

# Identities of Physician-Patient Interactions in the Medical Community of the Dying

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## *Abstract*

*Physicians as a community are not privy to the intimate details of the lives of their patients, and as a result of that, they explicitly cannot assume a proper understanding of any patient's priorities. Conversely, a presenting patient has visited the physician primarily because there is something abnormal in his health which he does not understand. One approach of physician-patient interaction, the informative, would tackle this potential dilemma by, after divulging all pertinent medical information, allowing the patient full autonomy to decide for himself what the best course of action will be, which in theory is comprehensive and responsible. However, this does not account for patient morality, as the physician will, by design, present the patient with all medical options and extricate themselves from the potential legal responsibility of counseling the patient. Thereby, through engaging in discourse with the patient regarding the elucidation of the patient's values, the interpretive approach will attempt to take into consideration patient morality. Ultimately, this approach will result in far more time-consuming clinic visits, as the physician and patient scrutinize what the patient would find morally tenable going forward; however, in the community of dying patients, that very discourse is what will allow the physician, in lieu of saving the patient's life, to save what remains of the patient's life.*

In the 21<sup>st</sup> century, more is known about science and medicine than ever before. Not only the United States, but the population of the entire planet has made unequivocal strides in technology in the last 150 years: not just the advent of modern life-sustaining technology, such as the mechanical ventilator, but even something so quotidian as the first electric home, which rapidly progressed to the invention of the first computer and, most recently, the miniaturization and un-tethering of those computers to fit in our pockets in the form of cellular search engines. Information is now more abundant and readily accessible than at any other point since the beginning of time, with our phones having access to hundreds of times more information than the entire Library of Alexandria and Library of Congress combined and at much greater convenience. This has led to billions of personal renaissances for the denizens of the world; typically the first step in solving a problem is to reach into a pocket and almost instantly have access to academic articles, blog posts, and encyclopedic data regarding a plethora of potential solutions. This information has been an annoyance to doctors for decades as patients have become increasingly emboldened to find information – perhaps accompanied by misinformation – for themselves, this is wittily depicted in the episode of *Scrubs*: “My Boss’s Free Haircut,” (2005) where the chief of medicine, Dr. Kelso, decides that he is going to start seeing patients again after twenty years of serving a purely administrative role. In his first patient visit, he is welcomed by Ms. Goldman, a patient whose eyes never leave her phone and who insists on interrupting all of his medical analyses with information she has discovered from the internet; she eventually vociferates: “Why am I paying you to tell me things I have already figured out on my own?” In the modern era, it is a matter of fact that the high exclusivity of medical knowledge, once relegated purely to doctors and physicians, has become

increasingly simple to descry with clever use of a Google search; while *Scrubs* humorously illustrates that concept, it is still undeniable that doctors possess the years of training and experience necessary to distinguish between similarly presenting illnesses and subsequently best aid the patient's recovery.

When an individual falls ill and needs to submit to a hospital to become a patient, that patient then wants all of the information: "why am I sick," "how long will I be sick," "how do I stop being sick?" with the goal being to stop being sick as quickly as possible. However, when that patient then finds out, whether from old age or terminal illness that they will not ever cease being sick, does that patient then still desire the knowledge only for the sake of knowledge? Do they seek something more? If Miss Goldman had arrived at the hospital to discover she had a measurable amount of time left in the world, would she have been so quick to dismiss what Dr. Kelso had to say? By the end of the episode, Dr. Kelso discovers that the root of Ms. Goldman's combative attitude was exactly the fear of what might happen to her. Despite her outward behavior, what she ultimately needed was to discover what meant the most to her in life and for Dr. Kelso to advise her of the best way to maintain that. While she thinks she has all of the information and only needs the doctors' technical prowess for the very drastic surgery she has opted for at the young age of 25, Kelso is eventually able to get through her facade to convince her that taking care of the condition herself without surgery, undoubtedly the more arduous course of action, will ultimately be the better one for the longevity and quality of her life.

