

ARE VETERINARIANS KINDER THAN PHYSICIANS AT END-OF-LIFE? IS PAWSPICE KINDER THAN HOSPICE? A VETERINARY ONCOLOGIST'S INTERPROFESSIONAL CROSSOVER PERSPECTIVE OF EUTHANASIA FOR TERMINAL PATIENTS

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INTRODUCTION

This discussion is an expert commentary on why and how society seems to maintain a dual ethic on standards for quality of life at the end-of-life between animal vs. human patients. Due to the cherished value of the human-animal bond in society, veterinary medical practitioners adopted the pediatrician model. The unique difference between a small animal practitioner's vs. a pediatrician's end-of-life approach is that their companion animal patients are considered geriatric babies!

This author is a practicing veterinary oncologist with 40 plus years of experience serving clients and their animal cancer patients with Pawspice, a practice which simultaneously embraces both palliative and standard care. When quality of life (QoL) declines to the point where the patient can no longer enjoy life, clients are compassionately counseled to consider the gift of humane euthanasia for their beloved pets. (Villalobos) When pet owners fail to recognize the relentless suffering and frustration of their dying companion animals, the attending veterinary medical staff endures distress which may result in a nagging moral stress that makes them more prone to compassion fatigue. Veterinarians serve society as healers. They have the oath and responsibility of compassionately preventing suffering in their patients. This includes preventing the misery and anguish of being forced to endure a prolonged or bad death. (Rollin)

Human longing for euthanasia is especially fulminate when the body is in relentless decline yet being kept in suspension to scientifically defy death. This is accomplished very well via modern medicine and life supportive care in ICU's and skilled nursing homes. The

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science ideology that death can and should be defeated, no matter the cost, is standard of practice for a large majority of physicians. This unique thinking is very American. It is encouraged by the innovative for-profit medical marketplace which has not yet defeated the inevitability of death. Physician detachment from death is unsustainable and imposes great emotional stress on patients and their families and a foreboding expense on the health care system for baby boomers.

DOUBLE STANDARD FOR ANIMAL VS. HUMAN DEATH

Society condones and encourages euthanasia for terminal animals to provide relief and prevent futile suffering. This allows a peaceful and painless passage for dying companion animal patients and emotional and financial relief for their devoted caregivers. Many people openly grieve more for their beloved companion animals than for their relatives. (Kaplan) This is because that particular animal was their joy, their social lubricant, the subject of their daily care giving, walking, hiking, reading, watching TV and living with unconditional love. The feelings of pet loss and bereavement are not much different than the loss and emotional grief suffered by those who have lost children or spouses whom they loved deeply and greatly cared for.

Bioethicist, Jessica Pierce, Ph.D. asks in *Psychology Today*, Why is euthanasia almost always considered the compassionate end point for our animals, but not for our human companions? (Pierce) <http://www.psychologytoday.com/experts/jessica-pierce-phd>

Table 1. Quality of Life Scale

Quality of Life Scale (The HHHHHMM QoL Scale)	
Pet caregivers can use this Quality of Life Scale to determine the success of Pawspice care. Score patients using a scale of: 0 to 10 (0 being the worst condition and 10 being ideal).	
Score	Criterion
0-10	HURT - Adequate pain control & breathing ability are of top concern. If the pet can't breathe properly, nothing else matters. This criterion outweighs all others! Is oxygen supplementation necessary? Is the pet's pain well managed?
0-10	HUNGER - Is the pet eating enough? Does hand feeding help? Does the pet need a feeding tube?
0-10	HYDRATION - Is the pet dehydrated? For patients not drinking enough, use subcutaneous fluids daily to supplement fluid intake.
0-10	HYGIENE - The pet should be brushed and cleaned, particularly after eliminations. Avoid pressure sores with soft bedding and keep all wounds clean.
0-10	HAPPINESS - Does the pet express joy and interest? Is the pet responsive to family, toys, etc.? Is the pet depressed, lonely, anxious, bored or afraid? Can the pet's bed be moved to be close to family activities?
0-10	MOBILITY - Can the pet get up without assistance? Does the pet need human or mechanical help (e.g., a cart)? Does the dog feel like going for a walk? Is the pet having seizures or stumbling? (Some carers feel that euthanasia is preferable to amputation, but an animal with limited mobility yet still alert and responsive, can have a good quality of life as long as the family is committed to helping their pet.)
0-10	MORE GOOD DAYS THAN BAD - When bad days outnumber good days, quality of life might be too compromised. When a healthy human-animal bond is no longer possible, the carers must be made aware that the end is near. The decision for euthanasia needs to be made if the pet is suffering. It is ideal when a pet's death comes peacefully and painlessly at home.
*TOTAL	*A total over 35 points represents acceptable life quality to continue with pet hospice (Pawspice).

