

Volume 2, No. 2, “Caring for the Dying: Reexamining Our Approach”

Wesley J. Smith, *Forced Exit: The Slippery Slope From Assisted Suicide To Legalized Murder*

Julie A. Finegan

In the book *Forced Exit*, Wesley J. Smith explores end of life decision making issues and asserts that legalized assisted suicide will lead to legalized murder. Smith presents his argument through a discussion of several key United State court decisions, the abuses of euthanasia in Nazi Germany and the Netherlands, the profit-driven structure of the American health care delivery system, and through family testimonials and anecdotal evidence.

In this book review, Julie A. Finegan takes an in-depth analysis of the strengths and weaknesses of Smith’s arguments. First, Finegan believes that readers may be troubled by the overall lack of statistical support for many of Smith’s arguments. Many of Smith’s points and distinctions could have been better strengthened by available statistics and studies. Next, while the personal stories throughout the book made it compelling, the reader is unsure whether Smith has merely found the one-in-a-million situation or whether the problems he addresses are widespread.

Finally, Finegan questions whether the varieties of alternatives that Smith offers are even feasible.

Finegan ultimately concludes that Smith has presented a slippery slope argument from assisted suicide to legalized murder and the book is an easy and interesting read that provides the reader with a key perspective on end-of-life decision-making.

Hospice at the Crossroads: Can it Survive?

David A. Simpson

For the past two decades, hospice care has become an emerging alternative for terminally ill patients and their family members. Despite its continued progression, author David A. Simpson asserts that the hospice movement has reached a critical juncture that could jeopardize its existence. In his article, Simpson evaluates the growth and evolution of American hospices as it meets emerging cultural and economic trends of the new century.

Simpson begins his article by providing a brief history on the emergence of hospice care. According to him, hospice care arose in response to a number of forces, including the patient control autonomy movement, technological advances in medicine that help to prolong life, and legal dialogues that support the right to die. Simpson states that though hospice has grown tremendously in the past decades, the threat lies in attempting to integrate the idea of death as a natural part of life in a society dedicated to eradicating it.

In the rest of his article, Simpson discusses in detail the strengths of hospice care as well as the challenges that threaten its livelihood. He notes that hospice has often been seen as the treatment for the terminally ill and serves a large number of patients. However, despite its relative strengths, hospice care has been plagued with a number of challenges, including aggressive government scrutiny and regulation and misinformation distributed to the public. In the final section of this piece, Simpson discusses the various mechanisms that may be implemented to both preserve and strengthen the movement so that it may evolve to meet the needs of a changing society. For readers who are interested in learning more about hospice care on the Internet, Simpson includes a list of websites and projects that deal with end of life issues and hospice care.

THE ROLE OF THE PHYSICIAN IN END-OF-LIFE CARE: WHAT MORE CAN WE DO?

DeWitt C. Baldwin, Jr., MD

Less than a hundred years ago, physicians recognized the limitations of their calling. The accepted role of the profession was not to cure, but to care and comfort the dying person and their family. With technological advances, however, death became the “enemy” to be defeated at all costs. Generations of medical students were indoctrinated with this philosophy, leading to excessive attempts at intervention in the name of preserving life, and avoidance of the dying patients and their families.

The past several decades have seen a countermovement leading back to the place of death and dying in society. Studies indicate that Americans want to die at home, free of machines, alert yet free of pain and surrounded by family. What they fear most is dying in an institution, alone, hooked up to a machine, in pain, and being a burden to their family.

Recently the medical profession has begun reexamining its role in end-of-life care. The author discusses the American Medical Association’s initiative for care at the end of life. The goals of the initiative include improve-

ment of the quality of care delivered by physicians, improvement of planning for end-of-life care, and improvement in the experience of dying in the US. The centerpiece of the AMA's initiative is the Educating Physicians for End-of-life Care (EPEC) Program. The goals of the program are to define the essential skills required for quality end-of-life care, and to train physician/educators who will teach those skills to practicing physicians. The author describes the curriculum design and selection of participants for the EPEC training.

The author describes death as an opportunity rather than a failure. Death can be a time to finish personal and family issues, create final memories, say good-bye and find spiritual peace.

