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Dying with Dignity

Marcus Aurelius' assertion that "an emperor should die standing up" and the Western pioneer's wish to die with his boots on exemplify the desire to die with dignity. Increasingly we lose this opportunity. Progress in the prevention and cure of acute illness has shifted most deaths to the chronic disease category and has made lingering terminal illness more frequent. In earlier days, most people died at home or at work, tended by friends and family. Now the terminal patient has largely lost the security of dying in familiar surroundings, for most deaths occur in a hospital or nursing home, where medical skill and sophisticated equipment sometimes prolong vital signs after all hope of recovery and sometimes after sentience and self-control have disappeared. These capabilities are sometimes used, yet typically the treatment given the terminal patient is poorer in quality and quantity than that given the patient who is expected to recover, for the interest of the hospital staff is in saving lives and restoring health. No member of the staff has had professional training in dealing with dying patients, their relatives, or the problems of bereavement. All of this makes for added stress for the patient and his family. One study has found that in the year following the death of one member of a family, the death rate among close relatives is twice as high if the primary death occurred in a hospital or nursing home as it is if the primary death occurred at home. We have the curious situation that medical progress has made death more stressful for relatives, more expensive for the family, and more troublesome for society. Because these are discomforting matters, we have pushed them aside; death seems to have replaced sex as the socially taboo topic.

Yet physicians, psychiatrists, and sociologists are becoming more interested in the conditions and circumstances of dying. Among research findings is the demonstration of a significant dip in death rates just before patients' birthdays, before such major events as Presidential elections, and among Jewish patients before the Day of Atonement. (Remember that John Adams and Thomas Jefferson both lived until the 50th anniversary of the signing of the Declaration of Independence, and died that afternoon.) This type of self-control of the time of dying poses few problems. More active controls—suicide and euthanasia—raise moral difficulties. And the physician's own increasing skill leads him into ethical dilemmas. When and for how long should he use heroic methods to continue life a little longer? Is a heart transplant worth the \$20,000 or more it costs? Would a billion dollars a year be well spent on 50,000 heart transplants, with their frequently short survival times and high maintenance costs? Which patients get, and which should get, the use of scarce facilities that permit a few of them to live a few more days or weeks?

Physicians alone cannot answer such questions. They call for wider attention, for they all involve scientific, ethical, humanitarian, social, and sometimes religious considerations.

Is society ready to analyze death and the prolongation of life in terms of cost-benefit analysis, or to consider shifting the use of expensive facilities from the hopelessly ill to those whose future holds more promise? What about the customary reluctance to administer powerful but addictive drugs until "near the end"? What do we think of the "senseless prolongation" of life? Birth is no longer blindly accepted, but increasingly is planned and timed. Does this development and the growing acceptance of abortion indicate a readiness to consider euthanasia? The taboo against the discussion of such questions will have to relax, and seems already to be doing so. A society increasingly concerned about the quality of life cannot omit the final chapter from its concern.

—DAEL WOLFLE