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They Shoot Horses, Don’t They?

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Friedrich Nietzsche once said, “To die proudly when it is no longer possible to live proudly. Death of one's own free choice, death at the proper time, with a clear head and with joyfulness, consummated in the midst of children and witnesses: so that an actual leave-taking is possible while he who is leaving is still there” ("Quotations About Death," n.d.). There has always been a debate over the termination of one’s own life when dealing with a terminal illness. It is important for not only any patient, but especially for elderly patients, to understand patients’ rights as well as have these rights fully enforced over the duration of an entire illness and lifetime. Even though it is not permitted in many states in the U.S., “Death with Dignity” is an effective way for the elderly to end their lives with respect and dignity in a way that they wish. It seems like a simple issue for the government and the U.S. citizens to figure out, yet a lot of different issues come into play. Arguments dealing with religion, ethics, constitutional and basic human rights, and also the definition of suicide are among a few of these issues. Overall, elderly sick citizens of the U.S. should have the right to terminate their own lives in a way which they desire without any pain or suffering, in a safe and comfortable place, and surrounded by the people they wish to be present to spend their last moments with.

Death with Dignity is a newer act that only three U.S. states have passed. This Act allows physicians to provide patients with a lethal dose medication upon a patient’s request in order to end their own life at a time they feel suitable (“Death With Dignity,” n.d.). For elders, this may offer something that the boundary between life and death has not commonly offered before: dying at a point in time that the patient feels is appropriate. The patient can decide to be in their own bed at home surrounded by their loved ones at the time of death opposed to attached to machines, in pain, and possibly alone when they cross over. It is important for death to be a time of reflection, quality, least amount of pain, as well as dignified. For many elders, their lives have been truly lived and the quality of life has been great. If a terminal illness continues on and the patient does not truly want to live, what are they living for anymore? If an elderly patient in pain feels lonesome, isolated, a burden, stressed about finances or government spending, or any other negative emotion that may come with the territory of the beginning of the dying process, it is important that these emotions be diminished and that the patient should only celebrate the life they lived in a way they wish to be respected. “Death with Dignity” keeps in mind all of the following: respect for autonomy, justice, compassion, individual liberty versus state interest, and openness of discussion (“Death With Dignity,” n.d.). Recently, a young woman, at the age of 29, decided to end her own life before her illness could affect her personality, life morals, quality of life, and dignity. Although some may argue that this act offers the stance of assisted suicide, it is lawful for an individual paired with a cooperative health care physician to execute this act.

Brittany Maynard, the 29 year old woman previously mentioned, was diagnosed with terminal brain cancer and had no interest in allowing the cancer affect her life or change her into a person she did not desire to become. Brittany Maynard was offered medication from her doctor that would terminate her life when she so desired after she was given only about six months to live and her pain was bound to only get worse with time (Maynard, 2014). Maynard and her family had done research of treatments that some of her doctors had brought to attention but Maynard concluded that, “There is no treatment that would save my life, and the recommended treatments would have destroyed the time I had left” (Maynard, 2014). Brittany Maynard ended her life with dignity on November 2, 2014 in her home in Portland, Oregon, surrounded by the people she loved and the people whom loved her. In an interview, after being asked to not go through with this act by many people throughout the nation, Maynard expressed, “I would not tell anyone else that he or she should choose death with dignity,” but her question to the nation was, “Who has the right to tell me that I don’t deserve this choice” ([Slotnik, 2014](http://www.nytimes.com/2014/11/04/us/brittany-maynard-death-with-dignity-ally-dies-at-29.html?_r=0)). With only treatments that would provide suffering, personality alterations, and pain for not only Ms. Maynard, but also those she loved, Maynard did not wish to live as so many do in the U.S. towards the end of their life: in a hospital, possibly alone, and painfully suffering. Although Maynard was a young woman, it was her individual right and choice to terminate her own life with dignity surrounded by her own people. The ill elderly also should be offered this choice towards the end of their lives.

