



VITAL SIGNS

Summer/Fall 2014

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Canadian Physicians
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Audrey: The Gift of Life

by Shari Tobias & Dr. Thomas Bouchard

This journey through the brief and impactful life of Audrey was co-written by Shari Tobias and her family doctor, Dr. Thomas Bouchard, of Calgary, Alberta.

Soon after we found a pro-life doctor – something we greatly longed for but never imagined we would find – we also joyfully discovered that we were pregnant with our eighth child. Little did we know at our first pre-natal appointment, that our relationship would be forged at warp speed due to the unforeseen complications of our pregnancy.

Leading up to our routine ultrasound at 20 weeks, we focused on preparing for our baby: three pre-natal appointments with our family doctor (Dr. Thomas Bouchard) which revealed a healthy heart-beat, choosing a property for a new home to make room for our growing family, looking at larger vehicles to seat 10, and batting around all of the possible baby names. At our ultrasound appointment, my husband Anthony and I were thrilled to see the face of our child and her strong heart beat. In our excitement, and with untrained eyes, we did not detect any concerns when the ultrasound tech excused herself from the room to review the pictures with the doctor. After an unusually long wait, the tech returned with the doctor by her side and we immediately knew something was wrong. In a matter of seconds our world was turned upside down as they delivered the news that our child had three serious defects: spina bifida (an open spinal cord), ventriculomegaly (enlarged fluid spaces in the brain) and clubfeet. Worries, questions, and fears ran through our minds, but at the same time, there was a deep sense of peace that everything was in the hands of our all-knowing and all-loving God. We had no time to process the information or to ask questions as we were already late to pick our children up from school.

That evening, we searched the internet for what all

of these terms meant for the life of our precious baby and we were relieved to see that each of these defects were treatable to varying degrees, either in utero or after birth, and that most people with these anomalies lived a long life. The next morning, I spoke with Dr. Bouchard with the anticipation that he would ease our fears. Instead, he expanded the realm of potential outcomes to include perinatal palliative care and the possible death of our child. The tears welled up, I couldn't speak anymore and I hung up the phone crying. Nervously then, we waited four days until the next, more detailed ultrasound.

It is a joy to take care of families who are open to life, but when devastating news is revealed on an ultrasound, it is difficult for all of us to deal with. When I received Shari's ultrasound report, I was also shocked by the multiple anomalies and was unsure of how to explain the findings and their implications to Shari and Anthony. I spoke with the maternal-fetal-medicine physician and researched the findings to help them understand what was going on. It certainly was one of the more severe cases that they had seen in years, and I realized it would be difficult to give an accurate prognosis for this little baby's life. Nevertheless, I wanted to be honest with Shari and Anthony about what to expect so that they could be prepared. Thankfully, a newly established perinatal palliative care program has been set up in Calgary and I wanted to make sure we had all the necessary resources in place to support them.

When we went in for the more detailed ultrasound, we hoped they had it all wrong and that our baby was fine. It seemed like an eternity as the team scanned my belly and discussed our baby in medical jargon. After the scanning was complete, we were grateful that they patiently and

(Continued on page 4...Audrey)

If you want birth control pills, go to a different doctor

by John Carpay

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Canadian Physicians for Life holds that reverence for every human life lies at the root of all medical tradition. Through the ages, this tradition has been expressed in the Oath of Hippocrates. It was rephrased in modern times in the Declaration of Geneva, which says in part, "I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity." We affirm this declaration.

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A Calgary doctor's refusal to prescribe birth control pills has triggered demands for her ouster from the medical profession.

Progressive Conservative leadership candidate Jim Prentice has denounced the doctor's choice to follow her conscience as inconsistent with "a doctor's obligation in a public health-care system." Apparently Prentice believes that a doctor should simply do and provide whatever the patient wants done and provided, regardless of the doctor's education, training, experience, conscience, and professional judgment.