The *identity* of care presented in this episode is what doctors need to seek to emulate with all non-emergency patients, not just terminal patients. While it is true that the doctor has very limited knowledge of the inner-workings of their patients' individual lives, the patients usually possess just as limited an idea of the breadth of impact of the various options and procedures available, even despite statistics and encyclopedic data. Then, at the point the patient has been told they are going to die – perhaps even approximately when – not only must they make crucial decisions pertaining to their health and well-being, they must also do so with the explicit understanding that ultimately, regardless of choice, the end result will be the same. Verily then, it is incumbent of physicians whose duty it is to administer care to the dying to employ the interpretive approach to healthcare, just as it is incumbent of the dying patient to analyze their own values and then at the very least respect their physician's advice; this requires fervent discourse between the two to determine what is most important to the patient as death approaches and therein explore, advise – rather than inform – and facilitate options which will best extricate the patient from the coming inevitable hardships and maximize the realization of those values. Disagreements on the application of this approach stem from assumptions of what is most fundamental in the providing of healthcare and the practice of medicine, such as the absolute opposition of death or allowance of the patient to have full control of their treatment by way of the physician adopting a hands-off, consumerism role. In the medical community, these fundamental values were applicable when death was something inevitable that could be confronted; however, in modern medicine, where biological death can be put off for long after the patient's identity has deteriorated, these fundamental values need to transform to incorporate what the *patient* would consider to be a good death: a death on their own terms.

## Contextual Definitions

Here will be explored the various facets of medical care specifically pertinent to dying patients, which will hence be delineated as those individuals who have a physician's opinion of a set amount of time to live and who still have capacity for critical thought; we will not then be discussing comatose patients or interactions with patients' families due to the patient being incapacitated. While families certainly are often a significant portion of the patient's decision making process, this paper aims to discover the extent of the physician's responsibility to assist.

The Oxford English Dictionary defines the term "physician" as "a person skilled in the art of healing : one duly authorized to treat disease : a doctor of medicine" (Physician. (n.d.). In Oxford English Dictionary). To this end, physicians will include anyone whose primary duty is patient care and who could be considered responsible for a patient. This will include nurses, primary care doctors, specialists, and palliative care specialists and not be restricted to individuals holding a medical degree.

In a medical ethics paper by Linda and Ezekiel Emanuel titled "Four Models of the Physician-Patient Relationship" (1992), four distinct approaches of physician-patient interaction are explored. The Emanuels provide detailed definitions and discuss the popularity and efficacy of each and apply them to everyday scenarios in patient treatment; this paper will use the definitions that the Emanuels laid out therein. The first of these models, the paternalistic model, will be readily discarded as it is widely recognized as only being effective or appropriate in emergency situations where patient consent for life saving treatment is not obtainable – situations which this paper will not be delving into. There will then be three central methods of providing medical services in this context: the informative approach, the interpretive approach, and the deliberative approach.

Firstly, they define the informative approach as follows: "In this model, the objective of the physician-patient interaction is for the physician to provide the patient with all relevant information, for the patient to select the medical interventions he or she wants, and for the physician to execute the selected interventions." So then, the informative approach will essentially be any form of physician-patient interaction during which the purpose of the conversation does not endeavor past the context of medicine with the end-goal being to deliver the most comprehensive and exhaustive summary of information and provide the highest level of patient autonomy.

They then define the interpretive approach: "The aim...is to elucidate the patient's values and what he or she actually wants, and to help the patient select the available medical interventions that realize these values." They go on to say that this does not absolve the physician from delivering a comprehensive summary of the relevant medical data. The interpretive approach will then be all physician-patient interactions during which the patient is urged to explore their own morals and values and be forthright with increasingly intimate details regarding their personal life, and during which the physician is a mediator of private introspective discourse, not unlike a counselor. The end-goal in these cases is providing the best maintenance of a lifestyle which preserves the patient's values.

Finally, they define the deliberative approach as having the aim of "help[ing] the patient determine and choose the best health-related values that can be realized in the clinical situation." So then the deliberative approach will be all physician-patient interactions in which the physician attempts to persuade the patient of the moral importance of healthy choices; for instance, suggesting

that a patient quit smoking, despite the patient's lack of desire, with the impetus being the preservation of the patient's health, which is obviously a greater concern to the physician than the patient. This approach will not be addressed in the primary argument but will be discussed within the context of the future.

The sub-categories of dying patients will be separated by the trajectories described by Dr. Joanne Lynn in her article "Serving Patients Who May Die Soon and Their Families."

