

A NATURAL DEATH

AN INTERVIEW WITH DR. MARGARET COTTLE

By Frank Stirk

ASSISTING IN A SUICIDE IS ILLEGAL IN CANADA. Many people think this is wrong and that the law should be changed. They have bought into the idea that the only way for terminally ill patients to be freed of their suffering is to grant them their wish to have someone – most likely their doctor – help them commit suicide.

But the reality is very different. There have been many recent advances in palliative care that make it very possible for doctors to relieve suffering and allow the dying a peaceful, comfortable, truly dignified – natural – death.

Dr. Margaret Cottle is a noted expert on the subject. A resident of Vancouver, she is a palliative care physician and a clinical instructor at the University of British Columbia. She and her husband, ophthalmologist Dr. Robin Cottle, have two grown children and a black Labrador retriever. Ceilidh, as she is called, has her own hospital photo identification and visits patients and families on the Palliative Care Unit.



IMFC: From a lay perspective, what is palliative care?

MARGARET COTTLE: The word “palliative” comes from the Latin “pallium,” which was a cloak that covered the garments that people used to wear. So the idea behind palliative care is something that alleviates as much suffering as possible when there is no chance of cure. And it’s not just physical pain we’re dealing with. There’s psychological pain, interpersonal or emotional pain and spiritual pain. If you don’t address all of those, then you’re not really dealing with the total picture. The other distinctive of palliative care is that we see the family as the unit of care, not just the patient.

IMFC: What have been some of the advances in palliative care in the past few years?

MC: To be honest, I think the biggest advance has been that the general public has really figured out that it exists, and that people have come to see this not as just a “fringy” thing but as part of what good medical care is.

In 1992, the palliative physician coverage for the home hospice program in the City of Vancouver was basically just ten hours a week. Now we have 24/7 coverage that the home care nurses and the general practitioners can have access to. We also have more palliative care units, more people on consult services, and more people in home care. I do have to commend the government for spending some more dollars on staffing and resources for palliative care.

Even from the symptom-management standpoint, there’ve been some very good advances in terms of dealing with pain issues, nau-

sea and other things. So we’re always getting better at what we do.

As well, more family doctors are learning about it. I think all the medical schools across Canada have some teaching on palliative care, so that student doctors are learning about pain management. So there’s much greater awareness within the profession and within the general public who used to say that “nothing can be done” for the terminally ill. We have made just some really big advances.

IMFC: Is British Columbia a leader in this area or is there a national awareness of the need for palliative care?

MC: I think there is a national awareness. But you can always use more. As the population ages, we’re going to need to increase the funding and put some other things in place.

IMFC: So what areas are there within palliative care that still need improvement?

MC: The place where there’s been a problem is support issues. We’re not able to get as much funding for homemaking and some of those other social services which are incredibly important if you’re going to keep people at home. Three days a week, two hours a day is really not enough support for somebody who’s completely bed-ridden.

And although there’s a lot of research being done, we’re still lacking some decent predictors, so that patients and families can have some kind of time-frame as to when death will occur – are we talking weeks or are we talking days? It’s quite difficult to actually

