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KEYNOTE

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FOR THE JOINT N.H.O. - GEORGETOWN U. SYMPOSIUM

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(GREETINGS TO HOSTS, GUESTS)

I'M DELIGHTED TO BE YOUR GUEST THIS MORNING, TO BE IN THIS COMPANY OF CONCERNED AND CARING PROFESSIONALS. I DON'T MIND CONFESSING THAT I REALLY FEEL I COULD LEARN MORE FROM MOST OF YOU THAN YOU MIGHT BE LEARNING FROM ME. YOU ARE, AFTER ALL, DIRECTLY INVOLVED WITH THE CARE OF HUMAN BEINGS, WHILE I NOW SEE THEM MAINLY AS LETTERS AND NUMBERS ON MANY, MANY PIECES OF XEROX PAPER. MY PRESENT POSITION DOES HAVE THIS UNFORTUNATE PAPER ORIENTATION AND I FIND IT DIFFICULT TO GET USED TO. SO THIS MEETING IS PARTICULARLY WELCOME FOR ME. YOU ARE CONCERNED AND CARING...AND, TO ME, CHARITABLE AS WELL.

NOW, LET ME BEGIN MY REMARKS THIS MORNING WITH A NOTE OF STRONG ENCOURAGEMENT THAT EACH OF YOU MAKE A PROMISE TO YOURSELF:

"I WILL NOT END MY INTEREST IN HOSPICE CARE WITH THE COMPLETION OF THIS PARTICULAR SYMPOSIUM."

VERY OFTEN, WE DO THAT. WE SIGN UP FOR THINGS THAT SOUND INTERESTING AND ARE INTERESTING -- BUT IN DOING SO WE PUSH FARTHER AND FARTHER BACK INTO THE DARK RECESSES OF OUR MEMORY THOSE INTERESTING THINGS WE SIGNED UP FOR LAST YEAR...AND THE YEAR BEFORE...AND THE YEAR BEFORE THAT.

BUT THIS SUBJECT HAS TO BE MORE IMPORTANT TO YOU THAN THAT...NOT BECAUSE I THINK ALL OF YOU WILL BE SPENDING YOUR PROFESSIONAL LIVES ACTUALLY MANAGING PATIENTS WITH TERMINAL ILLNESSES. I'M SURE MANY OF YOU WILL, BUT SOME WILL NOT. THEIR SKILLS AND TRAINING CARRY WILL CARRY THEM IN ANOTHER DIRECTION. NEVERTHELESS, THE SUBJECT BEFORE US TODAY WILL TEST YOU ALL THE DAYS OF YOUR PROFESSIONAL LIFE. AND IT WILL TEST YOU AS A HUMAN BEING AS WELL.

I'M SURE YOU FEEL THIS WAY -- AT LEAST TO SOME EXTENT -- OR YOU WOULD BE SOMEWHERE ELSE TODAY. SO I AM NOT GOING TO SPEND TOO MUCH TIME ON THE NEED FOR HOSPICE CARE, ITS HISTORY IN EUROPE AND IN THIS COUNTRY, OR IN OTHER MATTERS THAT, TO BE CANDID, OTHERS HERE KNOW BETTER THAN I. RATHER, I WANT TO TALK ABOUT THE SPECIFIC CHALLENGES THAT YOU AS AN INDIVIDUAL ARE INCLINED TO MEET, AS YOU BECOME MORE INVOLVED IN THE HOSPICE MOVEMENT AND MORE CONCERNED ABOUT THE CARE THAT TERMINAL PATIENTS GET FROM YOU AND FROM ALL THE HEALTH, SOCIAL SERVICE, AND OTHER CARING PROFESSIONS.