Original concept, *Oncology Outlook*, by Dr. Alice Villalobos, *Quality of Life Scale Helps Make Final Call*, VPN, 09/2004; formatted for *Canine and Feline Geriatric Oncology: Honoring the Human-Animal Bond*, Blackwell Publishing, 2007. Adapted for: AVMA, NAVC, VSIPP, IVAPM & AAFP Hospice Guidelines, 2013 SVME online Basic Veterinary Medical Ethics Course, *Canine and Feline Anesthesia, Consultations in Feline Medicine*, Nova Publications, with permission.

QUALITY OF LIFE SHOULD INCLUDE HAPPINESS

This author created a special user friendly quality of life scale that measures seven basic criteria which veterinarians accept as universal welfare for animals. The seven criteria were condensed into an easily recalled acronym of five H's: Hurt, Hunger, Hydration, Hygiene, Happiness and two M's: Mobility and More good days than bad days. This scale is called the "HHHHMM" Quality of Life Scale, wherein one pronounces the acronym like the word, hum. This scale went viral in the veterinary community and it has helped tens of thousands of pet owners worldwide identify if they were properly caring for their end-of-life companion animal. The QoL Scale helps the veterinary team partner with pet owners in the difficult decision making process of whether to continue their pet's Pawspice or if it is appropriate to provide the gift of euthanasia. Many people have used this scale in evaluating the status quo of their elderly and dying family members because QoL is not just the absence of disease and pain. See Table 1. (Villalobos)

WHAT PHYSICIANS WANT FOR THEMSELVES

Health care professionals are committed to helping their patients get the best outcome under the given circumstances of their disease conditions and co morbidities. Society readily condones the gift of euthanasia to relieve and prevent the relentless and futile suffering of animals. This reflects the good shepherd role that man is the steward and protector of the flock. Veterinarians who provide euthanasia as a professional service are able to remain emotionally intact as long as they believe that they are doing the right thing for their patients.

Physicians wistfully express their desire for humane euthanasia for themselves if their own QoL declines to a worthless state or if it will help them avoid a slow, cruel, frustrating death. A large percentage of society readily convey similar desires for a peaceful and painless passing over the dreaded fate of being caught up in the gears of the mindless machinery of medicine.

One of this author's great mentors at UCLA Medical School feared that his advanced directive would not be carried out if he were taken by ambulance to the emergency room. When he knew that his aging heart was finally failing him, he went into his study to lay down on his favorite couch. He asked his wife to lovingly respect his wishes and not call the paramedics until his heart rate was well below 25 beats per minute. He specified that he did not want resuscitation attempts clearly in his DNR which he laid conspicuously upon his chest.

MINDLESS MACHINERY OF MEDICINE

A survey of terminal cancer patients who elected salvage chemotherapy for recurrent disease found that a majority of the patients were under the unsubstantiated impression that chemotherapy could potentially cure them. (Weeks, et al.) It is well known that many patients in this situation endure chemotherapy related adverse events that compromises their quality of life or causes them to die badly in ICU's.

