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Upholding life's sanctity to the end

December 31st, 2015 / By: [Kay Adkins](#) / comments

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As political activists champion assisted suicide bills in state legislatures with euphemistic terms like “right to die” or “death with dignity,” some healthcare professionals are calling attention to an often neglected weapon in the battle for the sanctity of life—true, compassionate end-of-life care.

The day after California legalized assisted suicide last fall, leading public advocate for palliative and hospice care Ira Byock took to the airwaves of NPR’s Diane Rehm show to discuss the need for health care focused on improving the quality of a patient’s life.

In his books on the subject and his website, Byock asserts that palliative care “is the biggest advance in medicine that most people have never heard of” that has improved quality and length of life while also reducing health care costs.

Byock believes the nation is best served by addressing the root of the end-of-life crisis—the narrow focus on the physical care of a terminally-ill patient. As a result, the emotional, social and spiritual needs of the patient and his or her family are nearly excluded from end-of-life discussions, he said.

Lou Sharp spent more than 40 years working as a home-health nurse and hospice caregiver. In 1992, Sharp helped found Circle of Life, a hospice program in Northwest Arkansas. Patients with a prognosis for less than six months to live can be referred by their doctor to hospice care, typically covered by Medicare, Medicaid and some private insurers.

Circle of Life Hospice provides patients and their families with a team of hospice caregivers, including nurses, social workers and chaplains. Nurses administer palliative care to keep patients comfortable and attend closely to physical needs either in their homes or in a home-like setting.

Every human life, regardless of age or utility, is of equal worth. We equally bear the image of God.

“A chaplain can come in and talk to them one-on-one to ask the spiritual questions. Those are hard questions for a family member to ask. Chaplains really open up a lot of communication sometimes. It is often hard to admit you are afraid,” Sharp said.

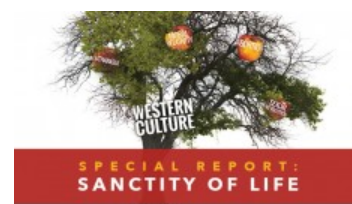
Social workers support both the patient and family members in coping with stress by listening, helping them express their needs and providing needed guidance and resources.



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Sharp retired several years ago to care for her own mother in her declining years. She has experienced the value of hospice care from both sides—as a provider and a receiver. She believes this level of holistic care is important for both patient and family members.

The Circle of Life website, nwacircleoflife.org, dispels several “myths” about hospice, clarifying that hospice is not “where you go when there is nothing more a doctor can do” but rather that hospice is “a philosophy of care providing medical, emotional and spiritual care focusing on comfort and quality of life.”

Terry Sutterfield, a board-certified hospice medical director, has served as a family physician of more than 25 years. As chief medical director for Circle of Life, he oversees the center’s daily operations, makes home and in-patient visits, and prescribes the palliative care medications and treatments.

Sutterfield explained that about 95 percent of Circle of Life patients receive hospice in their personal homes or in a nursing home, which involves several visits each week from a regular hospice team—people with whom they develop relationships. For those whose symptoms cannot be controlled well in their home, Circle of Life provides an in-patient hospice facility with round-the-clock care.

When asked what he observes in the lives of patients and their families, Sutterfield said, “The main thing we hear from families is what a relief it is to enter hospice. We can’t add days to life, but hospice can add life to days. Many have been in and out of hospitals and cannot improve, and their pain and symptoms are not being controlled. In hospice, we not only care for their physical comfort but also for their spiritual and social needs.”

Similar support programs operate in some critical care hospitals.

Rikki Hester has worked 10 years as a social worker, currently at Methodist Dallas Medical Center in the neuro critical care unit, where she works closely with patients and family members through assessment and ongoing communication to identify if and when choices will be made for palliative care, hospice or withdrawal of life support.

Hester is present when patients in her unit are declared brain-dead by a brain-flow study and the physician meets with the family to inform them of the test results. “As you can imagine, that is an incredibly difficult time for the families, and having the social worker present to offer emotional support is very important,” Hester said.

Hester also provides support to family members in emergency code blue situations—cardiac arrest.

“There is something very special about having the families trust you with their loved ones at the most crucial times in their lives. Even as a social worker, I may not have a direct impact on the outcome of their medical prognosis, [but] the families want anything to cling to and hope for during this time,” Hester told the TEXAN.

Through people like Sharp, Sutterfield, and Hester, end-of-life and critical care services offer compassionate care to those suffering with terminal illnesses and also provide resources and emotional support for their families. Regardless of those strides in end-of-life care, recent events have impelled a resurgence of the euthanasia debate.

On Oct. 5 California became the fifth state to de-criminalize physician-assisted death for certain terminally ill patients. The End of Life Options Act—which takes effect in January—came about, in part, due to the case of 29-year-old terminal cancer patient Brittany Maynard, a California wife and mother who in 2014 relocated to Oregon in order to obtain physician assistance to “die with dignity.”

Advocates for physician-assisted death assert that it is merciful to end a patient’s suffering because it increases personal autonomy. This argument is strategically linked to their choice of language to describe euthanasia: death with dignity.

Legalized euthanasia opponents, however, argue that a patient’s decision to die may be influenced by his perceived need to release families from care-giving burdens, thereby actually decreasing autonomy.

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As a practicing physician in a non-right-to-die state, Sutterfield said “sporadically” patients request assistance to hasten their death. “Many times patients who bring that up have seen family members or loved ones pass away in unpleasant circumstances. These patients and their families do not understand what is available in hospice. Studies have shown that patients often live longer in hospice care. We are asked [about physician-assisted death] occasionally, and we explain that it isn’t something we do, and then explain what is available to them in hospice.”

According to Sutterfield, research indicates that less than 50 percent of acutely terminally ill patients utilize hospice care. “Many die not receiving this kind of care,” he said.

Sutterfield agrees with Byock’s assertions that the public discussion typically focuses on only two options for the terminally ill: suffering or suicide. “In our culture we look at the hot issues. But there is so much that can be done in hospice and palliative care that can make the patient comfortable.”

Criswell College president and ethicist Barry Creamer told the TEXAN that the issue of euthanasia can be complex.

“It is okay for people to refuse medical care, but there can be a conflict of interests because other people are also invested in the decision of the patient—people who could make money, people who stand to inherit money,” Creamer said. “But when continuing care becomes unreasonable, saying no to medical care is an option to anyone.

“On the other side, it is simple. Every human life, regardless of age or utility, is of equal worth. We equally bear the image of God. When you make a decision about care, it should be the same whether dealing with Steven Hawking or with any disabled individual. We don’t have the luxury of devaluing human life.”

To guide family members and caregivers facing end-of-life decisions for loved ones, Creamer noted that while refusing medical care is an option to anyone, “people are not just valuable because of what they can experience. People are valuable because they are here, and we have the privilege to care for and love them.”



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