This raises some interesting questions. If a doctor, based on her experience and research, believes that liberation therapy (dilating and opening blocked neck veins) is not a good option for patients suffering from multiple sclerosis, must she provide that therapy simply because the patient demands it?

What about a doctor who is convinced that anti-cholesterol pills do more harm than good? What if a doctor refuses to prescribe birth control pills because she believes, apart from any religious teaching, that they compromise women's health? Should this physician disregard her own research, analysis and conclusions and prescribe what she considers to be a dangerous product?

Does it really matter whether the doctor's belief is characterized as scientific, religious, metaphysical, conscientious, or something else?

Certainly a doctor's beliefs about what is, or is not, good medicine will sometimes inconvenience a patient. But what would be the consequences of forcing doctors to abandon their professional judgment and violate their conscience in order to pander to patients' wishes? If the government compels doctors to supply whatever patients demand, this presupposes that a patient's knowledge, training and judgment is at least equal to that of the doctor's. And if so, why bother with a medical profession in the first place? If individual doctors don't have the right to reach their own conclusions as to what is good or bad, why bother to distinguish doctors from those who are not doctors?

These same questions apply to other professions and occupations. Would Jim Prentice (who is a lawyer) impose this same standard on lawyers who refuse to act for a client, or who decline to take a particular case, because the lawyer's conscience says that doing so would be wrong? Our legal system is as public as the medical system. Why not remove from lawyers their current right to refuse to advance a cause that the lawyer believes to be unjust? Should lawyers be permitted to inconvenience prospective clients by telling them to find another lawyer? Shouldn't clients be entitled to receive from a particular lawyer whatever services they demand?

The same question about a consumer's supposed right to be free from inconvenience arises in other contexts. Should a Jewish or Muslim butcher be compelled to sell pork to the public, just because pork is popular? Or should the citizens of a free society exhibit tolerance and respect for the conscience of these businessmen, and suffer the inconvenience of buying pork elsewhere?

A free and democratic society allows consumers and providers to accept or decline each other's business, without state coercion. In a free society, the government does not force doctors, lawyers, butchers and other people to do things that they do not wish to do. This is freedom, and it sometimes causes inconveniences. But freedom cannot coexist with a purported "right" of patients, clients and consumers to use government's coercive power to obtain whatever goods or services they want, from unwilling suppliers.

People who cherish our free society understand that the inconvenience of not immediately getting what you want is part of life. We live in a society where people have all manner of differing beliefs and commitments. Part of the price we pay for freedom is that not everyone will wish to help you do what you want. You may need to find a different doctor, or another lawyer. You may need to go to a different butcher or restaurant to buy pork. People who disagree with you are people too.

If Jim Prentice respects the freedom of lawyers to decline cases and clients, he should support the right of doctors — and everyone else — to do likewise. That would be consistent with the free society of which Albertans are rightfully proud. ■



6 things I wish I had learned in medical school

by Laura Lewis, MD

I wish I had learned...

1

That science could only describe the magnificence of life, not explain it.

Despite learning about oocytes, spermatozoa, cell division and embryology, I failed to appreciate the complex blueprint of life, established in the early moments of conception.

2

That in the name of “choice” many women have no choice regarding their unplanned pregnancy.

I never appreciated that the scared young woman sitting across from me in my office carried the fear of many others whose lives would be impacted by her unintended pregnancy. This fear often laden with pressure, subtle and overt.

3

That many men and women live with great regret about their children lost to abortion.

As I began to work with our local pregnancy support centre, stories of deep and hidden sorrow began to emerge from men and women who have never forgotten the day they ended the life of their child. I have been privileged to hear from those who are able to voice their regret. I wonder if we have done an adequate job providing real choices. I know the answer without hesitation. No, we have not. True choice is a choice made when options are real, tangible and available. True choice is made from a place of confidence not fear.

4

That despite our ability to treat a diseased heart we have no cure for a broken one.