A survey of terminal lung cancer patients, who chose palliative care vs. standard care (further chemotherapy), found that the palliative care group lived 3 months longer and enjoyed a higher quality of life. In addition, patients and their family members were more satisfied than those who chose standard care. (Temel, et al.)

Veterinary medicine has evolved parallel with human medicine in its technical ability to resuscitate and maintain trauma patients, poison patients, organ failure patients, neurologic patients, etc. Decisions of whether or not to continue life support comes up much sooner with veterinary patients. This is because the pet owner is the financially responsible principle who must commit to pay in full for professional services rendered for their companion animal. Less than 3% of America's companion animals enjoy pet health insurance plans. Most of those plans have a \$7-8,000 cap per illness or incident unless the pet owner purchased an extra cancer care policy. With facilities overhead, pay roll and urban expenses increasing, many pet owners find that medical care for a seriously ill companion animal can be costly. This feeling of expensiveness prevails despite the intrinsic value of services and cost of education and commitment of the veterinary profession. It is because financial responsibility rests solely with the pet owner that many elect euthanasia for their dying companion animals when faced with a poor prognosis for recovery or regaining an enjoyable QoL.

DELAYED REFERRALS FOR PALLIATIVE MEDICINE AND/OR HOSPICE

Most physicians think that if they refer their patients for palliative care, it would exclude their "can do" standard medicine. Could it be that today's informed physicians, who eschew difficult conversations about bad news and death, still view palliative medicine in the same frame as hospice care? Medicare and Medicaid might have caused this mindset when it was decided that life prolonging medical treatment for primary life limiting disease be excluded from hospice reimbursement. Is this misunderstanding, which remains pervasive in the medical profession, the real reason why physicians delay referrals? How can this outdated mindset be budged? Let this commentary make it well known that palliative medicine is not hospice although it may precede hospice.

There is no disagreement that American medicine is money driven and that the real needs of hospital patients, especially nursing home residents, exist in tension with regulatory goals. (The Hastings Center Guidelines) Are there rewards for physicians and facilities to blindly ignore patient needs, wishes and preferences and press on with their task-oriented, life at all cost philosophy of medicine? Why do physicians especially oncologists push onward with overtreatment? Why do physicians decline to refer patients out of their hemisphere of practice? What reimbursement motivators underlie the actual and rationalized truth in how physicians practice vs. what they would want for their own care? Why do physicians want

less of the mindless machinery of medicine for themselves than they recommend for their patients?

One experienced counselor made this comment regarding her husband's end-of-life care in March of 2013. *"Doctors are not interested in the end game. Families are not offered hospice soon enough for comfort care. Doctors view hospice as giving up. Most Doctors want to keep the patient in the hospital as they try various medications to try to beat death back. Families who want hospice and do not want their dying family member's wishes disregarded must often have to fight for hospice care."* Why is this mind set against accepting death as the last part of health care still the norm for so many physicians today when Vermont became the 4th state to pass aid in dying legislation and Quebec is leading the way in Canada?

PALLIATIVE CARE

Palliative Medicine can be delivered to patients regardless of an early or late stage diagnosis of a life limiting disease, regardless of the number of patient co morbidities or the need for other therapies. It can be delivered simultaneously with life-prolonging treatments or it can be delivered as the principle mode of care. The goals of palliative care are exclusively patient and family centered. This includes but is not limited to: preventing and relieving suffering while supporting the best QoL for patients and their families. Palliative care is a philosophy of care delivered by interprofessional teams highly trained in communication to avoid cultural pitfalls. It expands standard medicine by embracing important end-of-life goals such as enhancing QoL for patient and family, optimizing function, helping with decision making and providing opportunities for personal growth. As of 2006, the American Board of Medical Specialties has recognized palliative medicine as a subspecialty of medicine, with an unprecedented ten primary parent boards. (Meier)

"The hard question we face, then, is not how we can afford this system's expense. It is how we can build a health-care system that will actually help dying patients achieve what's most important to them at the end of their lives."

