

# Virtual Mentor

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## LETTER FROM THE EDITOR Dying in the Twenty-First Century

*It hath often been said that it is not death, but dying, which is terrible.*  
–Henry Fielding, *Amelia*, 1751

*There is an appointed time for everything. A time to give birth and a time to die.*  
–*Ecclesiastes* 3:2

Every living thing dies. Because of the mystery of this event, humans throughout history have created cultural and religious rituals surrounding the dying process and post-death period. Songs may be sung, texts read, prayers chanted, incense lit, special clothes donned. The *Oxford English Dictionary* defines “ritual” as “a religious or solemn ceremony consisting of a series of actions performed according to a prescribed order” [1]. The United States system of medical care has developed death rituals of its own as medical technology has evolved, particularly in our hospitals and intensive care units. These rituals are characterized by increasingly aggressive medical interventions that too often serve only to prolong the dying process. Even following cessation of a patient’s heartbeat and respiration, we routinely attempt resuscitation of everyone who does not have a documented do-not-resuscitate (DNR) order, regardless of that patient’s diagnosis or chance of recovery.

It has become increasingly clear to many physicians and laypersons over the years that these medical interventions for the dying too often have no medical rationale and may in fact violate a cardinal principle of medical ethics: first, do no harm [2, 3]. In these cases, patients are often subjected to invasive and painful procedures that are of no medical benefit and that rob them of the dignity and peace that we all wish for ourselves when our time to die has come.

Due to these ethical concerns as well as to patient [4], family [5], and clinician [6] dissatisfaction with U.S. end-of-life (EOL) standards of care, our culture has been undergoing a change. We are rethinking whether CPR should be the default standard of care for every dying patient [7]. We are searching for ways to spare patients inappropriate aggressive treatment wanted by well-meaning and desperate relatives during what is clearly the dying process. We are trying to refine our medical judgment and prognostic skills so as to employ sophisticated technology only when appropriate to stave off death. Above all, we are seeking to train young doctors to help patients and their families navigate the dying process in a way that upholds the dignity of the patient and ensures that he or she experiences the highest possible *quality* of life until the end.

As proof that society perceives deficiencies in end-of-life care, laws and court decisions now require certain patient-physician interactions pertaining to it [8-10], a circumstance that is rare in medicine. Although our profession is trying to ensure better care for terminally ill patients (and their families), physicians too often poorly navigate the difficult and complex ethical situations that arise. This has led to legislation in New York and California mandating that physicians offer palliative and hospice care to all terminally ill patients [8, 9]. One of the goals of our profession should be universal familiarity with, comfort with, and training in palliative care among doctors so that we offer the best possible care without the need for legislation to dictate our practices.

Thankfully, we are moving in that direction. Palliative care has been shown not only to improve patient quality of life [11-14] but also to increase the value of medical care (the quality-to-cost ratio) [15, 16]. The number of hospitals offering palliative care has increased from more than 600 in 2000 to more than 1,600 in 2010 [17], and this number continues to grow.

This issue of *Virtual Mentor* discusses end-of-life ethical issues that we believe all physicians should have an awareness and understanding of. One theme of the issue is the distinction between palliative care and end-of-life care. The Center to Advance Palliative Care defines palliative care as “specialized medical care...focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family” [18]. Palliative care can and should be offered to terminally ill as well as non-terminally-ill patients, and, contrary to popular belief, palliative care can be given in conjunction with curative medical interventions. Our contributing authors also explore innovations in teaching end-of-life topics, religious dictates concerning EOL decisions, the moral questions raised by treating patients with increasingly sophisticated medical technologies at the end of their lives, and the history and future of this field.

A single journal issue can only scratch the surface of the ethical complexities involved in end-of-life care with patients and their families. We suggest not only reading the articles within this issue but also consulting the suggested readings list.

Our hope is that exposure to and comfort with palliative care come to be seen as essential for all medical school graduates. Any physician involved in patient care will almost certainly encounter patients who are dying. Dermatologist, pediatrician, cardiac surgeon, or psychiatrist, whether or not you are the physician in charge, you should have the ability to listen to dying patients, attend to their needs, and help them assess their goals of care. Furthermore, physicians and other health care professionals are often approached by acquaintances for advice on how to relate to friends and family members who are dying. In these instances we have the opportunity to offer constructive suggestions that can contribute to a better societal understanding of the proper roles of medical treatment and palliative care in end-of-life situations.

## References

1. Ritual. *Oxford Dictionaries*. Oxford: Oxford University Press; 2013. [http://oxforddictionaries.com/us/definition/american\\_english/ritual](http://oxforddictionaries.com/us/definition/american_english/ritual). Accessed October 14, 2013.
2. Evers MM, Purohit D, Perl D, et al. Palliative and aggressive end-of-life care for patients with dementia. *Psychiatr Serv*. 2002;53(5):609-613.
3. Earle CC, Neville BA, Landrum MB, Ayanian JZ, Block SD, Weeks JC. Trends in the aggressiveness of cancer care near the end of life. *J Clin Oncol*. 2004;22(2):315-321.
4. Desbiens NA, Wu AW. Pain and suffering in seriously ill hospitalized patients. *J Am Geriatr Soc*. 2000;48(5 Suppl):S183-S186.
5. Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004;291(1):88-93.
6. Solomon MZ, O'Donnell L, Jennings B, et al. Decisions near the end of life: professional views on life-sustaining treatments. *Am J Publ Health*. 1993;83(1):14-23.
7. Blinderman CD, Krakauer EL, Solomon MZ. Time to revise the approach to determining cardiopulmonary resuscitation status. *JAMA*. 2012;307(9):917-918.
8. Right to Know End-of-Life Options Act, Cal Code sec 442-442.7 (2008).
9. Palliative Care Information Act, 331 New York Pub Health Laws sec. 2997-c. (2010).
10. State of New York. New York Department of Health memorandum for chapter 370 of the public health laws [1992]. <https://www.health.ny.gov/professionals/ems/pdf/srgdnr9232.pdf>. Accessed October 23, 2013.
11. Wright AA, Keating NL, Balboni TA, Matulonis UA, Block SD, Prigerson HG. Place of death: correlations with quality of life of patients with cancer and predictors of bereaved caregiver's mental health. *J Clin Oncol*. 2010;28(29):4457-4464.
12. Armstrong B, Jenigiri B, Hutson SP, Wachs PM, Lambe CE. The impact of a palliative care program in a rural Appalachian community hospital: A quality improvement process. *Am J Hospice Palliat Care*. 2013;30(4):380-387.
13. Brumley R, Enguidanos S, Jamison P, et al. Increased satisfaction with care and lower costs: results of a randomized trial of in-home palliative care. *J Am Geriatr Soc*. 2007;55(7):993-1000.
14. Rummans TA, Bostwick JM, Clark MM; Mayo Clinic Cancer Center Quality of Life Working Group. Maintaining quality of life at the end of life. *Mayo Clin Proc*. 2000;75(12):1305-1310.
15. Morrison SR, Penrod JD, Cassel JB, et al; Palliative Care Leadership Centers' Outcomes Group. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*. 2008;168(16):1783-1790.
16. White KR, Stover KG, Cassel JB, Smith TJ. Nonclinical outcomes of hospital-based palliative care. *J Healthc Manag*. 2006;51(4):260-274.

17. Center to Advance Palliative Care. Growth of Palliative Care in U.S. Hospitals, 2012. <http://reportcard.capc.org/pdf/capc-growth-analysis-snapshot-2011.pdf>. Accessed October 28, 2013.
18. Center to Advance Palliative Care. Defining palliative care. <http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc>. Accessed October 28, 2013.

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