Patients' sense of completion

Ray Morrison

Once upon a time when people gave up the ghost that was it. Now they are at serious risk from the enthusiastic bystander keen to pummel the ghost back into the body. If you want to die choose your place of departure with care. Even castaways will soon find life support machines already installed with resuscitation officers on call to parachute in. This is great if it is what you want but not if you do not.

Resuscitation is the prolongation of life at its most dramatic. Hippocrates would have cheered. Or would he? I have observed a more subtle version of the Hippocratic tradition that is far more worrying. This is to be seen in wards where the elderly are being cared for. From antibiotics to tube feeding, the professionals have an armamentarium of treatments to keep the very old and infirm alive a few days longer. Fair enough, if this is what the patient wants. But how often are the doctors right in their judgment of what the patient wants? How often are they swayed by thoughts of dissatisfied relatives or predatory lawyers? Their Hippocratic oath states that a doctor should do no harm to his patient. In 20th century medical practice this is too often mistranslated into "a doctor should always treat his patient." But doctors should not officiously keep alive.

Let me explain. A nurse recently asked me to talk to a patient who apparently wanted to die. I was expected to talk him out of such an unseemly wish. Yet I found a quiet, thoughtful man in his 90s, very much in his right mind, who was neither depressed nor distressed. He told me about his fulfilling and interesting life. Professionally he had achieved much and, though a widower, he headed a large family. But he sensed that the time had come for him to go. "I have lived

my life and have much to be grateful for."

Another time I visited an old lady who had decided against further surgery. She was a frail, bird-like creature, yet surprisingly she had survived raising eight children in a small country cottage—part of the time on her own during the war years. Her husband had died 19 years ago. Now a great-grandmother, she lived by herself in a town flat. Looking back over her life with a sense of satisfaction, she nevertheless recognised her shortcomings. But this did not deny her gratitude for life as a whole. She believed that the time had come for her to go. She did not dread going on living but felt that her life was rounded off. "After all there is a better life in store. If only God would take me," was her earnest wish.

My third example is an angry man who was, as he put it, "a victim of resuscitation."

"She did not dread going on living but felt that her life was rounded off."

He had done his stint in life and would have been happy not to have been brought back to life. Though not particularly worried about the future, he believed that it would have been the right time to die. He had lived his life. "The heart attack was sent to take me off."

These three stories typify those many patients who have opened up to me in the wards, revealing the common characteristic of what can best be called a sense of completeness about their lives. In their own way each is clear that they have fulfilled whatever it was that their life was about. So now they would welcome death as coming at the appropriate time.

If I am right doesn't it follow that we should take account of this sense of completeness when discussing the possibilities of further medical or surgical intervention? Nowadays the accent is on looking at the future physical quality of life for such

patients when making assessments. This ignores the equally important—if not more important—fact of the individual's own feelings about the present completeness of their lives.

I know that some people are now making a living will. This is a witnessed, written statement addressed to families and attending doctors in which individuals ask to be allowed to die and not be kept alive by artificial means if an illness or impairment is expected to cause severe distress or render them incapable of rational existence. This practice is neither widespread nor recognised yet in English law. Furthermore, a living will does not necessarily cover the circumstances I am describing since the patients are not always in severe distress or incapable of rational existence: they just sense that their time has come.

Of course, many of us, particularly in the caring professions, react quite strongly against the idea that someone may rightly want to die. Fuelled by the Hippocratic tradition, that professional reaction is no doubt reinforced by the trend towards defensive medicine. Patients who express such a desire are made to feel guilty, or may even be treated as if they were depressed. This is not helpful and violates the integrity of such patients just as seriously as the refusal to treat a patient who needs and wants medical help. Doctors and others caring for patients should listen more attentively to them. These patients are individuals whose feelings about themselves deserve respect. Prolonging their lives could be said to be doing harm to them. They may well know better than their doctors that their natural end has come.

I should like everyone to be able to echo the cry of Jesus which he made at the end of his life, "It is finished." The original Greek word in the New Testament means "it is completed or perfected." Jesus had done the job that he had come to do. Now he could bow his head and give up the ghost.—RAY MORRISON is the Church of England chaplain to the Eastbourne Hospitals NHS Trust

Can performance related pay work in the health service?

Stephen Vallely

Reviewing workload statistics for our department a couple of weeks ago I was not surprised to find that last year we performed almost twice the number of radiological examinations recommended by the Royal College of Radiologists. Since 1990 our outpatient workload has increased by 48%, our inpatient workload by 13%, and

our accident and emergency work by 6%. Similar figures could be quoted by most other consultants in the health service. I asked a member of the NHS Executive what effect this workload would have on my remuneration if performance related pay for health care professionals was introduced. The reply came "That is a matter for local negotiation." "What factors will determine performance related pay for doctors?" "A matter for local negotiation," was the predictable retort.

Consultation is taking place between the executive and the profession and implementation is reported to be as early as September 1994. What is clear from the answers to my questions is that central guidance on the implementation process is likely to be couched in the vaguest possible terms

with ample scope for local interpretation.

Do doctors have anything to fear from the introduction of performance related pay? If a fair, clearly constructed, centrally guided process is put in place with the full cooperation of the profession then it is difficult to see how any doctor in the new health service could do other than benefit. Most doctors, both senior and junior, work hours far in excess of their contracts and are treating an increasing number of patients despite the call for efficiency savings. But it is difficult to imagine that the outcome will be an increase in salaries. There is a finite and ever dwindling sum available for health service funding and it is unlikely that doctors will be given more control over their own remuneration.

Performance related pay will have to fit