

Elective Death and the Hospice Concept

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Modern medicine possesses an impressive arsenal of treatments and intervention strategies to protect and preserve human life. Surgery and drug therapy are among the best known intervention strategies and are widely accepted by the public as appropriate. Such intervention is expected in acute non-life-threatening illnesses. Even more powerful technological intervention is expected in situations where life is threatened. The availability of lifesaving equipment, such as the respirator, is critical to emergency rooms and trauma centers around the country. But the successes of our medical technologies have contributed to an expansion of their use, even into areas for which they were not intended. We find increasingly that equipment and techniques designed to save lives in crisis situations are being used to prolong lives in situations where no crisis exists, as in the case of the terminally ill. The effect often is to forestall death rather than to prolong life.

In the case of a terminally ill patient, the use of massive lifesaving interventions must be questioned and the patient's right to choice of treatment respected. This must be so even if the patient's choice is no treatment at all, which amounts to elective death. A distinction may be made between suicide and elective death. Suicide literally means "self-murder" and involves the element of intent; that is, the suicide engages in some activity known to result in death. Often, too, the suicide is a physically healthy person, albeit a despondent one, whose suicidal act itself is a cry for help. Elective death involves the decision by an already dying person not to undergo further medical intervention. The result of exercising this choice is death as the illness progresses

through its usual course. In an elective death situation, the patient continues a regimen of pain relief therapy as needed.

The medical model of efficient, objective treatment of illness is particularly unprepared for the patient to exercise the elective death choice. The health care team is trained to save lives and to relieve suffering, often with the aid of technological interventions. Some physicians even maintain the attitude that they must never give up their efforts to cure a patient and that they must fight on the patient's behalf to the very end, using whatever means are necessary. The problem with this attitude is that it can lead merely to a temporary postponement of the dying process, as respiration and circulation are mechanically maintained while consciousness and meaningful existence have ceased.

Delivery of health care is institutionalized through our hospitals, and hospital routine leaves little time to talk to patients about dying. In fact, the effort to maintain a glimmer of hope for the patient's survival often results in a conspiracy of silence in which little is said to the patient about his prognosis, and "awkward" questions from the patient are evaded or ignored.

Yet the information explosion of the last decade has reached patients, future patients, and health care teams alike. Laymen are aware that machines can maintain bodily functions for an indefinite period; ordinary people are concerned about spending their last days in a vegetative state; responsible citizens are increasingly expressing a desire to spare relatives the anguish and cost of a protracted terminal illness; and, importantly, people seem to embrace the notion that for each of us there is a time to die, and that obstructing the inevitable can be distasteful, perhaps even irreverent. As a result, a growing segment of the population is turning away from hospitalization, with its intervention strategies, during their final days, and turning instead to the old notion that family and friends, providing care in familiar surroundings, can be appropriate. Such therapy is embodied by the hospice concept.

Hospice is a program in which care and supportive services are provided to dying patients and their families. Usually an interdisciplinary team works with the dying patient, family, and friends to provide palliative care (medical relief of pain), comfort, and companionship. The patient is aware of his condition and is made as comfortable as possible, but no heroic intervention efforts are used. The hospice patient must have accepted the fact of impending death and elected not to undergo additional curative efforts. Hospice is for pa-

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tients with weeks or months left to live, not years. The objective of hospice is to make the patient's last days as comfortable as possible. Four basic principles are at work in hospice that serve to distinguish between hospice and hospital:

1. The patient and the family are considered to be the unit of care; the patient alone is the unit of care in hospitals.
2. An interdisciplinary team assesses not only the physical needs of the patient, but also the psychological and spiritual needs of both patient and family; in contrast, hospitals focus treatment on specific illnesses of the patient.
3. Pain and collateral symptoms associated with the terminal illness and its previous treatment are controlled, but no heroic interventions utilized; hospitals intervene routinely.
4. Bereavement follow-up is provided the family to help with their griefwork and emotional suffering; hospitals are not concerned with bereavement follow-up.

Although the hospice concept is not a new one, it certainly represents a major departure from the kind of thinking about death that has contributed to the growth of medical centers and hospitals over the last half-century. It is estimated that over two-thirds of all deaths in the United States occur in hospitals. While much of medical technology has focused on ways to save or prolong lives, hospice eschews medical intervention for the terminally ill. Such a perspective raises many questions, which cut across religious, legal, even scientific boundaries. Is medicine playing God by prolonging life? Do individuals have a right to die, free of medical intervention? What is death and when has it occurred? But perhaps the most fundamental question is whether or not it is right to allow individuals to die when medical technology can keep them alive. Those who choose hospice over other forms of institutional care provide an emphatic answer. To them, length of life is not the only consideration. They recognize that there are costs associated with prolonging the life of the terminally ill which go beyond monetary concerns. They acknowledge that artificial life maintained by extraordinary means offers them nothing. And, importantly, they have elected to be a part of the decision-making process that governs the nature of their final days. In fact, some hospice candidates are apt to challenge the medical profession regarding its role during the terminal period. When there is no chance of surviving the illness, some patients want to be in familiar surroundings, such as at home, and without further medical intervention.

