professional life more miserable; on the contrary, it restores the healing relation between doctors or nurses and the patient.

The article by Leget[1] is not only about the Dutch (or Belgians or Canadians) asking for (and receiving) euthanasia because of their specific attitude to life and death and autonomy. It is about the need for medical professionals to learn how to touch the soul of the sick, elderly, and lonely people to help them grow as unique human beings. It is the best way to protect our patients and free them either from the "duty to fight at all cost" (with demand to implement/introduce an overzealous or futile therapy) or from the "duty to die" (with the wish to hasten death).

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