Atul Gawande (2010)

Since 2000, the AVMA has recognized that palliative medicine and hospice care is beneficial for end-of-life companion animals in addition to euthanasia. Guidelines were developed that recommended practitioners who do not offer palliative medicine and hospice (Pawspice) services to refer clients to a colleague who offers this specialized end-of-life care. Both veterinary and human palliative medicine should ideally transition patients into hospice care when requested or when death is near.

Irresponsible and/or financially strapped pet owners relinquish their sick, old, incontinent, failing pets at animal shelters. Some are adopted by rescuers who might foster them or self-declared animal hospice care givers or sanctuary workers. Some are collected by hoarders who are mentally ill and blind to their suffering. Rescuers range from individual hobbyists to well run organizations, which employ various levels of veterinary supervision to almost none. A few eschew euthanasia and risk closure. Most seek donations to help their cause.

DISRESPECT OF ADVANCED DIRECTIVES

Physicians were trained to save lives by challenging death. Many view death as a defeat. “Not on my watch!” or “I don’t discuss death with my patients.” Doctors go into automatic mode when patients are wheeled into the emergency clinics which is the right thing to do for trauma patients and acutely sick persons. Many ethicists agree that “save life at all cost” may be the wrong approach for advanced age, frail people and for those with terminal disease who want to bypass and forego futile medicine via informed refusal.

For the oldest geriatrics, the admissions desk should conduct a deliberate quest for the person’s wishes. A hospital wide policy should be in place to respect their advanced directives and DNR’s. Sadly, in many scenarios, this is not the case. The emergency room doctors persuade family members to put their ailing, failing, frail parents on life support, intubations, tracheostomy tubes, feeding tubes, IV fluids, antibiotics, and a raft of other interventions and drugs, etc. Often, the patient wants to forego further futile medicine; however, they admit getting talked into it by their doctors or loved ones who want to avoid death at all cost.

Baby boomers are demanding that their advanced directives and DNR’s be honored by physicians and family members or proxies. They want to be assured that today’s medical system will support their right to die with dignity and according to their written preferences. Most people do not want to wind up unresponsive with gastric feeding tubes warehoused in the healthcare nursing system, which won’t or can’t address their desires due to disincentives resulting in an artificially protracted dreadful time that precedes their death.

Is the blatant disrespect of advanced directives and DNR’s a philosophic, religious or ethical problem for emergency care physicians? Should these physicians hand the case over to a colleague who believes in honoring advanced directives? Is the common disrespect of DNR’s simply the result of fear of litigation from relatives? Is it due to physician, “Not on my shift,” avoidance of death? Could it be a money-driven scheme to keep the ICU wards full and keep the nursing care industry’s beds full? If we examine the data on who wins by ignoring AD’s and DNR’s, the answers might be clearer.

FEAR OF HUMAN WAREHOUSING BEFORE DEATH

10,000 baby boomers turn 60 every day. Many are alone without immediate family members to be at their side when illness strikes. All fear deterioration at the end-of-life. They reject the system that puts declining old people out of sight and out of mind. They do not want to be one of those failing, frail, forlorn and forgotten bodies that fill the beds of nursing homes. Informed boomers want to forego the burden of cancer over treatment with one more chemotherapy agent. They want to refuse life-sustaining treatment when facing multisystem failure. It is well known that some persons who feel disrespected, choose not to eat and die badly. How can caregivers ignore their fellow human being’s cry for assistance to make a peaceful passage?

Modern society is all too aware that obesity is a chronic debilitating life limiting disease that chips away at the body with one minus after the other. Society knows that severely disabled, immobile and frail geriatric people are maintained in rest homes enduring further physical and mental decline. This is their fate despite their reluctance to move from their

homes and giving up their pets. Their woes of poor quality of life and no reason for living are ignored.