I wish that all parents, teachers, pastors, men and women facing an unplanned pregnancy could hear the cries of regret from those who have walked before them. A profound consequence matters, whether it is 1% or 100% of patients. Discussing this is disclosure. Understanding this and choosing still, is consent.

5

That a microscope, while magnifying an image can actually dull our focus.

A chromosome count can't measure value.

6

That we have failed our patients.

That is my word for it, failure. Our patients come to us for guidance, education and help during the chaos of an unplanned pregnancy. The response of the medical profession has been weak and often biased. I use the term ‘weak’ to refer to the weakness I see in the support and backing given to abortion alternatives. I use the term ‘biased’ to refer to the overarching attitude that abortion provision; accessibility and availability are given a greater platform than supportive alternatives such as adoption and pregnancy care support.

It is my hope, however, that the medical profession will become part of new system of response to those facing crisis pregnancies, looking beyond the scientific process and returning to the Hippocratic roots of our profession, a place where all life is valued and protected. ■

Announcing CPL’s 2014 Annual General Meeting

Sutton Place Hotel, Edmonton
Friday, November 9, 2014 at 5:00 p.m.

You are invited to attend CPL’s 2014 Annual General Meeting in Edmonton this November.

Please RSVP: **Email:** info@physiciansforlife.ca **Phone/Fax:** 613.728.5433

(Audrey...continued from page 1)

compassionately answered our questions and showed us the areas of concern while our little baby looked so content and waved at us and played 'peek-a-boo'. We were told that our baby had multiple abnormalities, including: a severe meningomyelocele encompassing the entire lumbo-sacral area, severe scoliosis of the spine greater than 90 degrees in the same location, severe ventriculomegaly, a Chiari II malformation with hindbrain herniation, severe bilateral talipes with limited movement, a possible missing right kidney, and a two vessel cord. It felt like we were in a medical nightmare, but by the Grace of God, Anthony and I had the strength to absorb the news and process all of the medical terminology and all of the implications that these anomalies would have on our child and myself. We understood that the prognosis for our baby was poor, but we still hoped that all of these abnormalities could be treated.

Next came the defining moment after the ultrasound when we were told that our options were to terminate the pregnancy, or to continue with the pregnancy and hope for the best. We didn't need time to consider the options. We knew right away that we would give our child every opportunity of life and love that we could, for as long as we could. Abortion would kill any possibility for hope and, even worse, it would kill our beautiful child given to us by God. Abortion was not an option! Thankfully the medical professionals did not push us towards terminating our pregnancy, and while abortion was still offered a few more times during the pregnancy (including up to a week before our delivery) it was only presented as an option and it never felt forced. Honestly though, I must say that this caused us to be skeptical as to the care our unborn child would receive and we wondered what lengths the doctors would be willing to go to in order to help us and our baby. After all, only seconds prior, and in the same breath, they had offered to kill our child! Thankfully our concerns never came to fruition and we would be very well cared for every step of the way.

After reading the more detailed ultrasound report, I was saddened about the multiplication of anomalies that were discovered. When speaking with the radiologist, they confirmed that they had not seen a case like this before, and that the prognosis was indeed poor. I knew Shari and Anthony had the moral courage to choose life, and was very impressed that the team of physicians caring for them did not push them towards the option of abortion. Indeed, it takes a great deal of strength to choose life in these circumstances when it seems "easier" to end the life of the unborn child. I knew that as Shari and Anthony encountered the various specialists, they and their baby were planting seeds and showing how ordinary people desire to give as much life as possible to their children, even when the prognosis is poor.

We were referred to an obstetrician who specialized in high risk pregnancies, and had many more ultrasounds, a fetal echocardiogram, an MRI, and consultations with genetics and a neurosurgeon. The neonatal palliative care team we met with included a neonatologist, a social worker. An amniocentesis was recommended as well. Amidst these countless medical appointments (and awfully expen-

sive parking fees), we remained in awe at the miracle of life and how precious each life is.