IN PREPARING MY NOTES FOR THIS MORNING, I DREW RATHER HEAVILY UPON MY OWN EXPERIENCES AS A PEDIATRIC SURGEON. IN THE COURSE OF MY 35-YEAR PRACTICE, I WAS FACED MANY TIMES WITH A YOUNGSTER FOR WHOM SURGERY OR

SOME OTHER "HEROIC" MEASURE WOULD SIMPLY NOT BE ENOUGH. SOMETIMES WE TRIED ANYWAY. MAYBE THERE WAS A CHANCE. THE PARENTS AND I WOULD HAVE WEIGHED THE PROs AND CONs. WE VERY POSSIBLY WOULD HAVE SOUGHT OTHER COUNSEL AND GUIDANCE: FRIENDS...CLERGY...COLLEAGUES. WE WOULD CHOOSE WITH CARE AND GREAT DISCRETION THOSE PERSONS WHO MIGHT HAVE GOOD COUNSEL TO OFFER US BEFORE WE MADE THE DECISION TO CUT.

WHAT DOES THAT TELL YOU? FOR A PHYSICIAN -- ESPECIALLY FOR A SURGEON -- IT TELLS YOU THAT MEDICINE MAY NOT HAVE ALL THE ANSWERS. WORSE YET, THE ANSWERS ARE AVAILABLE -- BUT <u>OTHER</u> PEOPLE SEEM TO HAVE THEM. I CAN TELL YOU THAT THIS IS NOT PRECISELY WHAT YOUNG GRADUATES OF MEDICAL SCHOOL OR NURSING SCHOOL HAVE IN MIND. HEALTH CARE CAN BE A VERY DEMANDING, EVEN GRUELING CAREER. YOU NEED A STRONG SENSE OF YOURSELF TO HANDLE MUCH OF THE STRESS THAT COMES WITH THE JOB. AND YOU TEND TO DEVELOP THAT STRENGTH ABOUT THE TIME YOU GRADUATE AND RECEIVE YOUR DEGREE. IT CAN BE A VERY HEADY FEELING.

THEN YOU ARE CONFRONTED WITH THE TERMINAL PATIENT. A CHILD. AN ELDERLY PERSON. A YOUNG ATHLETE. A GOOD PARENT. AND THE KINDS OF PROBLEMS THEY PRESENT ARE NOT SUBJECT TO THE RULES OF MEDICINE. YOU'VE GOT TO KNOW SOMETHING ELSE -- SOMETHING THAT YOU MAY NOT HAVE BEEN TAUGHT BECAUSE IT IS NOT, STRICTLY SPEAKING, <u>MEDICAL</u> AT ALL.

FOR EXAMPLE, THE SUBJECT OF MONEY IS NOT DISCUSSED TOO MUCH IN MEDICAL SCHOOL. I DON'T MEAN THE DOCTOR'S MONEY, I MEAN THE PATIENT'S MONEY. THAT'S A VERY SERIOUS PROBLEM. IT'S NOT A MEDICAL PROBLEM, YET EVERYONE OF US WILL ADMIT THAT THE PRESENCE OR ABSENCE OF MONEY DOES INDEED AFFECT A PATIENT'S CHOICE AMONG ALTERNATIVES. WE'D LIKE TO THINK THAT IT DIDN'T...THAT OUR GREAT POWERS OF PERSUASION AND OUR VAST MEDICAL KNOWLEDGE WOULD DO THE TRICK ALL BY THEMSELVES. SOMETIMES THEY DO. MOST OFTEN, THEY DO NOT. THERE ARE OTHER INFLUENCES AT WORK, TOO.

IN THE MANAGEMENT OF TERMINAL PATIENTS, WE OFTEN NEED TO SIT DOWN WITH THEM OR WITH THEIR FAMILIES AND LISTEN TO THEIR CONCERNS ABOUT COST. THIS IS THE KIND OF PROBLEM THAT REQUIRES OPENNESS BY BOTH THE PATIENT AND THE PHYSICIAN. I DON'T MEAN FOR ONE MINUTE THAT IN MY PRACTICE I IMPOSED SOME POCKETBOOK TEST ON ANY PATIENT OR FAMILY. THAT IS SOMETHING NONE OF US SHOULD EVER DO. BUT HOW THE FAMILY REACHES ITS DECISIONS...HOW THEY VIEW THE IMPORTANCE OF MONEY...HOW VULNERABLE THEY ARE BECAUSE OF THEIR LACK OF MONEY...THOSE ARE PROBLEMS THEY HAVE THAT I WOULD WANT TO KNOW ABOUT, WOULD WANT TO HEAR THEM TALK THROUGH, AND WOULD EVEN WANT TO HELP THEM SOLVE, IF POSSIBLE.