The nation has been facing issues dealing with death from terminating illnesses ever since the beginning of time. The difference over the past few decades has been advanced technology, the right to choose and be informed of all medical options and positions, but now, even more, there is a right to pass with their own true personality, surrounded by people whom they choose, as well as where they would like to pass in peace. If a patient in a health care facility can choose to be DNR, do not resuscitate, why do they not have a choice, when given a prognoses to only live another six months, to decide the time and place of death? For many elderly, as time goes on with a terminal illness, pain and suffering occur which can affect the quality of life, personality of the individual, as well as the relations in which they have with others: “financial affairs that may need attention; discussions about the kind of care needed and wanted; visits to spend time with loved ones; conversations to bring closure to any issues or relationship a person at the end of life may want to resolve and working through any fears that the end of life may bring” ("Pain at the End of Life," n.d.). Many people who eventually die in hospitals receive undesired treatments or procedures and have prolonged pain in order to serve for the science of medicine, because someone else told them to go through with these procedures or treatments, when both of these issues are immoral, unethical, and do not allow the ill patient to make decisions for themselves ("End-of-life Care Fact Sheet," n.d.). Not only do many elders whom are terminally ill face the issue of the pain and suffering physically and emotionally, another stressor dealing with health care is finance. If the patient does not desire to live or suffer any longer and would like the finances given by the government or paid privately to go towards another person, group, or purpose, the ill patient should be permitted to do so without criticism for their personal dying wish or desire.

Currently in the U.S., Medicare helps the elderly, sixty-five and older, receive the appropriate care without any concern of costs. Although this is what Medicare is said to do, there are a lot of finances that are not covered by the government financial aid and also do not take into consideration the personal choices of a terminally ill patient. For most elderly within the U.S., death is not a fear itself. The fear the elderly have of dying is the pain and suffering, being remembered as weak or someone who they were not before the illness had come along, leaving loved ones alone, as well as financial burdens. These stressors do not allow the ill elderly to pass with a high quality of life or the dignity they so deserve when they pass. The government financial aid does not cover any treatment to cure an illness, the prescriptions to cure this said illness, any care that has not been set up by a hospice team, room and board at a care facility, emergency room costs, inpatient care, and transportation ("Your Medicare Coverage," n.d.). If a terminally ill elderly patient no longer wishes to be treated, used as experimentation against their will, or simply live through the illness that is bound to end their life, they should not have to endure the typical end of life pain and suffering. Patients should have the choice to live in the pain and continue paying for it or put a dignified end to their own life when they feel it is necessary and proper. This statement is not to be confused with the thought that any health care employee recommend the terminally ill patient end his or her life if they do not desire this course of action. If a patient decides to continue treatment, tests, risk the pain and suffering, and try and beat the disease that has a prognosis to kill them in the near future, they have every right to. This “Death with Dignity” simply gives the patient the ultimate decision to the end of life situations in their individual care plan. This topic affects many different aspects in different departments such as social, ethical, societal, and political controversy.

Politically, the “Death with Dignity” or induced passing could become a very controversial issue over the next few years. This serious topic could play a major roll in elections, debates, and also laws. Although Medicare has helped allow medical finance assistance from the government for those sixty-five and older, it is time for the government to play a larger role in health care where there are so many injustices and legal confusion. Lately, the Medicare spending for the ill elderly has increased during end of life actions in order to keep them alive. In 2012, Medicare spending grew 4.8% to $572.5 billion, 21 percent of the total National Health Expidenture ("Research, Statistics, Data &," n.d.). The government spends enough money as it is on healthcare, which is extremely important, yet if money can be put to better use rather than keeping someone alive while in pain and suffering when they are tired and desire to pass with peace, why not take advantage of that opportunity? If a terminally ill patient with a prognoses of death within the next six months does not desire to live much longer, a lethal dose of medication would cost the government less money than keeping a person who no longer desires to live alive. Elderly patients are amongst the most expensive patients to care for in hospitals and other health care facilities: “Per person personal health care spending for the 65 and older population was $18,424 in 2010, 5 times higher than spending per child ($3,628) and 3 times spending per working-age person ($6,125)” ("Research, Statistics, Data &," n.d.). With such high costs, why not allow terminally ill elderly decide for themselves how they would like to pass? If a patient can sign a form for DNR, why can they not take action when they desire to let go and pass when, where, and with whom that they desire? Politicians will see health care increasingly due to all of the acts, insurance policies, and now this controversy that is legal in only three states. It will only grow and the government and the workers that reside in politics must be prepared to have opinions and knowledge on such topics as well as change the health care system for the elderly of the U.S. By allowing “Death with Dignity” for terminally ill elderly patients, new government positions could be created and filled, creating more jobs, more detailed attention to such issues, and lessen the end of life care decisions made illegally by hospitals and other health care facilities throughout the nation. The government can legally change the way end of life care occurs and it is important that society understand the basic rights of a patient associated with health care and each individuals’ opinion and wish for the termination of their own life with certain criteria and guidelines.

