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Ethical Considerations in the Care of the Dying Patient and the Hospice Concept

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As concern for care for the dying increases, including hospice care, it is important to examine some of the ethical considerations included in this concern and its implementation. There are three areas of consideration — first, ethical obligations which stem from the profession of medicine toward the dying; second, ethical problems which arise in attempting to secure those obligations toward individual patients; third, ethical features of providing social policy for the care of the dying, particularly the development of adequate hospice programs. I will briefly examine each of these.

Ethical Obligations Toward the Dying

Insofar as we are all members of society, all of us participate in general obligations of justice toward those in need.¹ In addition, those professing religious compassion have the urgings of charity which emphasize the obligations of justice. However, health professionals have additional ethical obligations to care for the living and the dying which stem from their profession to heal.²

Healing is a value which infuses the health care/patient relationship. The health care professional commits himself to this value by acting on behalf of the patient, not with respect to all the values of the patient, but with respect to health. The patient commits himself to this care, to the many indignities and passivities of the relationship, because he or she also values health and healing.

Among the obligations which arise from this relationship to patients for the health professional are the following: 1) do no harm; 2) respect the vulnerability of the patient; 3) treat each patient as a class

instance of the human race, without attention to his or her economic, social and political standing.³

It is important to remember that the patient's need for the skills of the health professional with respect to healing is the very lifeblood of the relationship. As the patient's need increases, so too does the intensity of the three ethical obligations cited above.⁴ Thus one might consider turning away a destitute patient with a minor cut on the finger, but health professionals must treat dying patients (obligation no. 3).

The major ethical consideration in this category, therefore, stems both from the dying patient's need for the skills health professionals can provide and for the shifting notion of healing operative in the relationship. With major diseases such as cancer and heart trouble it is never absolutely clear that a crisis will lead to death at this time. Although health professionals continue to respond to the needs of their patients in terms of "making them comfortable" or otherwise offering palliative measures such as new chemotherapeutic combinations or pain suppression operations, the operative notion of healing has switched from possible cure of the disease to providing several good months.

However, what the patient may now need is a broader conception of healing than cure, palliative measures, or pain-killing drugs. Although these should not be ruled out, the ethical obligation to heal now requires the health professional to ask some disturbing questions. Am I now, at this point in disease progression, merely prolonging life needlessly, adding to the pain and agony of the patient and family? What is the healing thing to do at this point? If I do not exercise some of my skills, am I abandoning the patient?

Most ethicists would agree with Paul Ramsey's view that the obligation to heal, in the case of the dying patient, does not mean to needlessly prolong life. Instead the obligation now turns, as the patient clearly deteriorates, to providing a decent death.⁵ This provision leads to the second class of ethical considerations.

Ethical Considerations for Individual Patients

I discussed above a health professional's general obligations toward dying patients. The real ethical problems occur, however, in trying to carry out these obligations for individual patients. If the obligation to heal no longer means to employ the general medical armamentarium useful for combating disease, what specific measures should be selected, withheld, and discontinued? Of course this is not only a medical question but also an ethical one because it is asked in the context of obligations toward the patient.

Each case varies. But the common ethical problems involving dying patients include selecting extraordinary means to preserve life,⁶

withholding some measures including those normally considered ordinary means, and discontinuing both ordinary and extraordinary measures. Let us look at these three actions in reverse order.

Physicians are less apt to discontinue a measure once begun than not to order it. This reluctance stems from the engagement with the patient created by these measures and their identification with providing for the patient's needs. In light of the above discussion on healing, however, neither ordinary nor extraordinary means need to be continued to carry out one's obligations when a dying patient or family member requests discontinuance. Not only respirators and other "heroic" measures, but also IV's and antibiotics fall under this consideration.

Withholding extraordinary means can depend on patient or family requests, living wills, or a no-code contract with the patient.⁷ Withholding ordinary means, such as IV fluids, antibiotics, or even the respirator if it is being used to adjust drug dosages for seizures and the like, is far more problematic. The same holds true for selecting some measures rather than others. The patient and family may not be the best judges of the current stage of the disease. These judgments will depend on the history of the disease, therapies already tried and failed, patient values about the true nature of healing, and the doctor's judgment.

Thus, if a patient has agreed to work for "some good months," and clinical indicators do not reveal whether a current crisis may be the last, the doctor should select everything available at his command, mindful of the difficulty of discontinuing therapy once the crisis is revealed as terminal. If the patient has opted for quitting, a severe injustice is done to order extraordinary measures, though ordinary means are still required until the crisis is judged not only irreversible, but terminal. If a patient has explicitly asked to be allowed to die, especially after a year or two of frequent hospitalizations, remissions and relapses, this wish must be taken seriously even though the doctor may think he could prolong the patient's life a few more months.