FOR EXAMPLE, MOST FAMILIES BLOCK OUT THE VERY IDEA THAT ONE OF THEIR MEMBERS COULD BECOME TERMINALLY ILL AND NEED EXTRAORDINARY CARE FOR A WHILE. IT IS SOMETHING FEW FAMILIES PLAN FOR. HOWEVER, WHEN THE TIME COMES, THEY NEED TO MAKE SOME DECISIONS RATHER QUICKLY ABOUT THE CARE AND COMFORT OF THE PATIENT. THOSE DECISIONS SHOULD NOT COME BACK TO HAUNT THEM LATER ON. THE ATTENDING MEDICAL STAFF OUGHT TO BE AWARE THAT, IN THE PRESSURE TO EASE A FATHER'S LAST DAYS OF LIFE, A SON MAY MAKE DECISIONS WHICH COULD POISON HIS OWN YEARS OF GROWTH AND AGING. AND DECISIONS ABOUT MONEY CAN TEND TO HAVE THAT EFFECT.

I FOUND THAT IT WAS HELPFUL TO BE A GOOD LISTENER FOR A FAMILY AS THEY TALKED THROUGH THE PROBLEMS OF THE COST OF CARE. SOMETIMES I WOULD KNOW OF A FREE OR A LOW-COST SERVICE THAT THEY WERE UNAWARE OF. THE IRONY IS THAT THESE LITTLE-KNOWN SERVICES WERE ACTUALLY PUBLIC SERVICES PAID FOR BY THE TAXES OF ALL CITIZENS -- INCLUDING THE FAMILY UNDER STRESS. IN MY POSITION AS A PHYSICIAN, I MAY HAVE COME UPON THAT PARTICULAR SERVICE SEVERAL TIMES A WEEK, WHEREAS THE AVERAGE FAMILY IN REASONABLY GOOD HEALTH MAY NEVER HEAR OF IT AT ALL.

BUT MONEY IS NOT THE ONLY DIFFICULT SUBJECT FOR MANY MEDICAL STAFF INVOLVED WITH TERMINAL PATIENTS. SPIRITUALITY IS ANOTHER. AND HERE AGAIN, WE ARE OUT BEYOND THE BOUNDARIES OF TRADITIONAL MEDICAL

PRACTICE. BUT THIS IS AN IMPORTANT CORNER OF THE "TRIANGLE" THAT CHARACTERIZES, FOR ME AT LEAST, THE TOTAL PROBLEM OF CARING FOR THE TERMINALLY ILL:

WE MUST BE CONCERNED ABOUT THEIR PHYSICAL HEALTH.

WE MUST BE CONCERNED ABOUT THEIR MENTAL HEALTH.

AND WE MUST BE CONCERNED ABOUT THEIR SPIRITUAL HEALTH.

LIKE THE MONEY ISSUE, THIS ONE IS ALSO INTENSELY PERSONAL. SOME OF US IN MEDICINE MAY HAVE STRONG FEELINGS IN ONE DIRECTION OR ANOTHER ABOUT ONE'S OWN SPIRITUAL LIFE. WE OUGHT TO ACKNOWLEDGE THAT OTHERS MAY ALSO FEEL JUST AS STRONGLY. IN FACT, WITH THE CERTAINTY OF DEATH BEFORE THEM, THEIR SPIRITUALITY MAY BECOME VERY INTENSE. CAN WE ACCEPT THEIR FEELINGS AS GENUINE...AND IMPORTANT...AND PART OF THE TOTAL ENVIRONMENT OF HOSPICE CARE? OR WILL WE BE DISAPPOINTED IN THEIR SPIRITUAL JUDGMENT OR THE DEGREE OF THEIR SPIRITUAL INTENSITY?

