

Perspective

Allowing Death - The Institutionalized End of Life

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The medicalization of the end of life causes more and more people to become patients shortly before they pay their debt to nature. However, medical treatment requires a patient's consent. When the decision-making ability is diminished, others take over responsibility for the patient based on "best interests" decision-making [1]. The family doctor is frequently the first one to be consulted. Whenever the family doctor cannot be reached, the emergency physician is called in. Then medical decisions are based on the recoverability of vital functions and the legal duty to render assistance. A palliative treatment plan could provide rapid information on the patient's current condition and whether CPR and hospitalization are advocated or not [2]. However, despite high user satisfaction by emergency physicians and nurses from nursing homes majority of family doctors is reluctant to use such a plan [3]. In order to escape medical paternalism, decisions, be they a noteworthy directive or a legally binding directive, should be made far enough in advance. Unfortunately, when life-threatening conditions arise, advance decisions are of limited use as lengthy documents in legalese are not conducive to the rapid decision-making called for in emergencies. Better to contact a trustworthy person and request him to take over guardianship or apply for a court-appointed person with power of attorney for health issues. Probably the best route is to apply early for palliative care and a hospice bed, because palliative care focuses on the patient and his close family members and not on medical diagnoses. Although nursing staff sometimes know a patient's wishes and 2 needs better than his next of kin know them, they usually do not hold the legal authority to approve or deny profound medical treatment. Relatives and close friends do not have a binding voice in medical decision-making either, but they can at least express the patient's presumed will.

Regulations governing the legally binding advance directive have become a milestone in regaining patient autonomy. Autonomy now accords more importance to the patient's will than to certified salvation by medical experts, thereby reversing a centuries-old self-understood tenet. Unfortunately, in its customary form a legally binding advance directive frequently causes only a minor shift from medical heteronomy to judicial heteronomy [4].

When in possession of the unimpaired ability to make decisions a patient can refuse medical treatment simply by not granting his or her consent and does not even need to give reasons for his refusal.

However, when he wants to give a legally binding advance directive, precious medical information provided by a physician becomes a compulsory precondition. Furthermore, limitations on the denial need to be determined. In addition, the patient has to pay for the directive and its validity is limited to a set number of years.

Institutionalized care for the dying was provided by Christian religious orders for many centuries. Nowadays medicine comes to the fore. Presumably, private associations will take over in the near future and provide terminal care. Profit orientation is common to all of them. However, even high ethical standards of institutionalized care cannot dictate what meaning and quality of life mean for the individual person. Oddly, in our age, quality is frequently confused with quantity. When we mention quality management, we frequently mean efficiency and maximization of profit. Whenever profit orientation is of overriding importance, the deficits experienced by the elderly appear to be more pronounced.

Allowing death does not include the right to decide arbitrarily on the end of life. By law, physicians are authorized to withhold medical treatment only in the case of terminal disease or advanced end of life. Otherwise, it is common practice and legal to administer analgesia to anguished, moribund patients despite the fact that it may shorten the patient's life. Furthermore, in patients who suffer from terminal illness and are admitted to intensive care units a step-by-step reduction of medical support is permitted. The decision is based on a consideration of potential benefits, risks and burdens to the patient.

Terminal care must be decriminalized. The regulations governing assisted suicide must be amended [5]. Today, attempted suicide is not punishable by law, but suicide assistance is still regarded as a criminal offence in many countries. This can cause a grave moral conflict for relatives and treating physicians of a loved one desiring to commit suicide. Society taboos suicide and every mention of it. In addition, persons who announce their intention to commit suicide or who have already attempted to take their life frequently experience discrimination. As a general rule, suicide assistance through omission should be exempt from punishment. Suicide assistance through an act performed by next of kin or by an attending physician should be exempt from punishment when there is evidence of a patient's serious and insistent, long-standing wish to terminate his life.

Decriminalization of terminal care includes amendment of the regulations on termination of life at the request of persons who wish to end their life, but are physically unable to do so [6]. On the one hand, it is comprehensible that in cases of incurable and terminal disease, at the patient's serious and insistent request and after careful assessment by a court of law and a committee of physicians termination should be allowed and exempt from punishment. On the other hand, an advance desire for euthanasia does not necessarily result in a euthanasia request [7].

Decriminalization of terminal care also means amendment of the regulations regarding failure to render assistance. Efforts that are

not deemed assistance by the victim cannot be compulsory by law or regulation. When patients wish to die at home without institutional assistance, this should be practicable without the patient's relatives being incriminated for failing to render assistance. When patients wish to die in a nursing home without further medical care, this should be practicable without the nursing staff being incriminated by colleagues, superiors or family members for failing to render assistance.

From a medical point of view, death is often seen as our adversary, but indeed death is our companion, too.

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