(a) a short period of obvious decline at the end, which is typical of cancer; (b) long-term disability, with periodic exacerbations, and unpredictable timing of death, which characterizes dying with chronic organ system failures; or (c) self-care deficits and a slowly dwindling course to death, which usually results from frailty or dementia.

Now, as her article is focused solely on care for the elderly, hereupon her demarcations will be added the caveats that the first trajectory will be indicative of *non*-elderly patients, while the second and third will be indicative of elderly patients and not particularly distinguished between. This delineation will also become relevant in the context of the proposal.

## Discussion

With these definitions in place, the advantages and disadvantages of both the informative and interpretive approaches will be investigated within these scenarios in addition to the responsibility of physicians to employ one method or the other.

## Autonomy

One contrivance of the interpretive approach that the informative approach lacks is an appreciation for moral autonomy, despite its propensity to allow patient autonomy to the most extreme degree. By design, the informative approach cannot deliver an appreciation for the moral prioritization that may necessitate from the presentation of a drastic medical decision, *especially* so when operating around a presupposition of death. This is a result of the exact autonomy it provides: by allowing the patient complete autonomy over which modes of treatment to pursue and which to disregard, the physician is afforded no room for any input beyond empathy without potentially manipulating the patient's decision. As the Emanuel's put it: "the informative physician is proscribed from giving a recommendation for fear of imposing his or her will on the patient and thereby competing for the decision-making control that has been given to the patient" (1992).

Proponents for the informative approach might argue that patient autonomy and education are the ultimate goods, citing all sorts of informed consent standards and laws. However, it is easy to see where arguments for this model begin to erode. When examining the informative approach, the Emanuel's liken the physician to a salesperson (1992). Expanding on their analogy, when comparing cold-weather coats for the coming winter season, a retail clerk will present the options, offer the relevant statistics (for example, what they are made of or what temperatures they are rated for), and say no more; their goal is to facilitate a sale and provide the requested good. This sort of topical application of retail values does not necessitate delving into the deeper values of the consumer. This type of consumer-merchant relationship can be very successful in a market setting, and some argue that this success continues to extend to medical settings. Since the invention of anesthesia that could render previously agonizing patients unconscious in 1847, surgeons have had the freedom to dive

evermore deeply into living human bodies (Fitzharris 2018); this revelation has led to the increasing necessity of specialization in medicine – the process whereby a physician, after completion of general medical studies, becomes a subject matter expert in one specific area of medicine, such as cardiology, dermatology, or oncology. The Emanuels recognized that those who argue in affirmation of a market-like exchange of medical practice for pecuniary capital do so on the grounds that the desideratum of specialization “militates against cultivating the skills necessary to the interpretive model” (1992), paving the way for the informative breed of physicians to quickly and efficiently provide their patients with the care for which the patient has visited them. The extreme autonomy that comes from this style of medical care, if it can be called care at that point, is precisely what pro-informative physicians cite when extolling this model, continuing to elucidate patient autonomy as the ultimate supplementary good to effective healthcare.

Does the argument then point to the combating of specialization? Certainly not, as forcing every medical school matriculant to master hundreds of lifetimes of dedicated study in less than a decade would be a quixotic and unreasonable endeavor. There is a compromise to be made, a compromise that manifests itself in the interpretive approach; Richard B. Goldbloom, MD, when he was the head of pediatrics at Dalhousie University, wrote:

Such physicians [family physicians] understand that their ultimate professional mission is the relief of anxiety, and that the accurate diagnosis of and cure of illness are merely means to that end, not ends themselves. They recognize that, while much human suffering is caused by disease, even more is attributable to the psychosocial context into which disease is implanted. (1978)

In summary, the ultimate good is *not* extreme autonomy, but rather the alleviation of pain – *Do no harm*, the Hippocratic oath echoes.

To effectively combat suffering on a psychosocial level, as Dr. Goldbloom described, a deeper understanding of the individual patient is required. To return to the Allegory of Retail, the salesperson might convey what the coat is made of but is unlikely to convey what the conditions of the factory are where it was made. They may inquire if the customer has a preference of tight or loose fit but are unlikely to inquire as to what kind of functionality is required. The end-goal of purchasing the jacket is not ever elucidated: do they want to stay warm on a park bench? Are they attempting to summit Everest? To such an end, the interpretive physician is not only allowed but *encouraged* to identify and behave in the capacity of both a counselor and doctor, and in the case of dying patients, an intrinsic property of that intimacy will be an *appreciation* of the moral autonomy – of the heavy existential weight placed on the patient’s shoulders, compelling the physician to aid in the furthering of the patient’s values and most effectively abate their suffering, even in the face of death, and even if the patient chooses to face their death.