The dilemma is that our society attaches such importance to the sanctity of life that a conflict with individual liberty can develop. Our health care system, like our legal and judicial systems, is based on the fundamental issue of preservation of life. Yet principles of individual liberty give rise to the right to privacy and to informed consent regarding medical treatment. Exercising these rights means that a person can elect to receive no treatment or to receive a form of treatment that will alleviate pain, but not attempt to cure. As unsettling as it may be, the terminally ill patient electing to forgo medical intervention is electing to die. What was once a matter between physician and patient has become a legal issue as well. For example, legal challenges to the notion of elective death may be brought by well-intentioned institutions or individuals. But the right to choose or to refuse treatment seems firmly ingrained in common law. So the real dilemma may be the cognitive dissonance accompanying the knowledge that a person may choose certain death over medical intervention and uncertain life. The growth of hospice programs may serve to reduce such dissonance and accentuate the futility of intervention in many cases, while also emphasizing that patients can maintain a sense of control over their lives even in the terminal phases. Personal care, alleviation of pain, and familiar surroundings can do much to make one's last days more tolerable. As families and institutions become more familiar with hospice programs, we can expect the dissonance generated by the notion of elective death to give way to the humanitarianism engendered by the hospice concept.

COMPREHENSION QUESTIONS

1. Hospice is a program that:
 - a. allows the patient to choose when to die
 - b. provides palliative care, comfort, and companionship
 - c. emphasizes hospitalization over home care for the terminally ill
 - d. helps to make dying easy
2. Some modern medical technologies are inappropriate for the terminally ill because:
 - a. such equipment was designed to save lives in a crisis, not to prolong the existence of the dying
 - b. health insurance does not cover their use with dying patients
 - c. the terminally ill cannot make reasoned decisions
 - d. doctors can always find a better use for the technology with patients who are not dying
3. A main objective of hospice is:
 - a. to eliminate hospitalization for cancer patients

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- b. to make the patient's last days as comfortable as possible
 - c. to stop physicians from playing God
 - d. to emphasize the sanctity of life over all else
4. The conspiracy of silence mentioned in this article refers to:
- a. the routine by which doctors and nurses communicate with each other
 - b. the fact that a dying patient's physical condition is confidential
 - c. evading or ignoring the patient's questions about his condition
 - d. the withholding of information about the cost of certain medical treatments
5. Powerful technologically based medical intervention is expected:
- a. whenever a physician agrees to treat the patient
 - b. for all terminally ill patients
 - c. for non-life-threatening situations
 - d. in critical, emergency room situations
6. In an elective death situation:
- a. the wishes of surviving family may overrule those of the patient
 - b. the patient continues a regimen of pain relief therapy
 - c. the patient's vital systems must be mechanically maintained for twenty-four hours
 - d. the physician should not be asked "awkward" questions
7. One can infer that Collins believes that the real dilemma of elective death is:
- a. medical
 - b. legal
 - c. societal
 - d. scientific
8. The author's approach to this subject is best characterized as one of:
- a. cynical despair
 - b. flippancy
 - c. adamant didacticism
 - d. reasoned debate
9. This author believes that hospices are:
- a. a humanitarian alternative for terminally ill patients
 - b. more cost-effective than hospitals
 - c. the closest thing to institutionalized murder
 - d. more likely to keep patients alive than hospitals
10. The main point of this article is:
- a. Elective death and suicide differ in name only.
 - b. Terminally ill patients have a right to elect the kind of medical treatment they will receive, even if they choose palliative rather than curative care.
 - c. Doctors are expected to prevent suicide regardless of the will of the patient.
 - d. Terminally ill patients often require massive medical intervention on their behalf.

ANALYSIS QUESTIONS

1. The concept of elective death has many ethical, religious, economic, legal, and other implications besides medical. Choose one area and comment.

2. Should hospice programs be financed through medical insurance? Through government assistance? Comment.
3. In such phrases as *sanctity of life*, *quality of life*, and *preservation of life*, the word *life* can be interpreted in different ways. Or can it? Discuss.
4. How do one's own beliefs on this topic influence one's understanding of the author's treatment of it?