

Timothy Diamond, a sociologist who spent several years working as a nursing aide in a variety of nursing homes, recounts the following experience:

Mary Ryan, like many others, spent all day in the day room, secured to her chair with a restraint vest. "How y' doin' today, Mary?" I once asked in passing.

She answered the question with a question. "Why do I have to sit here with this thing on?"

I responded automatically with a trained answer, "That's so you won't fall. You know that."

"Oh, get away from me," she reacted with disgust. "I don't trust anyone in white anymore."

Stunned by her rejection, and not completely confident of my own answer, I passed the question on to Beulah Fedders, the LPN [licensed practical nurse] in charge.

"Beulah, why does she have to wear that thing all the time?" Beulah accompanied her quick comeback with a chuckle. "That's so they don't have to hire any more of you."

We snickered together at the humor of her explanation, but an explanation it was, and more penetrating than mine to Mary. It posed a relationship between technology and labor, and in that connection Beulah explained that the use of one could mitigate the need for the other. A different kind of answer to the same question was given during our orientation [by the home's administrator]. "The restraint vests save on incidents..."

Beulah's answer was more accurate than "so you won't fall" and "vests save on incidents," because she connected them both to a common denominator—available labor. If no nursing assistant was there to be with Mary, to walk with her or anticipate her dizziness, and if she sat in the chair without a restraint and without anyone to keep an eye on her, she might have fallen, thus generating an incident. Her restraint vest saved on incidents while it saved on labor costs (Diamond, 1992:182).

As this story suggests, a central dilemma of the American health care system is how to provide care in profit-driven institutions, as well as in nonprofit institutions that must function within a broader, entrepreneurial system. In this chapter, we look at four settings where Americans obtain health care: hospitals, nursing homes, hospices, and family homes. We also consider a sociological analysis of the technologies that have become such a central part of care in these different settings, exploring what exactly we mean when we talk of "technology," how society decides which potential technologies should be developed and adopted, and how technology is affecting modern health care. We begin with a discussion of hospitals.

THE HOSPITAL

The hospital as we know it is a modern invention. Before the twentieth century, almost all Americans, whether rich or poor, received their health care at home from friends, relatives, and assorted health care providers. Because these providers used only a few small and portable tools, hospitals were unnecessary.

Some form of institution, however, was needed for those Americans who lacked friends or relatives to provide care at home or the means to purchase such care. For these individuals, the only option was the **almshouse**. Here they—along with orphans, criminals, people with disabilities, people with mental illnesses, and other public wards—received essentially custodial care. Conditions in almshouses generally were appalling. Inmates often had to share beds or sleep on the floor, and rats often outnumbered humans. Hunger was common and blankets and clothing scarce. These conditions, coupled with the lack of basic sanitation, made almshouses ideal breeding grounds for disease (Rosenberg, 1987:31–32).

The Premodern Hospital

Wealthy Americans considered almshouse conditions quite acceptable for those they regarded as lazy, insolent, alcoholic, promiscuous, or incurable (categories they believed included all nonwhites). By the end of the eighteenth century, however, wealthy Americans began to view these conditions as unacceptable for those they considered the “deserving” poor—the respectable widow, the worker disabled by an accident, or the sailor struck by illness far from home. With such individuals in mind, philanthropists decided to develop a new form of institution, the hospital, devoted to **inpatient** care of the “deserving” sick. These hospitals functioned as nonprofits and became known as **voluntary hospitals** because they relied heavily on unpaid (volunteer) charity work. Such institutions would protect the morally worthy poor from the degradations of living in an almshouse and associating with the morally unworthy poor. Not surprisingly, these early hospitals accepted only patients certified as deserving. Hospitals often required those seeking care to provide letters of reference from their employers or ministers (Rosenberg, 1987:19–20). In addition, hospitals generally refused patients with chronic, contagious, or mental illnesses, making exceptions only rarely for the few who could pay for care.

Early nineteenth-century hospitals differed dramatically from modern hospitals. Until after the Civil War, the large ward remained the center of all hospital activity. Admissions, diagnostic examinations, surgical operations, the last moans of the dying, and ministrations for the dead all occurred on the ward in full view of other patients and staff.

Although hospitals offered better conditions than did almshouses, they remained chaotic and dirty places. According to historian Charles Rosenberg:

Nurses were often absent from assigned wards and servants insolent or evasive. Chamber pots [used for urinating and defecating] remained



Engraving from *Harper's Weekly*, 1860. Museum of the City of New York
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A ward overrun by rats in New York's Bellevue Hospital. This woman's baby was eaten by rats.

unemptied for hours under wooden bedsteads, and mattresses were still made of coarse straw packed tightly inside rough ticking. Vermin continued to be almost a condition of life among the poor and working people who populated the hospital's beds, and lice, bedbugs, flies, and even rats were tenacious realities of hospital life (1987:287).