## **End-Goals**

From the first day of medical school, aspiring doctors are taught the sentiment, above all, to do no harm. From then on, they engage in a never ceasing process of learning how to diagnose and treat all manners of illness from the common cold to late-stage metastatic cancers. A doctor’s ability to diagnose and treat is paramount to having a successful career in medicine; in fact, a patient’s purpose for visiting a physician in the first place is almost always one of inquisition: to find an

answer to a question – a cure for an ailment. In this regard nothing more is expected of the doctor than to, again, diagnose and treat that ailment. In the case of a simple cold, this diagnosis and treatment may take all of fifteen minutes, to include the prescription and dispensing of Tylenol; here the informative approach is all that is necessary and, in fact, the far more efficient endeavor. In the case of late-stage metastatic cancer, however, the process of treatment devolves to a process of delay, and the patient is likely to remain institutionalized in some capacity for the remainder of their life. Assuming no miraculous breakthrough in healthcare is discovered over the course of progression of the disease, the patient will be under knife, radiation, and chemotherapy relatively persistently until their last day. The question then becomes: is putting off the end for as *long* as possible the end goal? Is longevity of life preferable to quality of life? The consensus medical practitioners need to come to is that it is not the physician's responsibility to determine the paramount objective of treatment, a sentiment which an informative physician would categorically disagree with under the claim that death should be opposed at all cost.

While this may sound like a dismissal of the physician's role in the care of the dying, it is actually indicative of a more in-depth role. In the Emanuel's description of the models, while they liken the informative physician to a salesperson, they denote that physicians adopting the interpretive approach will behave more like a counselor or adviser. Interacting with the patient more intimately or personally will allow the physician and the patient to confer, deliberate, and finally concur on what mode of treatment to pursue. In his book "Being Mortal," (2014) Dr. Atul Gawande summarized the Emanuel's definition of the interpretive approach as such:

"Here, the doctor's role is to help the patients determine what they want. Interpretive doctors ask "What's most important to you? What are your worries?" Then, when they know your answers, they tell you about the red pill *and* the blue pill and which one would most help you achieve your priorities. Experts have come to call this shared decision making."

Shared decision making is the cornerstone of what differentiates informative physicians from interpretive ones. As previously stated, both sides of this coin lack any knowledge of the other side, as they are both outwardly facing; therefore, the doctor delivers the medical information, the patient delivers the lifestyle information, and with this "fact-value division of labor" (Eddy 1990), they work toward a medical goal that will be the most beneficial for the patient's *values* and not necessarily the patient's health. In one anecdote, Dr. Gawande tells the story of a patient who, when discussing with his medical care proxy what "level of being alive" was acceptable, said "well, if I'm able to eat chocolate ice cream and watch football on TV. then I'm willing to stay alive; I'm willing to go through a lot of pain if I have a shot at that" (2014). The story continues with a complication that resulted in the need for a dangerous but life-saving surgery that was likely to leave him quadriplegic for the rest of his life. After determining that the complications would not bar him from living the life he had previously defined, they went forward with the surgery.

This story epitomizes the idea that what makes life worth living is diverse, complex, and absolutely dynamic for everyone. Had his desires included something as basic as being able to stroll a garden unassisted, the quadriplegia would have made that impossible, and he likely would have opted out of the surgery, which would have resulted in the rapid deterioration of his health. While, fortunately, in this scenario the patient's values and the medical answer to his immediate ailments did align, fate is not always so kind. If the odds were not as obviously in the favor of the patient, Dr.

Gawande and the archetypal interpretive physician would need to confer with the patient to decide on what exactly would allow for the patient to continue to live the longest tenable life, not simply the longest life.