Self-Determination and the Wrongfulness of Death

Robert A. Burt, J.D.

Self-determination has become the central idea governing medical treatment. Proponents of physician-assisted suicides rely heavily on this ideal that has been adopted generally by the medical community. On the other hand, opponents of physician-assisted suicides assert that applying self-determination to assisted suicides would eventually develop into involuntary euthanasia. The author identifies and illustrates three views of self determination in which internal tensions give credence to the argument against applying it to physician-assisted suicides:

- 1) The modern self as a philosophic proposition: The author explores the intellectual history by which the modern conception emerged from a quite different conception of the relationship between "self" and "cosmos".
- 2) The modern self as a psychological proposition: Next, the author highlights the developmental pathway by which individuals grow from infancy to adulthood and the way adults view themselves through the culturally prized philosophic idea of the self.
- 3) The modern self as an American icon: Finally, the author addresses the progressive acknowledgment of self-determination as an ideal in American cultural history from the Revolutionary War to the contemporary claims for patient self-determination.

The author concludes that by tracing each of the three views of the self, many contradictions and vulnerabilities exist and are magnified by the imminent approach of death.

Notes

Richmond Medical Center for Women v. Gilmore: Virginia Partial-Birth Abortion Act's Clarity Extinguishes Physician Standing

Lee Ann Lezzer

In *Richmond Medical Center for Women v. Gilmore*, the U.S. Court of Appeals, 4th Circuit reviewed a suit brought forth by a group of Virginia physicians challenging a Virginia statute that banned partial birth abortions. The court concluded that the plaintiffs failed to establish standing and granted a stay on a district court's order that enjoined the enforcement of the ban. In this case note, Lee Ann Lezzer examines the decision on four grounds and concludes that the Court of Appeals' decision threatens a woman's constitutional right to choose abortion as guaranteed by *Roe v. Wade*.

In her analysis, Lezzer states that the decision was problematic for four reasons: 1) the court's reasoning deviated from a standard usually employed in evaluating physician standing in partial birth abortion cases; 2) its conclusion that Virginia's statute was unambiguous was a deviation from the reasoning used in other partial birth abortion cases; 3) the court's decision placed too much weight on the state's assurances not to prosecute health care providers; and 4) the decision, as a matter of public policy, posed a threat to a woman's right to choose an abortion under *Roe*.

Lezzer concludes that physician standing is key to resolving the controversy over partial birth abortions. According to Lezzer, state statutes banning partial birth abortions pose a great threat to a woman's right to choose. In order to protect that constitutional right, physicians must be provided with standing to challenge bans as they arise.

Pharmacists, Physician-Assisted Suicide, and Pain Control

Alan Meisel, J.D.

Families of terminally ill patients have struggled for years with the idea of a sick family member living her final hours in pain. The health care profession has struggled to find a balance between provided quality care to relieve pain in terminally ill patients and the illegality of physician-assisted suicide. This article focuses on the role of pharmacists in end-of-life care and the possible legal concerns that pharmacists face in such situations.

First, the author suggests that there is a revolution underway in end-of-life care. There are two possible scenarios

that the revolution could create. The revolution could either lead to the legalization of physician-assisted suicide, or if not, it may lead to an increase in some physicians engaging in these practices covertly, though still illegally. The author notes that physicians are not the only health care professionals that play a role in end-of-life care. The author goes on to suggest that by prescribing the medication to control pain in the terminally ill patients, pharmacists ultimately play a large role in carrying out physician-assisted suicides.

The author points out that even where physician-assisted suicide is legal, pharmacists will face various consequences. Among these the author lists: conflicts with co-workers that hold opposing views, conflicts with vocal opponents of physician-assisted suicide, and the risk of liability if a lethal prescription injures a patient, rather than ending her life. The author notes that these problems are only magnified in jurisdictions where physician-assisted suicide will remain illegal. The author suggests that physicians and pharmacists in these jurisdictions will be wary of the potential regulatory and criminal pitfalls of prescribing such medication.

The author concludes that if terminally ill patients are to receive the medications they need to die peacefully, without preventable suffering, courts, legislatures, and administrative agencies will need to give pharmacists and physicians sufficient latitude to practice their profession in a manner that will allow terminally ill patients to receive sufficient end-of-life care without regulatory and criminal restraints.