An increasing percentage of modern society wants to exercise their right to a peaceful and painless passing vs. having to suffer humiliation and degradation as they decline toward death in a human warehouse. They don't want to slide down toward a non-functional and unresponsive state as their body joins the line-up for butts to clean and mouths to feed at end-of-life.

Oregon's Death With Dignity Act reported the top concerns of people who utilized their rights to physician assisted suicide in 2010. The top concerns were: 1) loss of autonomy (93.8%), 2) a decreasing ability to participate in activities that made life enjoyable (93.8%) and 3) loss of dignity (78.5%). (de Wachter) Surprisingly, pain was not one of the top patient concerns, which proves that adequate pain management is being addressed for most end-of-life patients and is appreciated in Oregon. The medical system forgets how important happiness is and how valued the ability to enjoy life is when considering one's quality of life.

AID-IN-DYING DRAFT

Rebecca Johnson, RN, Ph.D., FNAP, and the 2012-13 President of the International Association of Human Animal Interaction Organizations, gained experience in this arena while earning her doctorate at Iowa State University. She and her colleagues researched the intricacies and then drafted the Model Aid-in-Dying Act that could yield a potential policy/law. (Brandt, et al.) A hearing with Iowa state legislators concluded that the MD scope of practice, which viewed Aid-in-Dying as murder in 1989, blocked implementation. Johnson feels that this thinking or belief is still a major stumbling block in today's discussion. However, Oregon and Washington passed legislation allowing physician assisted suicide, Montana courts will not prosecute, Vermont passed legislation with aid in dying terminology, 6 other states have come very close in their voting for this measure and Quebec is pending.

Terminology can frame opponents with offensive names and skillfully loaded terms such as; "therapeutic homicide" or "death panels" or "culling grandma". Yet, the social ethic toward euthanasia is changing and views aid in dying as a much needed extension of health care. The conversation is highly motivated toward helping to solve a clearly unacceptable and sorry situation that has inadvertently and unjustly been created via modern technology.

One former rest home nurse said that her patients would often ask her to help them die because they were miserable and felt that their life was totally useless and not worth living. She always gave them her compassion and would hold a hand as she told them that it was not legal for her to help them die. She felt that her hands were tied behind her back during all those years on the job caring for hopeless unhappy people who did not want to be alive any more.

THE RELIGION ARGUMENT

Arguments based on religious fervor can cloud the real issues. It is very clear those who raise objections to death with dignity, terminal sedation, aid-in-dying and euthanasia are almost always based on religion or one's personal ethics or bias but not on science. Ideology

inspires inflexibility and rigidly held myths and incorrect assumptions that defy and deny the complexity of people in contemporary society.

Most religious arguments from physicians and ethicists frame or declare certain behaviors as immoral or unethical for themselves, their colleagues and the entire human race. However, in reality these same behaviors may be routinely accepted in other cultures and other belief systems. An example of an imposed ideology for the universe is the condemnation of people eating horsemeat, despite the fact that 5 million horses were consumed by the human race in 2011.

All too often personal and/or religious viewpoints provoke a strong emotional clash of values causing barriers instead of negotiations. For instance, measures that make sense for an over populated or modern society, such as voluntary birth control or abortion, may be overtly opposed based upon the religious beliefs of a segment of that population, which are allowed to practice their faith. Yet, it is well known that some of the most outspoken political opponents will clandestinely seek these same measures for themselves and their families if needed.

Some opponents retaliate by adopting scare tactics. They might claim: the world will self destruct or that society will lose trust in the medical profession or vulnerable members of society would feel threatened or coerced to die. They claim potential harm (not proven harm) if the slippery slope toward physician assisted suicide, aid-in-dying or euthanasia became legalized.

Potential claims of harm were not problematic in the Netherlands where physician assisted suicide is not legal but permitted and not prosecuted for almost 2,000 people per year. (Van der Mass, et al.) Threats of harm and distrust for doctors haven't ruined the medical profession in Oregon or Washington or Switzerland or Belgium where physician assisted death is legal.