After meeting with the specialists, we met with Dr. Bouchard to discuss all that had transpired and to get his opinion on the recommended amniocentesis. I was so incredibly thankful that we had a pro-life doctor to turn to in the midst of all of this chaos who would further support us in our decision to proceed with our pregnancy. I imagined that he would provide a glimmer of medical hope to all of the dismal news we had been hearing and we trusted completely that he would guide us in making the right choices for our baby. We were surprised when he suggested that the amniocentesis benefits may outweigh the risks. The thought of this saddened me greatly. We also discussed that he could no longer be in charge of my pregnancy; however, he offered to continue to meet with us regularly to support us and navigate us through the medical world, and to answer any questions we had whenever they arose. I left that appointment with a very heavy heart, but also with a great sense of security that we were in good hands.

As a family physician, I depend on the advice of specialists to help with decision making. In the case of this little baby's poor prognosis both before and after delivery, it was suggested that an amniocentesis might help with better planning what this little one needed. The usual risk of 1/200 chance of miscarriage with an amniocentesis had to be balanced against the benefits that the information provided. Like the later decision to proceed with ventriculocentesis (removing the fluid from the ventricles) prior to the delivery, I depended on the advice of the specialists with experience in this area, but also had to make sure that these decisions always considered the value and dignity of both Shari and the baby. A guiding ethical principle for me was that any intervention must be aimed first at helping the baby while minimizing the harms. Despite the difficult decisions, it was important that Shari, Anthony and I were on the same page regarding what care would be the most appropriate while respecting the dignity of this child.



The myriad of medical appointments, tests, procedures, and ultrasounds that were to follow were bittersweet as they gave us glimpses into the world of our precious child, but at the same time they always seemed to be accompanied with more surprising, confusing or devastating news. The amnio revealed that our baby had a normal fetal karyotype and while we were thankful that those results offered more hope for our baby, we still had feelings of frustration as it also meant we had no certainty of what to expect. The amnio results also delivered the delightful news that we were having a daughter; our children were thrilled that she would tie the score at 4 girls to 4 boys. We named her Audrey (of noble strength) Gianna (God's gracious gift) and our bond with her grew stronger every day. We cherished deeply the time we had with her in my womb, and we treasured everything: her movements, the sound of her heartbeat, our glimpses of her via ultrasound, and even my enormous, swelling belly! We knew she was safe and comfortable within my womb, and we only wished she could stay there forever and not have to face what was to come. *(Continued on page 6...Audrey)*

Establishing a Life Home in India

by **Laura Lewis, MD**

Recently I traveled to India with a group that is working to develop practical options for women who are facing an unplanned or unwanted pregnancy. I was invited to provide education on the value of life and the impact of abortion on women and families. Despite tremendous cultural obstacles there was a receptivity to learn.

Bethel House India has been working to establish a Life Home, a place of refuge for women facing an unplanned pregnancy. The home is being positioned to help women navigate the pressure of a culture easily inclined to abortion, female gendercide, and the practice of female infanticide.

I primarily taught fetal development and the impact of abortion on women. Once people were presented with some basic factual information, including being able to hold a 12-week fetal model, it was interesting to observe how quickly they came to realize that a developing fetus is truly a developing human life. In a culture where women are not normally educated about such matters and do not talk about issues such as abortion, as we taught, an openness began to emerge.

Although illegal, both female infanticide and gendercide occur. It became apparent that the subtleties of cultural and ancestral pressure can be overpowering and hidden. One young woman we met was named Geeta. At 21 she already found herself pregnant and widowed. Her husband hung himself after fighting with his intoxicated father. His father, upon learning of the death of his son, also took his own life. As we sat in their home one of her brothers passed me his cell phone

with pictures of the two bodies in glass-topped coffins. On top of this great tragedy, Geeta was under tremendous pressure regarding her unborn child. Her husband's relatives wanted the baby, but only if it was a boy. Geeta's situation underscores the pressure many women are faced with in India with respect to abortion, female gendercide and female infanticide. Most women have to navigate these difficult issues with no support network. Geeta was offered the opportunity to be the first woman to stay at the Life Home. I'm not sure exactly how her story unfolded. Perhaps that will be in the next issue.