A NURSING PERSPECTIVE ON END-OF-LIFE CARE: RESEARCH AND POLICY ISSUES

Linda E. Moody, Ph.D., MPH, FAAN
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Technological advances in medical care are extending the lifespan of Americans. However, aggressive treatment in the face of poor prognosis causes patients to suffer and does not address their needs as people. Nurses play a unique role in the quality of the dying process through facilitating communication and providing palliative care, which is therapy designed to relieve or reduce the intensity of uncomfortable symptoms, but not to produce a cure.

The authors discuss the principle of patient autonomy and informed consent, and identify the nurse as an interpreter for the patient and family. The nurse addresses issues and questions raised at each step of the consenting-adult autonomy paradigm and relays information to the physician on the patient's behalf.

According to nursing research, the use of advance directives as a communication tool raises several issues. Relatively few individuals have completed advance directives. Also, patients believe that physicians should initiate discussions regarding such documents. Health care providers lack basic knowledge about advance directives, and have little or no training on how to counsel or advise patients on the documents. Furthermore, time spent with patients discussing advance directives is not reimbursable. Providers are also more likely to follow the wishes of relatives than the preferences indicated in the advance directive. The authors recommend that advance directives should be viewed as an ongoing process of negotiated decision-making between the patient, proxy, and provider over the course of the illness.

One of the ironies of technological advances in medical care is the possibility of a medical fate worse than death. The authors make recommendations for future research on communication, decision making, and pain management at the end of life.

The Catholic Merger Crusade

Hollie J. Paine

In the past two decades, mergers between Catholic hospitals and non-sectarian hospitals have taken place at an alarming rate. The financial resources and economic stability of Catholic hospitals have casts them as ideal partners for troubled non-sectarian hospitals. However, the implications of such mergers have caused great concerns over the loss of patients' rights to obtain and refuse certain services.

In her article, Holly J. Paine explores the economic and social effects of these mergers to hospitals, communities and patients. Paine's article is divided into four parts. Part I provides a description of the Catholic health care system and the details of Catholic hospital mergers. Part II examines the issues associated with the Catholic hospitals refusals to honor patients' advance directives and refusal to accept unwanted treatment. In Part III, Paine discusses the concerns and consequences of allowing merged facilities to maintain certain Catholic policies that conflict with patients' rights to choose treatment scheme and end-of-life directives.

Paine concludes by suggesting that evidence introduced in this article demonstrates that patients' rights to choose will be severely jeopardized. Paine explains that patients' right to choose are called into question on a daily basis at merged hospitals around the country. The merger mania

that has swept the country will therefore further limit the rights, options, and control that a patient has over his/her care.

Medicaring: Quality End-of-Life Care

Anne M. Wilkinson, PH.D. and Janet Forlini J.D.

End-of-life care and physician-assisted suicide garnered increased attention in the late 1990's. The United States Supreme Court recognized the importance of these controversial issues in 1997 when it ultimately decided that the right to physician-assisted suicide was not an inherent right given to Americans by the Constitution and that the state legislatures had the authority to decide these issues. Despite the Supreme Courts ruling, nearly two-thirds of respondents in most polls seem to want a suicide option. This suggests a clear rejection of the status quo.

In this article, the authors examine the end-of-life care options currently available and compares them to the services that can be provided through the Medicaring of end-of-life care. In Part I the author uses an illness impact trajectory and a chart illustrating the median prognosis for two-month survival in examining current end-of-life care. In Part II the author conducts a cost-benefit analysis of Medicaring end-of-life care.

The author concludes that the aim of Medicaring is to help providers deliver care that will assist terminally ill patients in dying comfortably. The author notes that one reason that Medicaring makes this possible is because of its multidisciplinary approach. The author suggests that the multidisciplinary approach provides a better "fit" between the patient's needs and the services provided. Finally, the author concludes that the aging of the baby boomers paired with the constant improvements in medical technology means that everyone needs to be able to rely on a health care system that can meet the needs of the seriously ill, even if those needs span the course of years.