Many of the arguments against terminal sedation and physician assisted death will have difficulty holding ground in future ethical discussions, if they sincerely query, "What value is life if it has no quality? When is life not worth living? Why can't patient autonomy be respected at the edge of life?"

Arguments from fixed beliefs or special interest groups are often stacked with: denial, misrepresentations, hyperbole, exaggeration, distortion, overstatement, understatement, smoke screens, veiled threats of potential harm. These techniques do not address the issues instead they are meant to blur the issues, block change and maintain status quo. Sadly, this unacceptable problem is growing and so is the moral obligation to do something about it.

USE OF DENIAL

The medical community claimed that there is not enough data on the number and nature of patient requests for medical suicide and euthanasia. (McMurray et al., 1992 AMA Council on Ethical and Judicial Affairs) This data might have been lacking because the questionnaires also asked physicians the number of requests that have been granted. It is well known that patient requests for assisted death have been honored for some time. (Wanzer, Federman, Adelstein) If the questionnaire omitted self-incriminating questions, the data might be more forthcoming from respondents. Rest home care givers can provide requested information for their population of patients.

Instead of denying that there is not enough data for the US medical and ethical community to operate with, a new open conversation could accumulate and use the available data and extrapolate. This technique is used scientifically with most surveys, polls and population studies. Care for death is ethical.

Since Oregon, Washington, Netherlands, Switzerland and Belgium have transparent documentation; their current data could be used and confidently extrapolated. Oregon reported loss of autonomy, inability to enjoy life and loss of dignity as the major reasons for requests for physician assisted death.

Open international conversations about the ethics of physician assisted suicide, aid-in-dying and euthanasia depend on trust and courtesy that both sides will be listened to and contemplated and will never be disparaged for holding opposing viewpoints. Truthful conversations are enlightening whereas framing, overt denial and confrontations are inflammatory and degrading. For instance, using words such as killing or homicide, is incorrect and inflammatory and denies that the patient has requested their death. Is it not the physician's role to minimize pain vs. preaching and proselytizing to avoid confronting death, which after all is part of life and undeniably unavoidable?

FROM CONTROVERSY TO CONSENSUS

The Society for Veterinary Medical Ethics uses the theme, *From Controversy to Consensus*, for its Plenary Sessions presented at the Annual AVMA Conventions. The great Leo Bustad, DVM, Ph.D., Dean, WSU School of Veterinary Medicine, is the renown father of the term, "human-animal bond". A collection of Bustad's thoughtful writings and speeches titled, *Compassion: Our Last Great Hope*, demonstrates his realization that as stewards of the animal kingdom, mankind has an innate compassion for animals. His leadership in forming the Delta Society (Pet Partners), the American Association of Human-Animal Bond Veterinarians and the International Association of Human-Animal Interaction Organizations, gave a springboard and credence to the changing social ethic to be kinder to the animals and the global environment that sustain mankind.

The question is. "Why should all physicians be forced to disallow their dying human patients the same innate compassion that society grants for animals?" If society considers it ethically detestable for a veterinarian or a farmer to refuse euthanasia for a miserably suffering animal, then the same principle should apply to change regulations that won't permit willing physicians to help suffering or miserable patients who ask for aid-in-dying.

NEW LANGUAGE FOR HUMANE HUMAN END OF LIFE CARE

Today's discussion needs new sensitive language to achieve change. Baby boomers have changed the world and they realize that they have more skin in the decisions that are being made about their geriatric future. They demand more respect for their AD's and DNR's and they want physician assisted suicide, aid-in-dying and compassionate euthanasia rather than waste away in rest homes deprived of pride and joy. Baby boomers are becoming pro active about healthy aging and how they want their end-of-life years to be spent.

The new language of assisted dying needs to adopt aesthetic words and euphemistic phrases such as: aid-in-dying, well death, quality death, helping terminal patients make their transition, peaceful passage, dignified departure, changing worlds (Barbara Myers), crossing over the rainbow bridge, leaving the body, peaceful and painless passing, compassionate release, gift of a good death, letting go, embracing the light, going home, final farewell, etc.

