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Accepting Death As Natural Would Alleviate Fear, Stress

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Society continues to have difficulty accepting death as a natural part of life. We go on hoping it won't happen to us, at least for now, and when death raises its head, we look the other way. The result is fear, confusion, denial, poor decision-making and an unskillful use of resources. Thirty percent of all Medicare expenditures are attributed to the 5 to 6 percent of beneficiaries that die each year, and one-third of those costs are incurred during the final month of life. All concerned would benefit from more familiarity with the inevitable and a better understanding how we might pass gracefully when our time comes.

At the Hawaii Book and Music Festival, I led a panel about death and dying. At one point I asked attendees for a show of hands to see who would prefer to die in their sleep and who would like to know in advance that death was coming, so they would have time to prepare. Two-thirds of the participants indicated that they would rather go to sleep one night and not wake up.

The panel also discussed physician-assisted suicide (PAS). Unlike euthanasia, which is legal in the Netherlands and entails a physician administering an IV with lethal medication, PAS allows a physician to write a prescription for medication that would end a patient's life. A patient would have the choice to fill the prescription and take the medication at-will. The majority of panel attendees felt PAS should be legal.

This discussion made me question how much the public really understands about palliative care and hospice services. Palliative care offers comfort measures to those with chronic disease, some of whom might be terminal, and it can be offered concurrently with curative treatment. Hospice is reserved for end-of-life care and supports patients and their loved ones in letting go as comfortably and gracefully as possible.

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I have had the opportunity to be a principal caregiver at the end of life for two grandparents as well as my father, all of whom died in hospice. It has been my experience — not only as a physician, but also as a family member — that the correct balance of medicines effectively manages pain and anxiety. In hospice the dying can be made to feel relaxed and comfortable, and can be afforded the opportunity to make their peace and pass on when the time in the body comes to a natural end.

PAS and euthanasia seem both abrupt and premature. As a physician, it always struck me that since we cannot create life, we should not actively end it. A great many times, I have treated patients who were suicidal due to depression. With few exceptions, such patients came back to the light with proper medical treatment and enough time. I have also treated patients who suffered great physical trauma and patients who, when faced with a new diagnosis, thought that they did not want to go on. These patients were eventually able to adapt and live quality lives.

When it comes to PAS or euthanasia, the slippery slope is steep. One might argue that patients with metastatic cancer or no residual brain function should be put out of their misery. What about a middle-age person in the early stage of a cancer with a 50 percent chance of survival who asks for PAS? What about someone undergoing midlife crises and faced with divorce, bankruptcy and erectile dysfunction? What about a college student who has failed an exam and cannot face his parents? Where do we draw the line? Can we? Should we try? I don't think so. PAS is beyond our capacity for discernment.

In contrast, extending life by artificial means is a separate discussion. By becoming more familiar with the potential for a gentle death, patients, providers and families will feel less compelled to deploy any valuable resource to prolong life where quality is poor and chances of recovery are negligible. Guilt, desperation and defensive medicine are not good reasons to render high-tech treatment.

We need to get better at accepting death as part of living. Medicare now covers the cost of a discussion between patients and physicians about what patients might want for their end-of-life experiences. This is a discussion worth having. The discussion should include options for palliative care and hospice, and consider whether and when one might wish to decline heroic treatment.

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