THE WAR AGAINST DEATH

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To live well into our 90s in reasonably good health, enjoying family and friends, nature, hobbies, music, art and reading is a precious gift – but one that not all are privileged to enjoy. As we live longer, many will find themselves in a struggle with serious illness. We may view this struggle as a war in which our doctors and hospitals are the generals.

War is an anathema, but the war against disease is one we should prosecute vigorously. The research laboratory can be seen as a staging area for this war and the individual patient becomes the ultimate battleground. Sometimes we win spectacular victories against cancer and stroke, against diseases of heart, joints, kidney, lung, and liver. Such victories, however, can never be absolute. Most of us eventually will face months or years of gradually diminishing capacity, coping as effectively as possible with the pain and disability that accompany chronic disease. And so the war goes on.

Prosecuting this war, we understand that we cannot conquer death. Yet, even as we recognize this fact, we are tempted by the technologic imperative – the impulse to use every available weapon to defeat the enemy. It is difficult to resist this impulse. With our modern armamentarium, we sometimes try to barricade the door and keep death at bay as long as possible, counting every day as a victory in the long war.

As we try to stand our ground in a war that we must eventually lose, it is the patient who pays a price in terms of symptoms – initially manageable, but ultimately debilitating**:** pain, cough, shortness of breath, weakness, paralysis, constipation, diarrhea, incontinence and – most devastating – diminished cognition that robs the patient of the ability to recognize family and friends and, ultimately, of awareness itself.

Some of this deterioration is due to the implacable progress of disease, but some of it is the result of the weapons we use – irradiation of tissues, injection of toxic chemicals, insertion of tubes, ventilators, disfiguring surgeries – the whole panoply of our technologic expertise. In the war against death, the law of diminishing returns confronts us with a painful dilemma. Frequently, a time is reached when our weapons no longer extend life in a way that benefits the patient but merely extend the time it takes for the patient to die, and when victories in the war against death may be outweighed by what we might characterize as "collateral damage."

We need not surrender prematurely, for modern medicine wins many battles, often giving patients months and years of enjoyable life. But there is a point beyond which the patient may become the victim of a war that has dragged on too long. In war, if a general becomes blinded by the desire to achieve victory at any cost, then civilian authority must prevail. Similarly, in each patient's personal struggle as the end approaches, it is the patient (or an authorized surrogate, if the patient has lost the capacity to make decisions) who must take command of the field and determine when it is no longer reasonable to prosecute the war.

For many patients, illness reaches a stage at which it becomes apparent that aggressive life-sustaining treatment cannot produce a cure and may actually be subjecting the patient to distress that far outweighs the value of pursuing the current course of therapy. This does not mean that the physician must throw up her hands and stop all treatment nor that the patient must be resigned to accept the ravages of the disease and passively await death.

Great progress has been made in recent decades in developing palliative care techniques that provide substantial relief from the symptoms associated with advanced disease. Such techniques, in the hands of those trained in palliation, form the backbone of hospice care, which can provide invaluable support to those confronting end-of-life: the patient, the patient's loved ones, and the physician.

Some patients, some families and even some physicians seem to equate hospice care and the palliative techniques utilized in hospice with "giving up." Quite the contrary, this is an approach designed to optimize each patient's remaining time. And there is evidence that many patients

who receive hospice care not only live more comfortably, but actually live longer – and at lower cost – than comparable patients who do not receive such care.

Although we see this issue primarily in human terms, it is inextricably linked with the cost of medical care. Medical expenditures during the last year of life amount to more than one-fourth of all medical expenditures. One day in a hospital's intensive care unit costs many thousands of dollars. A patient with advanced disease may linger and suffer for weeks in a borderland between life and death. Heavy expenditures may buy us the ability to delay death for days, months, sometimes even for years -- but often at a terrible cost to the patient in terms of quality of life. Although no patient should ever be denied necessary and appropriate medical care for financial reasons, we must recognize that it is possible to incur costs blindly, doing harm rather than good. More is not always better.

The war metaphor that has underpinned much of this discussion, although useful in some ways, can be misleading if it tempts us to perceive death as an enemy we must try to defeat. To conceive of our physicians as our protectors against death under all circumstances is a mistake. In the end there can be no protection against death and its arrival must not be seen by patient, family or physician as a defeat. Faced, on occasion, with overzealous efforts to conquer death, we must realize, with Swinburne, "that even the weariest river winds somewhere safe to sea."

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