This new language needs to understand the religious fervor of those who oppose all forms of aid-in dying. Position statements by opponents should be honored as strong personal or religious beliefs, which are becoming more and more difficult to apply to all in today's society of multicultural and multi belief systems and modern technology. The new language can point out the damage that loaded terms create. Assisted dying advocates can deflate naysayers' dramatic inflammatory rhetoric. They can point out that selected phrases are emotionally loaded with the intent of suppressing independent thoughts and feelings with the intention for scaremongering. Is religiosity, indifference and denial ethically reprehensible when used to withhold aid in dying to alleviate pointless pain and or misery for end-of-life human patients?

GENTLE TECHNIQUES FOR A KIND PASSING

This commentary includes the ethics and rationale of using kind and gentle techniques for euthanasia of terminally ill companion animals and how these concepts may crossover to assist terminally ill humans. This author informs family members that euthanasia is a special service which we offer with reverence for life similar to a sacrament or a wake. We always provide a softly lighted room for our clients with blankets for the family to lay on the floor with their beloved dog. We bring flowers and candles to the room. We also encourage the family to bring their loved ones and household pets with them for this final goodbye to their beloved companion animal.

A heavy sedation is given IM, in the presence of the owner. This allows the patient to become totally pain free and to relax into slumber. This is the time that we help the family realize that their pet will lose consciousness in 5-10 minutes. We will leave the room to allow privacy but inform the family that the injection to follow is a strong barbiturate, which will cause their pet's heart to slow down and stop and the breathing to slow down and stop.

Our nursing staff will enter the room with me after a few minutes and place an IV butterfly catheter and deliver the euthanasia solution. During this time I have the client pet their dog's head and face and say goodbye.

If the patient is small, hypovolemic, hypotensive or dehydrated, we do not try to locate a vein to place a catheter. Instead, it is quite easy to locate the patient's heart and give the injection IC or if needed IP or into one of the kidneys or liver. We listen for a heartbeat and when there is none, the patient is pronounced deceased at that time. We often leave the room again so that the family can have privacy and hold a wake with their deceased pet. This is a special time which convinces the family that their pet will not wake up. We often come back into the room and sit on the floor with the family and read poetry from a special book, *Angel Pawprints* (an anthology of pet memorials), by Laurel Hunt. *Over the Rainbow Bridge*, (author unknown) is a favorite poem that describes eternal reunion and inspired Laurel to create this book.

The techniques described are gentle and compassionate and assures the family that their companion animal family member will have a peaceful and painless passing. (Villalobos) Occasionally, we euthanize a pet at exploratory.

All human health care workers need to allow themselves to absorb and consider how these concepts and techniques may crossover to assist the dying process for terminally ill people who request death with dignity. The aid-in-dying can be provided with carefully considered prescriptions which the patient can self administer. It would not be necessary for a physician to be present as his/her patient takes oral drugs prescribed under the careful scrutiny of physician assisted suicide, as patients and their families often prefer privacy for their passage. For end-of-life patients, unable to help themselves, palliative and terminal sedation are the most accepted techniques for aid-in-dying.

Despite many requests, veterinarians are not legally able to prescribe fatal drugs to their clients to administer to their companion animals for home euthanasia. Instead, a growing number of house call veterinarians who often use similar techniques described above, are filling the growing demand for in home euthanasia of America's beloved pets.

Veterinarians wear many hats. They serve as the one who may provide memorial keepsakes and makes arrangements for the pet's remains to be privately cremated, buried or rendered with the hospital's service provider.

Email tributes and eulogies are the new norm. Facebook and animal support web sites have become the place to memorialize a dearly beloved pet. Often the pet's family will make a donation to an organization that helps animals or does research to solve the disease that overcame their pet such as: Morris Animal Foundation at: www.morrisanimalfoundation.org, American Humane Association at: www.aha.org, Association for Pet Loss and Bereavement at: www.aplb.org, Veterinary Cancer Society at: www.vcs.org and Animal Health Foundation at: www.animalhealthfoundation.org.