THE CONVENTIONAL WISDOM TELLS US THAT "DOCTORS SHOULDN'T GET INTO THAT." FOR MOST PATIENT CARE SITUATIONS THAT MAY BE GOOD ADVICE. BUT

FOR THE TERMINALLY ILL PATIENT, THIS CONVENTIONAL WISDOM IS JUST NOT ADEQUATE. THE PHYSICIAN, THE NURSE, THE SOCIAL SERVICE WORKER...ALL SHOULD WATCH FOR SIGNS THAT THE PATIENT IS TRYING TO WORK THINGS OUT FOR HIS SPIRIT, AS WELL AS FOR HIS BODY AND HIS MIND. AND WHEN WE COME UPON THAT HAPPENING, WE MUST ADJUST TO IT, MAKE ROOM FOR CLERGY OR SPECIAL FRIENDS OR FAMILY MEMBERS, AND HAVE OUR MEDICAL SKILLS PLAY A SUPPORTING ROLE.

PATIENTS, AFTER ALL, EXPECT THAT KIND OF UNDERSTANDING AND ASSISTANCE FROM CHAPLAINS AND CLERGY. THEY TEND NOT TO EXPECT IT FROM THE PROFESSIONAL MEDICAL STAFF. THEREFORE, WHEN A DOCTOR OR A NURSE DOES, IN FACT, INDICATE A SENSITIVITY TO THE SPIRITUAL TRIAL A PATIENT MAY BE GOING THROUGH, IT IS ALL THE MORE MEANINGFUL TO THAT PATIENT.

OUR MEDICAL TRAINING -- OUR MEDICAL BIAS, IF YOU WILL -- USUALLY LEADS US TO CONCLUDE THAT INSTITUTIONAL CARE IS "BEST." THIS IS GRADUALLY CHANGING, OF COURSE, AND PHYSICIANS ARE COMING AROUND TO EXPLORING OUTPATIENT CARE OF DIFFERENT KINDS, INCLUDING OUTPATIENT SURGERY. WHEN THIS APPROACH IS DESCRIBED, IT HAS THE RING OF A DRY CLEANING AD: "IN BY 10, OUT BY 3." BUT FOR MANY PROCEDURES IT IS QUITE APPROPRIATE.

BUT THESE POSSIBILITIES ARE STILL RATHER NEW. FOR MOST PHYSICIANS THE TREATMENT ENVIRONMENT OF CHOICE IS STILL SOME KIND OF INSTITUTION, AN ACUTE CARE HOSPITAL, A LONG-TERM CARE INSTITUTION, A NURSING-HOME, OR OTHER NON-HOME ENVIRONMENT. HERE AGAIN, WE NEED TO RE-ADJUST OUR THINKING AND RE-EXAMINE THE FUNCTION OF THE TREATMENT ENVIRONMENT. WHAT IS IT SUPPOSED TO DO FOR THE PATIENT? WHAT IS IT SUPPOSED TO CONTRIBUTE TO THE REGIMEN OF CARE?

FOR THE CONTEMPORARY PHYSICIAN, THE HOME IS NOT A WELL UNDERSTOOD TREATMENT ENVIRONMENT ANYMORE. FOR A LOT OF GOOD REASONS, PHYSICIANS DON'T MAKE "HOUSE CALLS" ANYMORE. THEY ARE INEFFICIENT AND COSTLY. AND FEW HOMES OFFER THE KIND OF DIAGNOSTIC BACK-UP THAT IS PART OF ROUTINE MEDICAL CARE. SO FOR THE PHYSICIAN, THE PATIENT'S HOME IS BASICALLY A PLACE TO REST...TO STAY IN BED...UNTIL THE PATIENT GETS BETTER.

NOT SO FOR THE TERMINALLY ILL PATIENT. THE HOME MAY BE THE ENVIRONMENT OF CHOICE FOR SOMEONE WITH A PREDICTED FEW WEEKS TO LIVE. HOW IS THE MEDICAL DECISION TO BE MADE? WELL, TO BEGIN WITH, IT CANNOT BE AN ENTIRELY MEDICAL DECISION. I BELIEVE IT IS ESSENTIAL FOR ALL THE PROFESSIONALS -- THOSE FROM THE SOCIAL SERVICES, MAYBE THE

CLERGY, ALSO -- TO SIT DOWN WITH THE MEDICAL STAFF AND WEIGH THE ADVANTAGES OF A TERMINALLY ILL PATIENT BEING IN A HOSPICE OR BEING AT HOME AND RECEIVING HOSPICE CARE. WE ALL ARE FAMILAR WITH MANY OF THE PROs AND CONs OF HOME CARE -- PROXIMITY OF FAMILY AND FRIENDS... FAMILIAR NATURAL SCENES...COMPLEXITY OF TREATMENT FOR PAIN...ADDITIONAL LIVE-IN OR VISITING MEDICAL HELP -- THE REASONS CAN GO BACK AND FORTH.