By the time I left India, the Life Home was officially opened and local people were running it, reaching out to others around them. The director began to teach the lessons that she learned during our stay using some of the resources we were able to provide her with. This support network for life is just beginning to be strengthened in India. There are not many options for women – but there are some. There is such a vital need for education to help change the way the unborn are viewed and to communicate the risks of abortion to women.

Canadian Physicians for Life board member Dr. Laura Lewis is a physician in Huntsville, ON.



Announcing the 2014 MEDICAL STUDENTS FORUM

November 9 - 11, 2014
Sutton Place Hotel
Edmonton, AB

We offer to pro-life medical students a broad range of seminars and workshops designed to not only inform them with regards to sensitive and emerging issues, but to equip them with the confidence to 'make their case' when interacting with colleagues and the public who may question their stance on life issues. Pro-life medical students and residents are encouraged to apply for a scholarship to attend.

We also encourage our physician and retired physician members to attend the forum. This is a great opportunity to network with pro-life colleagues, and interact with some exceptional medical students from across Canada.

Full speaker and session information, as well as scholarship applications, is available on the Canadian Physicians for Life website (www.physiciansforlife.ca).

Advance registration is required. Contact KC McLean at info@physiciansforlife.ca or 613.728.5433 for more information.

(Audrey...continued from page 4)

As the pregnancy progressed, we were getting mixed messages about her prognosis and what to plan for after the delivery. We later discovered this was due to the fact that there isn't much data for the doctors to rely on, as most people terminate pregnancies that involve these anomalies. We found these mixed prognoses to be extremely frustrating and mentally draining; whether or not to

have a vaginal delivery or C-section; whether to go on a family vacation to Mexico; whether to put wheelchair ramps into our new home, and on and on it went. Not knowing what to expect was one of the biggest challenges Anthony and I faced throughout the pregnancy as we felt we couldn't plan or prepare for anything. What made it worse was that, in the midst of this confusion, we felt pressured by doctors to make decisions about the course of action we wanted to take for Audrey after she was born, with regards to interventions, surgeries or palliative care. How in the world could they expect us to make life and death decisions about our daughter when no one even knew what we were to expect when she was born? We made up our minds to hope for the best while preparing for the worst; which meant praying for a miracle and meanwhile meeting with palliative care services and preparing mentally for the possibility of a funeral. Furthermore, we resolved to accept the fact that doctors are human, that they don't have all the answers, and that they can't fix everything. Those were some hard lessons to learn!

As Shari and Anthony were frustrated with the mixed message, I too struggled in knowing what message to deliver. I did not want to abandon hope for a miracle, or even for a baby who would be vigorous enough to survive surgery, but at the same time I wanted to present an honest picture of what they could expect. I wanted to support them in any way possible, but at times I did not know what words would offer them the support they needed. To balance a message of hope with realistic expectations was hard to do. We all agreed that there might be things (for example, a surgery for her spine) that might overly burden her little body in her first days of life, and perhaps dying with the family was better than dying during an operation.



provided us with sound advice and guidance in making ethical decisions for Audrey which were in alignment with our faith, and gave us the book "[A Gift Of Time: Continuing Your Pregnancy When](#)

[Your Baby's Life is Expected to be Brief](#)" by Amy Kuebelbeck and Deborah L. Davis. While it wasn't a book I wanted to read while on our family vacation in Mexico, it proved to be an invaluable resource. Thankfully too, our obstetrician eventually noticed the frustrations Anthony and I were experiencing with mixed messages, and planned a multi-disciplinary meeting to discuss our case and plan the delivery with the best possible outcomes for Audrey and I in mind. This brought Anthony and I much peace of mind as we neared the end of our pregnancy!

