Panel examines right-to-die statute

Hospices also aid terminally ill

By MELODY WARD
Of the Emerald

For Oregon's terminally ill, life is an existence in limbo.

"The terminally ill are put on a medical roller coaster over which they have no control," state representative Mary Burrows, R-Eugene, said Friday in a right-to-die symposium at the University Law School.

"They (the terminally ill) have to contend not only with dying but with being kept alive," Burrows said.

Oregon's recently passed 'right-to-die' statute enables persons to write 'living wills' so they will not be kept alive through artificial means if they become terminally ill.

Other panel members included Saul Toobert of the University Counseling Center, Eugene physician Hugh Johnston, and Byron Smith, vice-president of Portland's Good Samaritan Hospital.

While panel members agreed the statute was good because it brings the "issue of dying" out into the open, several were concerned that it may hamper rather ttan facilitate individual decisions.

"The reason for the legislation is because of the way we die in this society," Toobert said. "It's almost impossible to die at home anymore. But suppose you file a living will and then die in another state. It just isn't foolproof."

Johnston said some of the statute's wording is ambiguous.

Toobert felt that the law puts too much responsibility on doctors for deciding when to discontinue artificial life-support.

"It's a heavy responsibility laid on the doctor to pull the plug alone," he said. Toobert suggested the physician and family argue the patient's case before an impartial jury.

Legally, hospitals and doctors may decide not to honor 'living wills' and transfer their patient to those that do. Smith said Good Samaritan Hospital of Portland accepts the wills and he thinks the law will have a minimal affect on the hospital.

Following the panel discussion Jack Ewing of the University Gerontology Center gave a presentation on hospices as an alternative to more conventional rest homes or hospitals for the terminally ill.

"It hasn't always been true that it is the old people who die," Ewing said.

"More people are living longer," he observes. "We've always had people who lived to 70, but not so many."

In the late 1800's the only people hospitalized were insane.

"It isn't until 1942 that you get data on people dying in hospitals," Ewing said. "In 1977, 73 percent of the deaths occurring in New York City were in hospitals."

Ewing said death is now frequently a prolonged experience and, consequently, it introduces the need for reinforcement of the dying person's personality and soothing of fears about death.

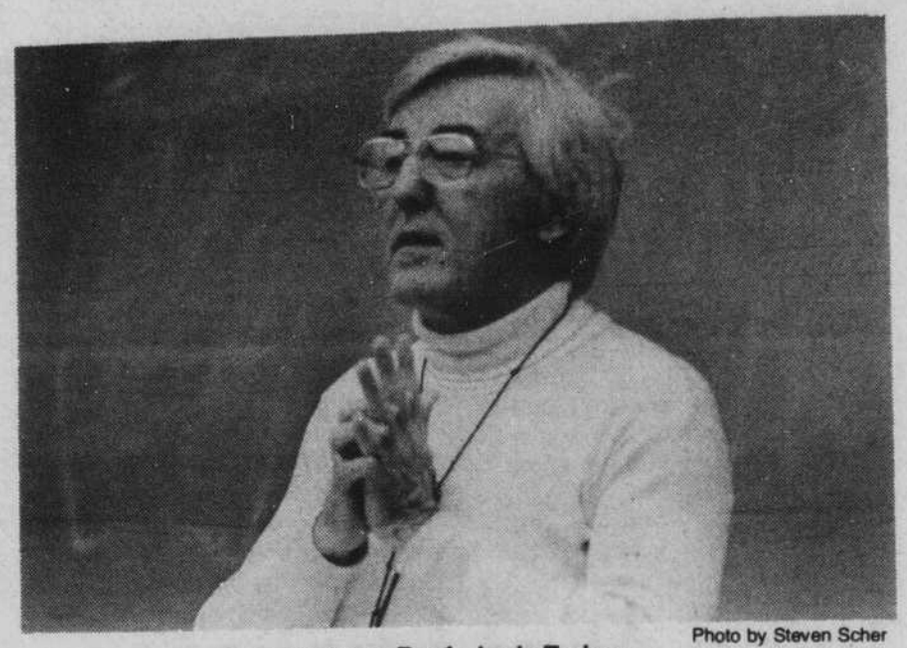

Photo by Steven Scher

Gerontology Prof. Jack Ewing

Each are needs that hospitals are not as well suited to meet as the English-developed hospices.

"The fears persons have most often reflect personal needs," he said. "Most often they fear becoming quietly isolated and being subjected to painful procedures which may prolong existence, but not the quality of life."

Traditionally, hospices were resting places for travelers.

"Now, they are places to rest and be refreshed on your final journey," Ewing explained. "Their main concern is to manage the needs of the patient so that they go on living until they die."

Ewing said the hospices he's observed prefer to keep the person at home as long as possible.

"No one presents hospice care as a replacement for medical care, but as a complement to it," he added.

The hospice is ideal for persons who are past the help of any curative treatment and wish to die with dignity, among friends.

"We still have a situation where people are sitting around watching others die," Ewing said of nursing homes. "We either overtreat or abandon and there's no place in between for the person who needs simple care and simple loving."

Basic to the hospice is the premise that the family unit is essential to the patient's care. "The other major concern of the hospice people is to relieve both pain and the fear of pain," Ewing remarked. "This is done in almost every case without eliminating consciousness."

Ewing says most directors of English hospices are women physicians who have done a lot of research into pain-killing drugs.

"They use a lot of morphine and heroin in England," he said. "The effort is to make one's last days as good as possible."

Other features of the hospice approach include a team of nurses, physicians, and if desired, a chaplain who devote themselves entirely to the dying person and a fairly balanced community of young children (of the staff) adults, and elderly persons, whose average stay is about three weeks.

"What really sold me on this whole process is the attitude of compassion that exists in those facilities," Ewing concluded. "But there are two threats to hospices tat must be conquered: fadism and overcommercialization."