I DON'T BELIEVE THE DECISION TO OPT FOR HOME CARE OR FOR INSTITUTIONAL CARE SHOULD BE LEFT TO ANY SINGLE STAFF INTEREST. THEREFORE, SOCIAL SERVICE PERSONNEL, CLERGY, AND OTHERS NEED TO BE FORTHCOMING IN DISCUSSIONS WITH THE MEDICAL STAFF. AND <u>ALL</u> PARTIES SHOULD DISPENSE WITH SHOWS OF CONDESCENSION OR RESERVE OR DIFFIDENCE. THEY MUST BE MUTUALLY ATTENTIVE. EACH KNOWS SOMETHING THE OTHER DOESN'T, PARTICULARLY IN THIS SENSITIVE BUT CRUCIAL MATTER OF THE ENVIRONMENT FOR THE TERMINAL PATIENT DURING HIS OR HER FINAL WEEKS AND DAYS.

I THINK THE INTERDISCIPLINARY APPROACH TO CARE FOR THE TERMINALLY ILL -- THE APPROACH WHICH CHARACTERIZES SO MUCH THAT IS EXCELLENT ABOUT THE HOSPICE MOVEMENT -- IS AN APPROACH THAT NEEDS TO BE NOURISHED AND STRENGTHENED BY EVERYONE CONCERNED. IT REPRESENTS, AT THE VERY LEAST, A MAJOR "HUMANIZING" OF MEDICAL AND SOCIAL PRACTICE.

NOT TOO LONG AGO, THE LATE DR. RENE DUBOS, AN EXCEPTIONAL SCIENTIST, PHILOSOPHER, AND HUMAN BEING, WROTE THAT "MANY OF THE PROBLEMS THAT MANKIND FACES TODAY ARE THE CONSEQUENCES OF DISJUNCTION BETWEEN MAN'S NATURE, HIS ENVIRONMENT, AND THE CREATIONS OF SCIENTIFIC TECHNOLOGY." I THINK THERE ARE FEW OCCASIONS THAT THIS "DISJUNCTION," AS DR. DUBOS CALLED IT, CAN BE SEEN AS CLEARLY AS WHEN A PERSON IS FOUND TO BE TERMINALLY ILL, HAS JUST A BRIEF PERIOD -- RELATIVELY -- TO FINISH LIFE...AND BE GONE:

- OUR "NATURE" URGES US TO DO SOMETHING SPECIAL, SOMETHING "HEROIC" IN THE CAUSE OF LIFE AND AGAINST THE CAUSE OF DEATH.

- OUR ENVIRONMENT -- HOME, FAMILY, FRIENDS, BOOKS, COMFORTABLE CLOTHES, FAMILIAR FOODS -- OFTEN CANNOT SURVIVE BEING DISRUPTED OR COMPROMISED BY THE SUCH NATURAL URGES.

- AND OUR "SCIENTIFIC TECHNOLOGY" HOVERS AROUND BOTH NATURE AND ENVIRONMENT, ITS AWESOME POTENTIAL AVAILABLE TO SATISFY MAN'S NATURE -- AND, IN THE PROCESS, DISABLE MAN AND PERMANENTLY ALTER HIS ENVIRONMENT.

HOSPICE CARE, WHEN IT IS AT ITS MOST EFFECTIVE, OVERCOMES THIS PROBLEM OF "DISJUNCTION." IT BECOMES A WAY OF RECONCILING FOR THE INDIVIDUAL THOSE CONTENDING FORCES OF NATURE, ENVIRONMENT, AND TECHNOLOGY. SUCH CARE IS, ALMOST BY DEFINITION, COMPLEX AND DELICATELY BALANCED. AND I BELIEVE THE GREATEST CHALLENGE TO THOSE INVOLVED IN THE HOSPICE MOVEMENT IS TO DO WHAT THE PATIENT REQUIRES WHILE MAINTAINING THIS DELICATE BALANCE OF POWER.