It was decided that due to Audrey's severely large head, the best course of action would be to perform a ventriculocentesis before delivery and that the most favourable option for delivery would be a C-section at 37 weeks to avoid the risk of pre-term labour and enable the whole medical team to be in place and ready for Audrey's arrival. In addition to having Anthony as support, they also allowed Dr. Bouchard to be in attendance. We were grateful to have a large waiting area for our children, my parents, my sister and our priest while I was in surgery.



With Anthony and Dr. Bouchard by my side, the ventriculocentesis began. After removing 1.1 litres of fluid from Audrey's head without any apparent complications, they decided to stop the drainage and proceed with the C-section. At 10:06 AM our beautiful daughter, Audrey Gianna, was born weighing in at an even 8 lbs. We were filled with cautious excitement as we waited to see how she was doing. Anthony and Dr. Bouchard immediately followed Audrey to the

warming table while I was being stitched. It gave me a huge sense of comfort knowing that Anthony wasn't on his own as Dr. Bouchard was right next to him, explaining all that was happening to Audrey medically. I was told that Audrey wasn't breathing on her own, so she was quickly hooked up to a ventilator and she soon started to pink up, move her arms and open her eyes; she was more vigorous than expected!

Moments later, Audrey was taken away into the NICU with Anthony and Dr. Bouchard. I caught my first glimpse of Audrey as they wheeled her past the operating table, pausing for seconds. She looked so vulnerable and fragile with so many things hooked up to her. I was taken to a recovery room where I tried to process all that had just happened: I just had major surgery; I hadn't labored and pushed; I never heard Audrey cry; Anthony didn't get to cut the cord; Audrey wasn't laid in my arms for me to cuddle and nurse; and worse, I was alone and isolated from Audrey and Anthony!

(Continued on page 7...Audrey)

(Audrey...continued from page 6)

Dr. Bouchard's quick visits from the NICU with brief updates on Audrey were a huge gift to me as he was my only connection to her after her birth and my only way of knowing what was transpiring. Thankfully, due to Dr. Bouchard's request and persistence, after less than an hour in the recovery room, I was united with Audrey and the whole family in the NICU where, with our priest, they awaited my arrival so Audrey could be baptized. Unfortunately, while I was being wheeled over to the NICU, Audrey took a turn for the worse. By the grace of God, I arrived to the sounds of my children's wailing, but in time to watch medical staff place Audrey into Anthony's arms for the first time and then to witness her baptism. It was a truly sacred moment filled with profound love, joy, sorrow, and faith which I am grateful I didn't miss. Only moments after her baptism, at 11:58 AM, Audrey passed away peacefully due to an undetected internal bleed in her head. Our beautiful Audrey was ushered from her daddy's loving arms into the loving arms of her Heavenly Father.



I was grateful that the very large team of doctors allowed me in for the delivery, and it was an honour to be with Audrey and the family from birth to death. Prenatal ventriculocenteses are rare procedures, so many physicians and residents were present to witness it. More fluid was taken off than I expected, but I trusted that the obstetrician with prenatal surgical experience knew what he was doing. As her large and delicate head was drawn out during the C-section, I stared in amazement. I watched as Anthony took pictures of her disfigured head and realized that this was a father in love. He saw the "Audrey" through all of the anomalies. I was elated when she was vigorous enough to be intubated, which was done by the neonatologist with ease. Being ventilated allowed her to survive as long as she did. As Anthony and I went to the NICU and Shari was kept in the recovery room, I watched Audrey's vitals keenly. She was holding her own, and I was able to convey this to Shari in the other room. However, the neonatologist became worried about her condition, and I quickly realized that their desire for a baptism should be arranged as soon as possible. I requested that the usual recovery protocol be relaxed to bring Shari to the NICU, and we were able to enjoy her last moments together as a family.

