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Brief Academy

Commentary on “Reflections about euthanasia in Colombia”[☆]



Comentario sobre “Reflexiones acerca de la eutanasia en Colombia”

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We have read with great interest the Reflections about euthanasia in Colombia.¹ It has reminded us that the support to decriminalize euthanasia is usually based on ordinary arguments²: an emotional appeal of someone else's pain, rejection of disproportionate therapies, and praise to the autonomy of the individual.³ All of the above are mentioned in the text. With the emotional argument of *mitigating pain and suffering* to accomplish a *smooth and easy transit* or the idea of love and *feelings of human solidarity with the sufferer*,⁴ empathy is the logical consequence (“I wouldn't want to go through that”) and presume that what is appropriate and piety-deserving is giving the patient an efficient and immediate exit. The rejection we all have against therapeutic obstinacy (cause useless suffering because of failure to adapt the therapy to the patient's situation, prognosis and values) leads to extreme positions that present euthanasia as the only option to avoid and prevent such disproportionate treatments. Finally, this autonomist and individualistic argument, transforms the respect for the right to refuse therapy or choose among several options inherent to *lex artis*⁵ into submission to the patient's wish, imposing his/her will as the only healthcare criterion. Beyond these arguments, when the debate turns into radical positions, the rejection of euthanasia is frequently presented as a religious issue, a *Jewish-Christian* cultural atavism

or a moral imposition in the name of beliefs alien to a secular society.

The legal situation of euthanasia in Colombia is paradoxical,⁶⁻⁸ something that is increasingly evident from the outside. Although the Constitutional Court decriminalized *piety homicide*, until 2015 the Ministry of Health failed to pass a Resolution specifying how it should be done. The authors of *Reflections about euthanasia in Colombia* express their points of view on the subject, with particular emphasis on the definition of euthanasia. Regrettably, the glossary of the Protocol for administering euthanasia in Colombia of the Ministry of Health describes euthanasia as “The action or practice of killing or allowing to die from natural causes on compassion grounds; i.e., to relieve ...”⁹ is but one more example of the inconsistency in terminology. As the authors claim, *allowing to die* should not be part and parcel of the overall concept of euthanasia; changing or adapting the therapeutic approach, presuming an advanced and incurable condition and acting consistently, are ingredients of a sound and proportionate medical practice. In fact, under this scenario of poor semantics, it is not unusual that the term *dignified death* (o dying with dignity) is interpreted as a *light* synonym of euthanasia and assisted suicide. The mere ambiguity of the concept of euthanasia hinders the debate; the semantic discussion

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tending to limit the dignity of death to euthanasia or assisted suicide, also fails to make it clearer. Furthermore, this discrete manipulation of terms may discredit the practitioners that respect and promote the dignity of the patient, including his/her last few days, without causing death.

Euthanasia is not a substitute for Palliative Care. Neither is it complementary.¹⁰ Palliative care reduces and controls the physical symptoms characteristic of advanced conditions¹¹ and help to partially relieve the issues associated with loss of autonomy, gloominess or anhedonia that account for the few requests for euthanasia or assisted suicide in countries with properly developed palliative care.^{12,13} In Spain, the social debate on euthanasia re-opens occasionally when the media publicize a *borderline case*, with practically no impact on the healthcare arena. This is even more striking in the case of end-of-life care, where surprisingly, professional caregivers seem to be more reluctant to practice euthanasia.¹⁴ Also anesthesiology, defined as a means to alleviate pain, is apparently reluctant, or at least does not intervene in causing the patient's death. Finding papers in scientific journals that discuss the direct participation of the anesthesiologists, beyond certain cases of euthanasia within the family or domestic environment is not easy.⁴ At any rate, it is quite unreasonable to stir the social debate on euthanasia while the immediate and universal palliative care needs are still unmet. Would it be ethical to present euthanasia as the way to eliminate suffering in a group of patients for whom adequate symptom control is not accessible?

Lastly, the decriminalization of euthanasia should be supported by a regulatory framework protecting the rights of patients. While it should be possible to assess any medical action, further control shall be mandatory when practicing euthanasia. Understanding oversight after the procedures as something useless that delegitimizes the evaluation of the Interdisciplinary Scientific Committee and breeds legal distrust, equates to forgetting that any rule should have a control system to ensure adequate compliance. We physicians are also law-abiding citizens and hence should be able liable for our actions, particularly when these actions directly and irreversibly impact the lives of other people.

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