FOR THE NURSE AND THE PHYSICIAN, THIS IS AN ESPECIALLY SIGNIFICANT CHALLENGE. TO QUOTE DR. DUBOS ONCE MORE, HE WROTE THAT "...TECHNOLOGY AT ITS HIGHEST LEVEL SHOULD INTEGRATE THE EXTERNAL WORLD AND MAN'S NATURE." IN OTHER WORDS, THE HIGHEST GOALS OF MEDICAL PRACTICE OUGHT TO BE <u>INTEGRATIVE</u>. THEY SHOULD BE GOALS THAT PROVIDE EVERY PATIENT WITH A KIND OF PHYSICAL, MENTAL, AND SPIRITUAL UNITY...A SINGULARITY OF ESSENTIAL HUMAN EXPERIENCE.

THE GREAT SPANISH WRITER JOSE ORTEGA Y GASSET SAID, "LIVING IS PRECISELY THE INEXORABLE NECESSITY TO MAKE ONESELF DETERMINATE, TO ENTER INTO AN EXCLUSIVE DESTINY..." I THINK THAT IS A WONDERFUL PHRASE TO REMEMBER, AS WE CARE FOR THE TERMINALLY ILL PATIENT. EACH

PATIENT IS EXHAUSTING THE LAST MOMENTS OF LIFE TRYING TO INSURE THAT IT WAS A SPECIAL LIFE...THAT THERE WAS SOME POINT TO IT...AND THAT THIS FINAL STRUGGLE IS NOT SO MUCH A HUMILIATION OR AN INDIGNITY AS IT IS A TESTAMENT OF ONE'S INDIVIDUALITY.

FOR MANY YEARS I HAVE FELT THAT, AS A CULTURE, WE CONFUSE THE AGING PROCESS WITH THE DYING PROCESS. THE AGING PROCESS GOES ON FOR MANY YEARS. THE GENETICISTS SAY IT BEGINS AT BIRTH, THE INDIVIDUAL'S PREDISPOSTIONS TOWARD SUCCUMBING TO ONE OF THE MAJOR KILLER DISEASES -- HEART DISEASE, CANCER, OR STROKE -- IS PRINTED INDELIBLY IN THE D.N.A. THE INFANT CARRIES INTO THE WORLD. I FIND THAT KIND OF DETERMINISM TO BE VERY THICK SMOKE TO BREATHE. I SUPPOSE THERE IS A GOOD DEAL OF TRUTH TO SUCH A THEORY. BUT I DON'T PARTICULARLY CARE FOR THE IMPLICATIONS.

NEVERTHELESS, WHETHER YOU THINK THAT AGING BEGINS AT BIRTH OR LATER ON, WHEN YOUR JOINTS START HURTING IN YOUR MID-THIRTIES OR WHEN YOUR LIFE INSURANCE PREMIUMS GO UP AND YOUR ENERGY LEVELS GO DOWN IN YOUR MID-FIFTIES, YOU PROBABLY HAVE AT LEAST AN INTUITIVE FEELING ABOUT WHEN PEOPLE BEGIN "GROWING OLD."

THE AGING PROCESS, TO MY THINKING, IS CONCLUDED IN A DISCREET PERIOD OF TIME THAT ACCOMMODATES THE "DYING PROCESS." DURING THE AGING PROCESS, THE INDIVIDUAL RECEIVES A VARIETY OF MEDICAL, SOCIAL, AND SPIRITUAL SERVICES THAT HE OR SHE IS PRIMARILY RESPONSIBLE FOR INTEGRATING. SO IT IS USUALLY THE INDIVIDUAL, RATHER THAN THE TECHNICIAN, WHO TENDS TO HUMANIZE THE TECHNOLOGY. THIS MAY NOT BE THE OPTIMUM SITUATION, BUT THAT SEEMS TO BE THE WAY WE FUNCTION. BUT THE SERVICES CHANGE DURING THE "DYING PROCESS." HERE, THE PEOPLE WHO PROVIDE THE SERVICES MUST BE PRIMARILY REPSONSIBLE FOR INTEGRATING THEM FOR THE PATIENT, SINCE THE PATIENT'S CAPACITY FOR SUCH WORK IS BECOMING SEVERELY LIMITED.