September 24, 2013 is a day forever imprinted in our minds. A day where birth and death collided. What joy! What sorrow! It is hard to explain how our hearts could ache so terribly at the loss of our

daughter whom we had only just met, yet at the same time we were able to truly rejoice for her and the joy she was experiencing at that moment in heaven. The doctors, nurses and photographer who were with us in our grief were so incredibly compassionate, respectful, and professional. They allowed each member of the family to hold and cuddle Audrey and were so patient with all of our children clamoring around the room while they worked quietly in the background. When Audrey finally made it into my arms for the first time, the photos would tell you that I had a smile amidst the tears as I took in the beautiful details of her tiny, perfectly formed hands and delicate face, which looked just like all her siblings, while at the same time I mourned the fact that our time together on earth had just come to an abrupt end. We were deeply touched by the way the hospital staff treated Audrey with tremendous dignity, and we especially noticed it as the nurses bathed and dressed her with great care.

Just a few months prior, we were given the choice of life or death for our child. We chose life, and we are incredibly thankful to every member of our medical team for respecting and supporting us in our decision to continue the pregnancy.

To journey with Shari, Anthony, Audrey and their family was a precious gift to my vocation as a physician. Not only do I need to constantly improve my knowledge to help patients, but also to deepen my wisdom to offer moral direction in medical decisions. Together, we walked through the prenatal challenges, navigated the delivery plans, and cried when Audrey died. I was able to say goodbye to Audrey at her funeral and debrief with the family in a home visit the following week. No one who met Audrey in the womb or out of it will ever be the same. She did not walk or speak, laugh or cry; she simply wanted to be loved. And she was.

Ultimately, it was terribly difficult to leave the hospital with an empty womb as well as empty arms, with the intentions to go plan our baby's funeral, but our consolation was, and still is, that our hearts are full of joy and gratitude for the life and love we shared with Audrey and knowing that we now have our own little saint in heaven where she is no longer burdened with her frail earthly body. Audrey's brief life may have been contained within this one year that has passed, but her memories and our love for her will last for an eternity and the many lives she touched will remain forever transformed. ■



*Imane Belcaid is a medical student and former CPL board member.
The English version of this article can be found on the Web at
www.physiciansforlife.ca*

L'abus des personnes âgées a largement été rapporté au cours des dernières décennies. La première fois que je me suis heurtée à un conflit familial au sujet du traitement d'une personne âgée, j'ai réalisé la grandeur du problème sociétal que l'on vit présentement considérant la légalisation de l'euthanasie.

Lors d'un stage rural récent, j'ai rencontré une patiente âgée, connue pour son souhait de ne pas être réanimée. La patiente a été admise à cause d'un épanchement pleural, pour la 3^e fois consécutivement durant les derniers 2 mois. Cette présentation clinique est secondaire à une sténose aortique sévère qui lui a causé une insuffisance cardiaque terminale. À notre rencontre, la patiente était alerte, orientée, ambulatoire et indépendante pour sa nutrition. Après avoir discuté de son cas avec mon précepteur, nous avons considéré de lui offrir une thoracocentèse hebdomadaire de routine pour éviter des hospitalisations futures secondaires aux épanchements pleuraux.

De retour au chevet de la patiente, je l'ai trouvée en compagnie de son fils unique. Je leur ai présenté notre plan de prise en charge actuel avec l'option de thoracocentèses routinières dans le futur. La patiente était ravie de la proposition, mais le fils était plutôt contrarié. Il s'inquiétait du fait que ce soit une mesure trop invasive pour sa mère, que ça pourrait en effet prolonger sa vie, mais au prix de sa qualité de vie. D'ailleurs, le transport à lui seul est devenu une tâche exigeante pour la patiente, qui lui impose un besoin de récupération prolongée. De plus, il ne serait pas en mesure de la transporter sur une base régulière vu qu'il habitait assez loin. Il a rajouté qu'il pense que « ce serait le temps de baisser les bras, et laisser le seigneur faire son travail ». En jetant des coups d'œil à la patiente, j'ai pu clairement percevoir la peine que lui infligeaient les propos de son fils.