RETHINKING SUMMARY

The ethics and rationale of using kind and gentle techniques for euthanasia of terminally ill companion animals is presented in this commentary for consideration and crossover into human medicine. By 2030, one in five Americans will be older individuals at risk to endure social poverty from physical and psychosocial degeneration causing depression and loss of independence, mobility, memory, dignity, joy and desire to live. (Helfand)

As a veterinary oncologist, who has fought for remissions and quality of life, it brings great reprieve and relief knowing that most of my Pawspice patients will have a quality death. Providing emotional support and decision making tools such as the HHHHHMM QoL Scale for family members helps them make the final call for the gift of euthanasia. Some veterinarians might view this as a burdensome obligation; however, this oncologist views it as a professional privilege and an honor to alleviate pointless pain and suffering.

It is clinically obvious to this author that providing access to a quality death actually reduces the moral stress and distress of our oncology team while bringing great relief to the patient and their caring families. Today's social ethic frees veterinarians to kindly and compassionately usher their chronically ill and dying patients over the rainbow bridge, when the time is right. Modern society wants to be let off the torture rack of dying slowly or badly as well.

Imagine the day when AD's and DNR's become totally respected instead of creating ethical dilemmas for vulnerable family members and inflexible physicians to sabotage or compromise. Imagine if aid-in-dying becomes a personal choice for the chronically ill and aging human race at the end-of-life. Imagine having a role in the global health concern discussion and decision making that converges to offset the enormous magnitude of predictable human erosion, wastage, misery and cost. Imagine a world without forced end-of-life misery.

Imagine transforming end-of-life care from a fixed to a flexible decisional authority based on the individual's wishes. The courage and moral character it will take to change legislation to allow humane aid-in-dying for humanity would pledge willing physicians to recognize the patient's truth. This would create an end-of-life health care system that helps humans as humanely as veterinarians help their patients transition from a world of hurt.

RESOURCES

Aging Resources, Interprofessional Health Care: Working Together for Healthy Aging, National Academies of Practice, Spring Forum, April 5-6, 2013
 American Association of Human-Animal Bond Veterinarians, www.aah-abv.org
 Society for Veterinary Medical Ethics, www.svme.org
 Pawspice, www.pawspice.org

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PAWSPICE & “HHHHHMM” QoL SCALE SYNOPSIS

Alice Villalobos, DVM, DPNAP, developed “Pawspice”, a program for quality of life (QoL), which starts when a companion animal is diagnosed with a life-limiting condition or disease. Pawspice embraces both palliative and kinder gentler forms of standard care to treat serious disease. It transitions to hospice [comfort care] as the patient approaches the final weeks, days or hours of life.

Pawspice protocols should not be considered synonymous with hospice which implies “giving up.” Instead, Pawspice uses low toxicity standard care and immunonutrition to avoid adverse events and support QoL. Pawspice helps and counsels the family to simultaneously and consistently focus on pain and symptom management to improve QoL. Pawspice patients often gain longer survival times than patients treated with the standard “can do” approach.

The *HHHHHMM QoL Scale*'s scoring system 0-10 asks family members and veterinary teams to assess various criteria that compose basic QoL. Use the scale on an as needed basis [weekly, daily, hourly]. The acronym's five H's stand for: *Hurt*, *Hunger*, *Hydration*, *Hygiene* and *Happiness* and its two M's stand for *Mobility* and *More* good days than bad days. This QoL scale also serves as a helpful decision making tool. It assists the V-Team and pet lovers as they struggle through the difficult and emotionally draining process of making the final call for the gift of euthanasia when it is needed to provide a peaceful and painless passing for a beloved pet.

A Feline QoL Scale may be downloaded at www.pawspice.com from the Quality of Life page.