DURING AGING, WE OUGHT NOT TO ACCEPT THE IDEA THAT THE END OF LIFE IS UP AHEAD. I PLEAD WITH PHYSICIANS, FOR EXAMPLE, TO ADVISE THEIR ELDERLY PATIENTS -- PEOPLE IN THEIR SIXTIES -- TO STOP SMOKING, TO EASE UP ON ALCOHOL, TO OBSERVE A FEW RULES OF GOOD DIET AND PROPER EXERCISE. THE PRACTITIONER HAS NO RIGHT TO ASSUME A PATIENT IS ALREADY "ON THE WAY OUT" BECAUSE SHE JUST HAD A 65TH BIRTHDAY. SHE MAY HAVE A DOZEN MORE YEARS OF LIFE, IF SHE IS AN AVERAGE WOMAN. THOSE COULD BE GOOD, HEALTHFUL YEARS. THEY OUGHT TO BE SHAPED THAT WAY WITH THE HELP OF THE PHYSICIAN.

BUT OUR STANDARDS ARE DIFFERENT, ONCE WE KNOW THAT DEATH IS CERTAIN AT THE CLOSE OF A CERTAIN ESTIMATED PERIOD OF TIME. WHAT WOULD BE A CLEAR CASE OF DRUG ABUSE DURING THE AGING PROCESS MAY BE A COMPASSIONATE AND HUMANE DOSAGE DURING THE DYING PROCESS. WHAT MIGHT BE AN APPROPRIATE ACT OF MEDICAL "HEROISM" FOR AN AGING PERSON COULD BE A COSTLY ACT OF FOLLY FOR THE DYING PATIENT, WHOSE BURDEN OF PAIN OUGHT NOT TO BE INCREASED BUT RELIEVED DURING THE TERMINAL PERIOD.

I THINK THE DIFFERNCE BETWEEN THESE TWO KINDS OF CARE IS VERY IMPORTANT. AND IT WILL BE MORE CLEARLY UNDERSTOOD AND ACCEPTED, THE MORE OUR SOCIETY UNDERSTANDS AND ACCEPTS THE CONCEPT OF HOSPICE CARE AND ASKS FOR IT WHEN THE NEEDS ARISES. BUT WE SEEM TO BE A LONG WAY FROM THAT TIME. JUST DURING THE PAST FEW YEARS HAVE WE EVEN ACKNOWLEDGED THAT WE NEED TO LEARN MORE ABOUT THE AGING PROCESS AND HOW TO CARE FOR THE AGING PERSON. NOW, AS EACH YEAR PASSES, MORE AND MORE PEOPLE ARE BEGINNING TO SPECIALIZE IN GERIATRIC MEDICINE.

JUST BEHIND THIS DEVELOPMENT IS THE CONCERN FOR THE TERMINALLY ILL PATIENT...CONCERN FOR HOW WE CAN HELP A PATIENT LIVE THROUGH THE LAST MOMENTS OF LIFE. SO I WANT TO CONGRATULATE THE NATIONAL HOSPICE ORGANIZATION, THE LOMBARDI CANCER RESEARCH CENTER OF GEORGETOWN, AND

THE CONTINUING EDUCATION STAFF AT GEORGETOWN'S MEDICAL SCHOOL FOR MAKING THIS SYMPOSIUM POSSIBLE AND FOR INVITING ME TO TAKE PART IN THE PROGRAM.

LET ME ASSURE YOU THAT THIS IS IMPORTANT WORK AND THAT, WHILE IT MAY END FOR EACH PATIENT AS TIME RUNS OUT, THE WORK DOES NOT END FOR THE HUMANIZING OF OUR SOCIETY, OUR TECHNOLOGY, AND OUR OWN PROFESSIONAL LIVES.

THANK YOU.

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