There are only two arguments to be made for the sacrifice of values in exchange for a chance of extended life: firstly, the possibility of restoring those values after a miracle medical breakthrough – an option which is often too heavily relied upon, even in cases where such advancement is unlikely. In a 2009 NCBI article by Horace M. DeLisser, M.D, another stark example is presented with an unresponsive 75-year-old woman:

It is the conclusion of the attending physician and the medical team that the likelihood of recovery for someone her age with multisystem organ failure is very small. Therefore, they meet with her children to advance her level of care to comfort measures only. The family vigorously resists this suggestion, insisting that mechanical ventilation be maintained and cardiopulmonary resuscitation (CPR) be provided in the event of a cardiac arrest because, “We know a miracle will occur.”

Another article from CBS News documents the case of a family of the Followers of Christ Church, “a small church that shuns conventional medicine in favor of faith healing” (Smith, 2009). The story follows a court case that arose when the family’s 15-month-old daughter died of simple pneumonia. Dr. Dan Leonhart, a licensed pediatrician, testified: “the child could have been saved at almost any point, including soon after she stopped breathing,” but he continued on to say that there was no even a remedial effort to revive her or call an ambulance. While these two cases are starkly contrasting, they both serve to highlight the lengths to which individuals may go when depending on a miracle.

The second argument is the fear of death, which is synonymous with the informative physician’s idea that death is the ultimate enemy. In “My Rabbit,” an episode of ABC Studio’s *Scrubs* (2007) the main character confronts his friend-surgeon about why he did not perform a risky surgery which could potentially alleviate his patient’s chronic pain. In this scene, the surgeon explains that he only agreed to the surgery before he found out that the patient was a father. The surgeon made an initial call to perform the operation despite the risk of catastrophic and fatal hemorrhage because the pain rendered the patient’s life untenable. Finally, citing the existence of the patient’s daughter, he amended his decision to perform the surgery, concluding that the patient and his daughter both had everything to lose by taking the risk.

This example corroborates Goldbloom’s conclusion that tackling the *psychosocial* suffering of the patient is often of greater importance than actually treating the patient’s immediate symptoms. The interpretive approach to physician-patient interaction allows for the psychosocial as well as the medical circumstances to be accounted for. While the episode does not specifically delve into the realm of doctor-patient interaction, in the real world of medicine, the weight of which end-of-life treatments to pursue and which to disregard should not exclusively be left in the hands of the patient to determine as the informative physician would argue: it should be a consensus achieved by the patient and physician together through rigorous analysis of the patient’s values and the available medical options. Only through such conference can a definition of a tenable life be established and enforced on an individual basis.

### **Cause & Consequences**

With the catalyst of anesthesia and the transformation of medicine from brutal trade to cunning science as *The Butchering Art* depicts (Fitzharris, 2018) and the response of American health policy to promote specialization (Stevens, 2006), emphasis on a market exchange of patients from diagnoses to specialists has facilitated, over decades, the preference of the informative approach. While this highlighting of efficiency is logical and economical, it does little in the way of prioritizing the patient; in one study, it was discovered that almost half of outpatients experienced dissatisfaction due to a lack of time spent with them by the doctors, whose treatment, as a result, was perceived to be “careless” (Talukder, 2011). As a direct result of this proliferation of the informative approach, patient mistrust and budgetary prioritization have been allowed to pervade the medical sector. This is not because the informative approach is evil or inherently bad, but because the gaps in patient care left by the promotion of a free-market strategy that disincentivizes working outside of a specialty have allowed for them to suffuse.

#### *Mistrust*

With the mitigation of psychosocial suffering identified as the end-goal of medicine, physicians must actively engage in activities that enhance the notion of trust between patient and physician while extricating themselves from any activity that might threaten it, as mistrust in the presence of power would undoubtedly contribute to the very psychosocial circumstance that medicine aims to abate. Every procedure in medicine has an absurd number of risks associated with them, and the informative physician would ensure that the patient has access to all appropriate verbiage regarding every various known risk. What an informative physician would not do, however, is underscore the specific risks that might infringe on the patient’s personal goals and values, because the physician would never have elucidated those values in the first place. This may result in a pianist losing feeling in their fingertips or a sommelier losing their sense of smell; these are not outcomes that resulted from poor doctoring – indeed under any model of physician-patient interaction these outcomes are sometimes unavoidable – however, under the informative approach, the patient is more likely to be caught off guard by an extraordinarily adverse consequence, leading to a breach of trust between the physician and the patient.