Le fils ayant remarqué la même chose, a vérifié avec sa mère si elle considérerait la thoracocentèse de routine, et elle a vivement approuvé en soulignant qu'elle veut encore vivre. Après avoir rassuré la patiente que nous allons respecter ses vœux et adapter nos soins à ses besoins, je suis retournée discuter avec mon précepteur. Peu après, le fils nous a rejoint en colère en raison de mon renforcement de la position de la patiente face au traitement proposé. Il stipulait que sa mère n'est plus en position de prendre des décisions éclairées, qu'elle n'a pas une autocritique de sa situation de vie globale et n'est plus en mesure de faire un bon jugement. De plus, il partait en voyage au sud le lendemain et personne ne pourrait offrir à sa mère un transport régulier à l'hôpital. Enfin, si elle décédait durant son séjour à l'hôpital, tous les arrangements étaient déjà faits pour que les funérailles se déroulent paisiblement.

Nous n'étions pas d'accord avec le point de vue du fils. En fait, selon nous, la patiente gardait un bon jugement et était bien consciente de sa situation actuelle. Après une longue discussion, c'était clair pour nous que le fils était exténué et qu'il n'avait plus d'énergie pour supporter sa mère. Mon précepteur a adopté une approche douce mais directe pour clarifier au fils que notre mandat est de respecter les vœux de la patiente tant et aussi longtemps que le traitement considéré aurait plus de bienfaits que de méfaits. Ceci est un processus dynamique, et la décision de procéder ou non à un traitement peut varier d'une journée à l'autre dépendamment de la progression de l'état général de la patiente.

Cette situation délicate m'a surtout mis à l'aguet vis-à-vis l'abus potentiel auquel sont sujettes les personnes âgées. À cause de leurs fragilités, plusieurs personnes âgées deviennent dépendantes de leurs entourages. Ceci les met dans une position de vulnérabilité et plusieurs risquent de devenir victimes d'abus psychologique, verbal, physique, financier ou autre. En fait, la plupart des cas d'abus de personnes âgées rapportés au Canada sont infligés par des membres de la famille.

Selon ma perspective, j'ai été témoin d'abus verbal et psychologique au moment de la rencontre. Le fils exprimait sa frustration vis-à-vis la condition de sa mère et son souhait de continuer des traitements, au point que je me suis sentie personnellement mal à l'aise, alors je peux seulement imaginer les sentiments de la patiente face aux propos de son fils. Je me suis inquiétée vis-à-vis son comportement en l'absence d'observateurs et les répercussions, à la longue, qu'auront ses propos sur les décisions de fin vie qu'entreprend la patiente. En pensant au fait que son seul support social est son fils unique, et qu'il la pousse assez agressivement à se laisser aller, il serait définitivement capable de l'aliéner à opter pour l'euthanasie si cela devient légal. Je suis certaine que le cas que j'ai témoigné n'est qu'un exemple parmi tant d'autres. « The slippery slope » ou plutôt le risque de dérive est un danger réel où l'euthanasie ferait partie du continuum d'abus infligé aux personnes âgées.

Toutefois, c'est difficile de juger des intentions véritables du fils dans ce cas, voulant censément protéger la qualité de vie de sa mère. Si sa réaction était en réponse à l'épuisement de l'aidant naturel, il avait sûrement besoin de support communautaire pour la prise en charge de sa mère. Nous avons mis la patiente dans une liste d'attente pour un lit en soins de longue durée et nous avons impliqué le CLSC pour de l'aide à domicile. Ceci permettrait à la fois de donner du répit au fils, ainsi que d'introduire un observateur régulier de la situation familiale et de l'état psychologique de la patiente. Ce cas m'a appris à être plus vigilante à l'égard du risque d'abus que vivent les personnes âgées en communauté. Assurer un suivi devient clé dans ces situations pour mieux cerner les enjeux impliqués et le degré d'intervention nécessaire. ■