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SUICIDE, EUTHANASIA AND COMMON SENSE

The importance of neurolinguistic knowledge for modern medicine is difficult to overestimate. The analysis of language creation and evolution, perhaps music too, seems to be an excellent source of information about gene functioning mechanisms; however, the dialog between linguists and psychologists who have a humanistic background and biologists and physicians who come from the scientific circles encounters serious difficulties (Marcus, Rabagliati, 2006).

Unfortunately, the aim of my deliberation is not to provide any solution as to how to overcome these difficulties as it is simply impossible. Nevertheless, these problems should be mentioned at the beginning of the text written by a physician which is addressed to psychologists above all. The phenomenon which I am going to discuss should be perceived from both medical and social perspectives. The public viewpoint is mostly shaped by diversified political forces and the media. I see it mainly from the angle of the relationship between the physician, or the health service and the patient who has decided to commit suicide. The position and significance of the physician here is exceptional because people usually die in hospitals, and if it happens somewhere else, for instance at home, hospice, or in the street, according to the law the doctor has to declare him or her dead. Not only does the physician passively accompany us in these final moments of life, but also plays a key role in making decisions which can either shorten or prolong our lives. In a considerable number of cases the death of a patient is connected with “end of life decisions” (Van der Heide *et al.*, 2003). Moreover, such situations are

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not of episodic nature. A doctor's actions, or more often abandonment of them, are in a very close correlation with the death of many patients, and in many countries the number falls by half. Since it concerns the countries where medicine is highly developed, it can be expected that other developing countries will face the same situation in the future. It should be emphasized that it immensely concerns the abandonment of the so-called persistent therapy and the treatment improving the quality of life (mostly to relieve pain), which carries the risk of early death (double effect principle) (McCabe, 2008). Although the problem of euthanasia and related to it physician - or nurse-assisted suicide concerns a relatively small number of patients, it evokes significantly stronger emotions. Apart from the medical literature data, I can refer to my own professional experience of an internist. I have not kept any precise statistics, but I suppose I have treated approximately 25,000 to 27,000 of patients so far, of whom 600 to 700 died in my presence or in the wards I have been in charge of. Therefore, I can say that I know the circumstances of their death. The significance of euthanasia here seems even less important because I have only met two patients who really asked me to kill them, whereas the ethical problems connected with further escalation or abandonment of therapy occur in my medical practice every week, if not more often.

Suicides in internal wards happen rarely, approximately once per month, though there are times when a few patients commit suicide at the same time. It may be due to the weather or some other biopsychosocial conditions. However, the division of suicides into two types seems to be much more important than the statistic itself. The first type is a dramatically urge to attract attention, a less or more conscious "call for help", while the other one is a real "end of life" decision. Both types of suicides can be distinguished by circumstances. Those "calling for help" (Brown, 2005) attempt suicide are committed in places where the victim is likely to be found and rescued quickly, whereas "wishing to die" patients do it in secluded places. The former (mostly women) usually poison themselves, the latter most often hang themselves. I do not aim at summarizing a psychiatry or first-aid textbook here, but wish to emphasize that suicide which actually occurs in hospital is treated above all as a mental dysfunction and it is cured as such. Of course, appropriate measures have been taken to remove the social causes which have led to a suicide attempt.

It would be every physician's worst nightmare (at least in Poland) to witness passively his or her patient's death and perhaps relieve only the pain of such a person who has decided to die. Unfortunately, I think it is conceiv-

able that there will be such legislators who will have physicians perform this procedure only in the name of patient's freedom of choice. Dire consequences of recognizing that patient's rights are much more important than his/her health are also (but not only) premature deaths of those who did not agree to necessary treatment. In a sense the escalation of these rights may lead to the situation when physicians will have an obligation to witness the death of suicides or even quicken it. Evidently, medical knowledge seems to have difficulty in paving the way to legislators' minds, and the British Mental Capacity Act of 2005 is still an exception (Griffith, Tegnah, 2005).

Now I would like to return to the language deliberation and the idea of making suicide (regardless of its motifs and circumstances) and euthanasia equal. This suggestion is associated with the idea of accepting only such measures which do not harm others. This condition, however, limits to a similar extent any other kinds of behavior which can be accepted in the civilized world.

I regard this viewpoint, or rather idea as dangerous despite the noble intentions it seems to be based upon. It may increase "the number of human tragedies", even though the aims of its authors were completely opposite. The authors of this idea would certainly like to increase "the amount of happiness", but they did not consider the practical consequences of such an approach carefully. May an idea expressed in English lead to a different consequences than the one translated into Polish? Thinking is a language function and not everything, if any, may be easily translated. We appear to be good at translating words, but much more helpless with regard to acceptance and the melody of words, and this is how the French speak. The tune of an utterance influences its meaning. It does not mean that the communication between people who speak different languages is impossible. Yet, such a communication may be completely devoid of subtlety and different shades of meaning. Instead, the answers to a cruelly simple question remain. Should the physician be obliged to rescue life and relieve suffering, or does the contemporary world set him or her a "more important" task?

A doctor's participation in a death sentence execution or tortures appears as the ghosts of a bygone era, though still present. Meanwhile, the "assisted suicide" or the out-of-pity murder committed by a doctor (euthanasia) is meant to be the herald of "new better times", "Brave New World". But it seems to be an illusion, looking for a way to nowhere.

In the face of human suffering and inevitability of death I find it natural for a doctor to look for a way to alleviate this suffering, but not through killing the patient or accepting his or her suicide. The improvement of treatment

efficiency, symptomatic for instance, is undoubtedly necessary. It is significant to encourage the use of new courageous solutions such as palliative sedation.

It is possible that the right to euthanasia and/or assisted suicide significantly increases the sense of security of healthy people. They do not need it at the moment but they want to have such a possibility “just in case”. And when the problem really concerns them, they may literally “be left speechless”. Therefore, respecting different views, in my opinion incorrect ones, I see the need of public debate concerning advanced directives (Haras, 2008) also in respect to linguistic contexts.

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