#### *Money*

To once again reference the Allegory of Retail, a rational consumer would be right to not expect a completely impartial answer from a retail clerk regarding product functionality, as such a consumer might forever after have the lingering thought that perhaps to the seller, the best product might simply have been the most expensive. This is a reasonable concern in medicine as well; as one study found, “Doctors emphasize that their medical decisions are influenced by the funding situation and by operational management, often with negative consequences for treatment quality, patient safety, and the medical staff themselves” (Wehkamp & Naegler, 2017). The informative approach is no medicine to this disease of budgetary struggles and constraints which plague the medical world, which is the entire essay in and of itself. The propensity for medical administrators to maintain a broad view of the micromanagement of their hospitals is most certainly advantageous for the longevity of the institution; they go on to say: “[Administrators] have to make profits, but are forbidden by law to exert influence on medical decisions. Nonetheless they must ensure that the organizational processes are designed in such a way that they promote the interest of the body



running the hospital” (Wehkamp & Naegler, 2017). The issue comes, however, where administrators make long-term decisions to the detriment of individual patients. Wehkamp and Naegler’s article is not a condemnation of doing what is best for the survival of hospitals, it is a condemnation of the commercialization of hospitals for the sake of pleasing shareholders who now take priority in medical institutions as a result of the vicious economic circle of profit generation.

#### *Proposal*

The proclivity of the informative approach in complex scenarios to ignore the onus of the physician to monitor ethical variables leaves much to be desired in the way of medical policy. Herein, one possible near-future of medical ethics will be expounded upon, along with its consequences. A potential amelioration will then be proposed, and the pragmatic implications of that proposal on the communities of the sub-trajectories of dying will be explored.

### **The Deliberative Future**

The stark opposition of the informative approach by progressive physicians is likely to result in the consideration of the interpretive approach as too moderate and not enough of a departure from the flaws of the informative approach. A potential consequence of this consideration might be the wide-spread adoption of the Emanuel’s fourth model of physician-patient interaction: the deliberative approach. Certainly, the fact that this model elucidates some moralities as being superior to others can seem superior to individuals with an education rooted in ethics or medicine. The idea that the average smoker has appropriately valued the ethical ramifications of their habit in the various necessary contexts external to themselves; the effects of second-hand smoke on children, for instance, is asinine. Even in scenarios where there are few external consequences, such as type-2 diabetes and contiguous consumption of red meat regardless of the physician’s disapproval, certain outcomes are demonstrably preferable to others; no rational, future-minded individual would similarly value the summation of thousands of dollars of medical costs, tens of hours in hospital visits, in addition to their very life to that of the ability to consume a steak. In both scenarios, it is easy for a rational third party to see where foresight ends and the desire for instant gratification beings.

In such scenarios, the tendency of the deliberative approach to levy the authority of the physician (within the boundaries of the Hippocratic oath) to persuade the patient to make the *best* ethical choice can be markedly appealing to physicians. Even many patients might appreciate the abolition of at least some of the responsibility of “doing the right thing.” In summary, the deliberative approach solves the issue of ignoring certain ethical variables, without much of the immense consumption of time that the interpretive approach demands, due to the predefined moralities of medicine being superimposed equally into every situation.

However, when there is no medical panacea for the ailment with which a patient has been diagnosed – a late-stage metastatic cancer, for example – the morality of the physician, the morality of medicine, will no longer be of any benefit. If survival is no longer a realistic, sustainable option, then the patient will begin the process of conceding more and more aspects of a healthy life in order to avoid death. Under the deliberative approach, the physician, too, will undergo the process of fighting the losing battle against the inevitability of death: *in respect to the dying, the deliberative approach is no more effective than the informative approach.*

### **The Interpretive Solution**

While the deliberative approach indeed might be the future of standard medicine, it simply is not appropriate for the dying, nor is it at all compatible with the idea of palliative care. Arthur Frank, in his book *At the Will of the Body: Reflections on Illness*, brilliantly articulated this notion: “Care begins when difference is recognized. There is no ‘right thing to say to a cancer patient,’ because the ‘cancer patient’ as a generic entity does not exist” (2002). Here, he basically provides a slogan for the interpretive approach. Under the deliberative approach, there would be a blanket rulebook of deemed-appropriate moralities and ethics, perhaps even a script, applied to those patients categorized as end-of-life cancer patients. This script would be convenient for physicians as it would remove the hardships of deliberation and moral ambiguity; however, it is that very ambiguity that I believe separates physicians from astrophysicists. There is but one of the four models set forth by the Emanuels that can account for this incongruity of values from patient to patient and across both sub-trajectories of dying: the interpretive approach.