Given the emphasis on cure in medical training and the technological capacity of modern medicine, withholding therapy seems inconsistent with the goals of health care. However, serious reflection on the needs of the patient who is dying and the nature of the healing obligation can offer some moral guidelines to those who care for dying patients.

Ethical Basis of Hospice

The hospice, whether home health care-based or hospital-based or both, rests on the same fundamental moral principle as does the doctor-patient relationship and should be viewed as an extension of

the relationship. Thus, it is based on patient need for healing and, at least partially, on health care obligation to provide that healing. By definition one is not referred to hospice care unless he or she is suffering an irreversible terminal disease in its end stages. No more than six months of further life are anticipated.⁸

Hospice care should not be viewed as an alternative to health care, but rather, as a supplement. If it is construed in the former fashion, the prior bond between doctor and patient is ruptured. Referral to hospice would appear in the doctor's mind as abandoning a long-term patient rather than as supplementing the medical needs of the patient with other needs modern medicine cannot provide. Among these needs are a family environment (at home or in specially designed care institutions), legal, spiritual, economic and social support. Of course, these are major needs. However, they, too, fall under the rubric of healing that infuses the health care/patient relationship as well. If viewed in this way, hospice care is an extension of health care and shares its moral basis. The patient still needs the palliative measures medicine can provide and will need extensive individual attention for problems of pain, mobility, anxiety, and bed care. Being under hospice care will diminish the two fears patients have about dying — a fear of abandonment and a fear of sudden catastrophe.⁹

With respect to physician obligations toward the patient discussed in the first two sections, hospice referral can resolve many of the ethical dilemmas faced when caring for dying patients in traditional environments. One has been mentioned already. Such referral does not mean abandoning the patient or bouncing him back to a nursing home to be seen again in the emergency room when another crisis develops. The physician still manages the patient's case. The general obligations to do no harm, respect the vulnerability of the patient, and treat each patient as a unique person are fulfilled in hospice care. Specific ethical decisions about medical treatment are also made in advance, so to speak, because such referral with patient or family consent means that no further medical interventions will be attempted, except perhaps, pain control surgery. Truth-telling problems are avoided. Hospice patients and their families know they are dying.

Most of all, hospice care can lend some much-needed reality to the obligation to provide for a "decent death" discussed in the first section. In normal hospital circumstances a "decent death" can still be misconstrued as one filled with heroic measures and resuscitation attempts. The family is often absent as hospital patients so treated die in pieces, as it were, one organ system failing after another. If, indeed, health care professionals do have an obligation to heal dying patients by providing a decent or dignified death, then hospice referral is the best current means to insure that that obligation is carried out.

Conclusion

I have deliberately avoided a discussion of economic and pragmatic ends in the care of dying patients, not to neglect their importance as well, but to highlight the moral obligations attendant on health care professionals and the health care system in treating dying patients. Attention to the healing value of the doctor/patient relationship and the patient's growing need for healing when health becomes impossible can provide the moral basis of special duties toward the dying. While all of us share in these duties as a matter of justice and charity, health care professionals have more intensive obligations toward the dying based on their commitment to heal.

REFERENCES

1. Aquinas gives his view of the basis of social justice by defining man as naturally political and social; in this he follows Aristotle: "Homo est naturaliter animal politicum et sociale, ut probatur in I Polit" (*Summa Theologiae*, II-II, q. 64, art. 5). However, virtually all modern thinkers from Hume and Voltaire, Locke and Kant to the present consider man essentially a single free entity. Consequently obligations of justice to other human beings rest, for these thinkers, not on the nature of man but on social contracts such as beneficence (Hume and Voltaire) and the preservation of the freedom and dignity of others (Locke and Kant).
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4. Thomasma, David, "Professional and Ethical Obligations Toward the Aged," *Linacre Quarterly*, Feb., 1981, pp. 73-80.
5. Ramsey, Paul, *The Patient as Person* (New Haven: Yale University Press, 1970), pp. 118-124.
6. There is some dispute about the meaning of "extraordinary means" among ethicists. It is meant here in the sense originally proposed by Pius XII, "The Prolongation of Life: An Address of Pope Pius XII to an International Congress of Anesthesiologists," in *Death, Dying and Euthanasia*, ed. by Horan and Mall (Washington, D.C.: University Publications of America, 1977), pp. 281-292.
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8. Cf. National Hospice Organization, "Standards of a Hospice Program of Care," 6th revision, 1979, p. 11.
9. Kubler-Ross, E., *Questions and Answers on Death and Dying* (New York: Collier Books, 1974), pp. 154-171.