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APPROACHES TO END-OF- LIFE

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ABSTRACT

Throughout human history, Physicians and other healthcare providers, Clergy, governing bodies and the lay public had issues with end-of-life decisions. Therefore,often they became last minute challenges. This lack of coping was brought to the forefront in 1969 when the Swiss-American Physician, Elizabeth Kubler Ross described the stages of: Denial, Anger, Bargaining, Depression, Acceptance (1) making both professionals and the public aware of the necessity to better plan for death and dying.

In recent decades options have been proposed to assist in making critical decisions. These include Euthanasia, Palliative Care and Hospice. This

submission will address historical data, describe these advances and

explain their differences and the options they offer.

Keywords: Death, dying, Euthanasia, Palliative Care, Hospice

INTRODUCTION

About 2.7 million Americans die each year and many more millions die worldwide. The end-of-life is often complicated by the way different cultures cope with it. In some cultures, talking openly about death has been considered disrespectful and may lead to despair. Therefore, many people of various ethnic backgrounds have found death too distressing to contemplate and it is ignored or avoided. However, others have found ways to address their imminent demise. David Goodall, an Australian scientist made history several years ago when he flew to Switzerland to die at an assisted suicide-clinic putting an end to a life that he found increasingly difficult to live. The practice at the time was illegal in Australia where it has since become available in six states at l;east in some measure because of his action. Goodall had the choice of Switzerland, the Netherlands, Luxembourg and Belgium at the time he chose his site and now it is also legal in Austria, Canada, Germany, Portugal, Spain and eleven U.S. States and the District of Columbia with pending “Death with Dignity”or Medical Aid with Dying legislation in many more. However,it is also expressly illegal in several states and some residents of these states have chosen to move to more hospitable ones as their lives approach the end.

These rapid sociological changes have allowed for us to understand choices that now may be made for end-of-life.

EUTHANASIA

This is a method in which a Physician is allowed by law to end a patient's life by painless means as long as the patient and family agree. Euthanasia may be Voluntary –defined as with consent or Involuntary as when a patient is unable to give consent and another person makes the decision, Terms sometimes associated or synonymous with Euthanasia include:

Physician assisted death (PAD)

Physician assisted suicide (PAS)

(A doctor assists a patient to commit suicide if they request it.)

Passive euthanasia is an obsolete term referring to allowing a patient to die by withholding or withdrawing treatment.

The arguments for Euthanasia include freedom of choice, quality of life, dignity and easing the suffering of loved ones. Witnesses generally approve and we have done this for our pets for years and years.

The arguments against it include that Physicians may violate their Hippocratic Oath, moral, religious and cultural conflicts, the competence of the decision maker and possible unanticipated recovery from what appears to be a terminal illness.

Organized medicine has been polarized: the American Medical Association and American College of Physicians have been in opposition. The American Association for Hospice and Palliative Care have been neutral. The International Association for Hospice and Palliative Care advocates Palliative Care first and opposes involuntary Euthanasia and the American Association of Suicidology states “It is outside our focus”.

PALLIATIVE CARE

This is an interdisciplinary medical specialty that focuses on preventing and relieving suffering and on supporting the best possible quality of life for patients and their families facing serious illness.

This movement was initially rooted in the care of patients with cancer and the term it self was coined in 1974 in Canada. It first became recognized as a specialty in the U.K. In 1980; it received United Nations recognition in 2000 and was incorporated by the WHO into mainstream medical care in 2013 and 2014.

In the U.S. initial, mostly voluntary programs began in the 1980s. The first hospital based Palliative Care consult service began in Detroit, Michigan in 1985 with programs developing nationwide in the U.S. soon after,

Presently, between private and state hospitals larger than 50 beds, it is estimated that over 80% have such programs.

Although there are about 5000 Palliative Care Physicians it is felt that another 6000 to 18000 are needed.

Palliative Care provides relief from pain and other distressing symptoms while affirming life and regarding dying as a normal process. It neither hastens nor postpones death. By using a team approach it integrates psychological and spiritual aspects of patient care as it offers a support system to help patients live as actively as possible until death and helps families cope with both the illness and bereavement. It is often most useful early in the course of illness in conjunction with necessary investigations and chemotherapy and/or radiation therapy.

Although 40 million people are felt to be in need of Palliative Care in any point of time for a wide range of illnesses, it is estimated that only 14% have ready access to it. This is particularly true in underdeveloped places in the world.

Most end-of-life observers express a preference for Palliative Care over Euthanasia.(3)

HOSPICE

Hospice is simply defined as a home providing care for the sick or terminally ill. Although the concept of Hospice-like care has long been informally practiced and often by religious practitioners, its formal introduction to medicine was by Dame Cicely Saunders in 1967. (2) Dame Saunders, a nurse, social worker, physician and writer founded the first Hospice Service at St. Christopher's Hospital, London . It may be embarked upon along with Palliative Care or serve as its own entity since there is so much overlap. The majority of Hospice Care is offered as home care along with dedicated facilities in Extended Care facilities and smaller in hospital dedicated services. In the U.S., Medicare fully covers Hospice care but it requires referral by a Physician and not by a Nurse or Physician's Assistant. It is anticipated to be used when life expectancy is 6 months or less but may be discontinued if a patient improves or extended and even reinstated upon Physician recertification.

DISCUSSION

Over the course of the late nineteenth and early twentieth century it has become possible to openly consider the issue of end-of-life. Many traditional cultural taboos have been replaced by an understanding that death and dying will occur and may be addressed in different ways and that preparing both the terminally ill and concerned family is possible. Hospitals have initiated programs to educate their staffs so healthcare professionals are prepared to participate with all who may be facing end-of-life situations. (4) The three most common ways in which this is approached, Euthanasia, Palliative Care and Hospice have been presented and the choices they offer delineated.

CONCLUSION

The cultural, religious and sociological barriers to dealing with end-of-life situations which often prevented openly addressing them have largely been replaced by both recognition of and acceptance of the need to do so. Over recent years, the alternatives of Euthanasia, Palliative Care and Hospice and combinations of them have been introduced are now recognized and publicly discussed.

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