#### *The elderly trajectory*

Elderly patients under the informative and deliberative approaches may find themselves on either end of a spectrum of mis-care: on one end being seen by the physician and family as beyond help and thusly more or less given up on, or on the other end being over-treated and thusly robbed of the very bodily autonomy that those approaches would seek to sustain. In an article titled “Comprised Autonomy,” in the *Journal of Hospice and Palliative Nursing*, Liz Blackler says, “When patients are unduly pressured by their families to make medical decisions that are not in line with previously held values, beliefs, or perspectives, autonomy is compromised” (2016). What the interpretive approach does is allow for the patient to divulge the importance of ice-cream and football on television in the first place. If we cannot have access to the things that make our lives tenable, why then would we want to continue living?

#### *The non-elderly trajectory*

Younger patients, from young children to middle-aged adults, are unfortunately vulnerable to cruel over-treatment in the hopes that some miracle might unveil itself and save the patient from the brink of whatever malady they may be suffering. Anything less than every conceivable attempt at full-recovery would be deemed unacceptable by the patient’s family, and as a result, the patient’s wishes might be discarded in favor of those of the physician or family in the same respect that Blackler’s article set forth. One study in the *Journal of Palliative Medicine* showed “younger aged patients not desiring life-prolonging care were *less* likely to receive care consistent with their treatment preference compared to middle-aged or older adults” (Parr et al., 2010). The idea that one can be “too young to die,” is an unhealthy concept that is more likely to result in useless over-treatment than it is in saving the life of the patient. The idea of being “too young to die” is a superfluous sentiment which disease does not recognize and adds nothing to the already universal sentiment: “life is valuable.”

### **Future Studies**

This paper contains but a small fraction of the issues that relate to this demographic and the care categorized by it. Dr. Atul Gawande, in his books *Being Mortal* and *Better*, sets forth a staggering number of case reports backed by broad statistical evidence that is at least tangentially or causally

related to his topics. Conducting more far-reaching studies on some of these case reports will undoubtedly bring to light the truth behind the ethics of what he pontificates in these books. One of these studies should include massive surveys of what varying demographics, particularly age, gender, and racial demographics, value most. Over decades and hundreds of thousands of participants from around the world, information could be obtained such as: what people value, what they expect to value in the future, and later how those expectations met with reality.

Additionally, the original concept of what Keren Brown Wilson intended for assisted living facilities is something else that deserves exploration. The industrialization, monetization, and perversion of what were supposed to be places that the elderly can go to safely live into, very simply, places where the elderly go to die has been a detrimental and toxic process that, according to Dr. Gawande's research, causes a very high level of consternation among the elderly (2014); this directly contributes to, rather than abates, psychosocial suffering and thus is unacceptable. In this vein, further iterations of Bill Thomas' Chase Memorial nursing home should be tried and documented. In this experiment, as Dr. Gawande tells it, Dr. Thomas essentially took on the task of transforming the nursing home from an institution to a home (2014), and it was met with remarkable success. But, of course, the hallmark of scientific results is that they should be able to be replicated.

Finally, open and extensive conversation between the American Medical Association, the American Psychological Association, the National Ethics Association, and patients and their families should ensue, and these deliberations should include the aforementioned suggested research on developmental values and morals in the human life-cycle with the ultimate goal of expanding on what it means to do no harm.

### **Closing Remarks**

In a free-market society, we all have the freedom and responsibility to conduct research when selecting a primary care physician or specialist; this ability to "shop around" is a fundamental part of living in a society where individual autonomy and freedom is elevated above all else. In medicine, however, a certain set of rules and policies must be in place to ensure that the best, most ethical care is provided to all living things. In the context of dying patients, the interpretive approach offers the best, most ethical chance for maintaining what the patient considers to be a life worth living.

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