Just as the government can play a large role for this topic of controversy in the U.S., the society of the U.S. also plays an important role. Due to the democratic government, the issue must be voted on by the U.S. people before any course of action can be taken. Prior to voting, the topic up for debate must be fully understood by voters and it is important that the people of the U.S. understand rights of the patient as well as a citizen. A major component to a patients’ right with health care states that, “all patients have the right to informed consent in treatment decisions, timely access to specialty care, and confidentiality protections” ("Principles of Patients' Rights," n.d.). This also leads to the importance of a patient’s right to decide the course of action with more aspects other than only informed consent, including any action to be taken in their care, especially in end of life care. It is obvious that there will be opposition to “Death with Dignity”, as in any other political and social controversy. Overall, individual rights of a person should overcome the assumption that this act only allows suicide to be legal because this is not the case. This is when laws and thorough descriptions from the government should be enforced. As of now, the “Death with Dignity” Acts state that a patient must have the prognosis of six or less months to live, be 18 years of age, and capable for making and communicating health care with the health care team members. These regulations may stand as long as medical tests show that the patient truly is declining in health, in order to remain law abiding. Physicians and hospitals must place their licenses and certifications at stake, just as they do any day or night on the job, and truly abide by the law as well as respect what each specific patient desires. There must be evidence that the person requesting the lethal dose of medication is declining in health and will more than likely experience pain and suffering within the near future. As criticism comes about over time dealing with the issue at hand, it must be brought to attention that humans are mammals just as domestic or agricultural animals are mammals. In this sense, the U.S. allows veterinarians to end an animal’s life to end suffering and pain when it is not even the individual who is passing’s decision. If a human being can decide whether or not to have his or her domestic or agricultural pet “put down”, why, then, is it not the right for a human being, themself, to decide to be “put down” to avoid extensive suffering and pain as well as personality changes and lesser quality of life?

“By 2023, health expenditures financed by Federal, State, and local governments are projected to account for 48 percent of national health spending and to reach a total of $2.5 trillion; in 2012, such expenditures constituted 44 percent of national health spending and $1.2 trillion,”: With expectations such as these, why is the U.S. health care system not granting those laying in beds, being given medications and treatments, and possibly wasting federal spending on these patients that no longer desire to live due to the pain, suffering, and overall lesser quality of life ("Research, Statistics, Data &," n.d.). End of life care occurs at different times varying from individual to individual. For the elderly, it has been found that many evaluate their lives based on personal morals, gage personal success, and review their life happily as they age. Unfortunately, it is common for the elderly to plan how they will expire, but fortunately enough, when he or she does pass, the loved ones are knowledgeable that these were the choices of the patient themselves. This means that no other person had to make critical decisions on how, when, or where to end a terminally ill patient’s life. Many elderly die every day with altered memory, a different personality, in excruciating pain, suffering daily, helpless, and without the dignity that every person so deserves. It is crucial to allow the terminally ill, especially elders, to decide on where, when, and how they will die and be remembered. It is a basic human right to decide for oneself, as long as it is not infringing the rights of another, the course of action that will be taken when dealing with their life, finances, and health care. Dr. Patel, who was once the head of Priory Clinics in the U.K. but is now head of HC-One, made a statement that, “Everyone deserves a pain-free death, in the place of their choosing and to be surrounded by loved ones” ([Innes, 2013](http://www.dailymail.co.uk/health/article-2358685/Let-sick-elderly-choose-want-die-says-care-home-boss.html#ixzz3IWt9XdMv)). With dignity and respect, a patient has the right to pass in an environment they wish to reside, under circumstances they are comfortable with, and at a time that they feel is appropriate. This gives the patient and loved ones time to grieve together and become more accepting of the time when it comes along. “Death with Dignity” allows time to make preparations with the conscious opinion of the patient themself in all things such as financial and legal matters, organ donation, how they will be remembered, and any desired funeral plans. Although some may argue over “Death with Dignity”, who is to say that another person, one whom may be a stranger to a terminally ill (elderly) patient, has a right to have any say in the course of end of life actions if it is what the patient strongly desires?

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