

Respect Life

Care for the Dying

A Physician's Perspective

By JOHN J. FISHER, M.D.

Death, the universal human experience, is rarely mentioned in medical teaching and is avoided in textbook discussions. The complete physician must be able to treat the dying if medicine's goal is to care effectively for the whole person. The task of the physician is not to comprehend what is sometimes incomprehensible, but to make the natural process of death and mourning more meaningful and more productive for the people whom he serves.

Since the advent of the hospice movement, the percentage of deaths occurring in hospitals is decreasing. Nevertheless, many patients still die in a hospital and a great percentage of these deaths are caused by malignancy. For practical purposes, when one speaks of a dying patient one usually speaks of a patient in the terminal phase of cancer. Patients suffering from cancer may present the most difficulties and discomfort for the physician and the hospital staff, and frequently neither is able to respond adequately to fatally ill patients and their families.

The Need for Dialogue

When one encounters a patient, of whatever age, with a fatal illness, there should be an open-ended discussion about as many questions covering fatal diseases as possible. One should be certain that the patient and the family understand the disease and that the physician knows what they have been told. It should be emphasized that we do not know the cause of the disease and cannot isolate the factors, caused by action or omission of the patient, which are responsible for what has occurred. The lack of contagiousness of a malignancy should be related.

Occasionally a patient, and more frequently a family member, may want a second opinion or referral, even when the patient is preterminal. This should be done expeditiously, without rancor on the part of the physician. But the physician should emphasize that there are no "patients" in medicine and assure the patient that, if they have heard of a cure in Tijuana, Japan, or elsewhere, they should realize this drug would be provided if it were of benefit. It is important that the family, patient and friends have all their questions based on printed articles and rumors about treatment answered.

A realistic picture of the disease

and the dying patient should be discussed and family members helped to understand how differently people react to grief, whether it be by escape, denial, self-pity, self-blame, hostility, intellectualization, crying, or self-numbing, etc. Understanding this helps them to deal with family members and others.

Four basic needs must be met in the terminal stage of a patient's illness: prevention of pain; alleviation of emotional suffering; maintaining of dignity; and avoidance of isolation. None of these should be overlooked. Pain may be more adequately handled in a non-institutional setting. Often, when a patient is "written off" as terminal, the tendency of the physician and the hospital system is to withdraw and reduce communications to a minimum. The physician should not withdraw from the dying patient or delegate responsibility for the patient's care to the health team. If the physician becomes an "absentee doctor," hospital personnel may also rationalize their withdrawal from this "hopeless case," which will only worsen the isolation of the dying patient.

Caring for the Young

In treating the child, adolescent or young adult who is dying, the physician must use his or her therapeutic skills with the greatest understanding, for the death of these patients confronts the doctor with one of the most difficult tasks. The child who is age 6 or younger has no clear concept of the finality of death. Very young children do not know that people die. If they are aware of death at all it is as something that happens only to other people. In treating the young child who is dying, the greatest support has to be provided not to the child, but to the parents and the family, as well as to the treating personnel.

The meaning of dying is appreciated by the teenager but the reality of personal death is not accepted. More than in any other age group, the adolescent and young adult ask, "What have I done to deserve this?" The specific emotional reaction of the adolescent to death is conflict — inner struggle over dependency and self-sufficiency, guilt, anger, loving, and rejecting. The adolescent and the young justifiably feel that death should come only to those who have lived completely. The dying young adult may occasionally alienate



himself or herself from the family. If the physician and staff can understand this natural rage they see in the young adult, they may be better able to help him or her cope with this emotional reaction.

Caring When We Cannot Cure

Most physicians gain their greatest professional gratification from treatment success. Therapeutic achievement is usually measured by the rehabilitation of the patient and restoration to health. For many physicians, the patient who is not getting well may become ungratifying to treat. Often, the treating physician may react as if the patient has failed him. Occasionally physicians wonder why a patient dies after all they have done for him.

The elderly, conversely, may have fears of being aggressively over-treated against their will and this has been heavily exploited by supporters of euthanasia. The "Humane and Dignified Death Act," a means of physician-assisted suicide, is being sponsored by the Hemlock Society and its political arm, Americans Against Human Suffering. While some of this Act's supporters have a genuine humanitarian desire to minimize terminal suffering, the initiative would cut across long-established ethical norms of professional behavior and dangerously weaken standards of care for many segments of society — ultimately reaching beyond the terminally ill. It is an act we do not need.

"Death with dignity" has become something of a cliché, seen by many as a self-chosen death which includes assisted suicide for terminally ill patients. This should not be confused with the legitimate refusal of unwanted and ineffective medical care, especially life-supporting technology. The initiative would legalize physician-administered active euthanasia, not the right to withdraw extraordinary medical aid from the hope-

lessly dying.

The growing interest in active euthanasia has paralleled the rise of the hospice movement, as both movements seek to counter the fearful specter of modern medical technology with its attendant indignities — its tendency to make the treatment worse than the disease. Hospice is life affirming, seeking to support the patient through aggressive social care in conjunction with symptomatic relief. The family is the unit of care in hospice; "assisted suicide" is the diametric opposite of hospice care, dignity achieved only by definition, devoid of the complex supportive systems essential to hospice.

It is often asserted that there is irremediable pain associated with dying patients. This is not true, especially with the use of morphine drips, oral morphine preparations, and other pain control mechanisms.

Although the basis for the Humane and Dignified Death Act is a universally shared concern about the capacity of modern medicine to worsen human misery, its enactment as law would raise many more problems than it would solve. There is no reason to abandon longstanding medical ethics, reverse accepted policy toward suicide, or undermine the growing movement to enhance the care of the terminally ill.

No human being is well-equipped to deal with the problem of death, but euthanasia is not the answer. Physicians must appreciate and learn to manage their own normal reactions to death and to make the natural work of death and mourning more meaningful and productive for the people they serve. The care of the dying patients is more a manifestation of the art of medicine than the science.

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