These conditions, plus the severe limitations of contemporary medicine, kept **mortality** rates high and taught the public to associate hospitals with death rather than treatment. To make matters even worse, hospitals functioned as **total institutions** (described in Chapter 7) in which patients traded individual rights for health care (Rosenberg, 1987:34–46). Hospital rules regulated patients' every hour, even mandating work schedules for those who were physically capable. Patients who didn't follow the rules could find themselves thrown into punishment cells or frigid showers.

Beginnings of the Modern Hospital

Given the rigors of hospital life, the **stigma** of charity that accompanied hospital care, and the popular association of hospitals with death, early nineteenth-century Americans entered hospitals only as a last resort. **The Civil War**, however, began to change this (Rosenberg, 1987:98–99). During the war, the need to care for sick and wounded soldiers exposed middle- and upper-class Americans to hospital care for the first time as both patients and health care workers. Of necessity, during the course of the war, hospital organization and

care improved, at least for the better-financed Union Army. These changes demonstrated that hospitals need not be either deadly or dehumanizing.

After the war, widespread adoption of new ideas about the dangers of germs and the importance of cleanliness helped to make hospitals safer and more pleasant. So, too, did technological changes such as the development of disposable gauze and cheaper linens, which made cleanliness feasible (Rosenberg, 1987:122–141). Concurrently, demographic changes such as the growth of cities, and the tremendous spurt in immigration, the growth of cities, and the resulting overcrowding and dire poverty made it impossible for many Americans to recuperate from serious illnesses or injuries at home. Meanwhile, the growth of industry and technology fostered accidental injuries, and poor and crowded living conditions bred contagious diseases that required hospital treatment. Medical changes, too, made hospital care more necessary as doctors came to value the technologies and germ-free surgical conditions available only in hospitals (Rosenberg, 1987:149).

Yet affluent Americans remained generally unwilling to tolerate the conditions on even the cleanest hospital wards. As a result, and to compete with the **for-profit, private hospitals** that began appearing during the second half of the nineteenth century, voluntary hospitals developed a class-based system of services (Rosenberg, 1987:293–294). Those who could pay for private accommodations received better heating and furnishings, exemption from many hospital rules, and privileges such as more anesthesia during operations. In addition, as hospitals increasingly became involved in medical education, private patients retained the right to treatment by their private doctors, but charity patients endured treatment by inexperienced medical students or **residents**. Through these changes, voluntary hospitals began to lose their ethos of service and became increasingly similar to their for-profit competitors.

The Rise of the Modern Hospital

By the early twentieth century, the hospital as we now know it had become an important American institution and a major site for medical education and research. Between 1873 and 1923, the number of hospitals increased from 178 to almost 5,000 (Rosenberg, 1987:341). These new hospitals also included **public hospitals**, established to provide services to those groups—people with mental illnesses, people with chronic illnesses, and the “undeserving poor”—that voluntary hospitals considered unworthy and for-profit hospitals considered money losers. However, African Americans still could obtain care only in a few segregated, poorly staffed, and poorly funded wards and hospitals; in municipal hospitals where medical students and residents could learn skills by practicing on African American patients; and sometimes in other hospitals for emergency care (Stevens, 1989:137).

This hospital building boom reinforced the class division within voluntary hospitals. According to Rosemary Stevens (1989:112), the voluntary hospital of the early twentieth century “was like a multiclass hotel or ship, offering different facilities for different prices. The grade of semiprivate patients, tucked in between private patients and the wards, seemed the logical development of a new ‘cabin class’

between 'first class' and 'steerage.'" Thus, by the 1920s, voluntary hospitals had abandoned much of their original charitable mission and become big businesses. As such, they had come to reflect the American ideology that individuals should get only what they pay for in health care as in other areas (Stevens, 1989:112).

By this time, surgical admissions to hospitals far surpassed medical admissions (Rosenberg, 1987:150). Most patients went to a hospital to have their tonsils, adenoids, or appendixes removed; their babies delivered; or their injuries treated (Stevens, 1989: 106). The emphasis on technology as a defining aspect of modern hospitals further reinforced hospitals' tendency to focus on the care of **acute** rather than **chronic illness**.

The number of hospitals increased dramatically after passage of the 1946 Hill-Burton Act, which provided funding for hospital construction. During the next 14 years, 707 voluntary hospitals and 475 state and local hospitals were built, and the rate of hospital admissions increased substantially. Unfortunately, the federal government did not use this opportunity to develop a rational and national health care system. Instead of tying funding to regional health needs, the government allowed hospitals to pursue their private financial interests: focusing on acute rather than chronic illness; discouraging nonpaying patients; reinforcing local norms of racial segregation; and buying expensive, esoteric technology even if it duplicated equipment owned by nearby hospitals (Stevens, 1989:200-232).

Hospitals Today

Federal subsidies for hospitals expanded substantially after the implementation in 1965 of **Medicaid** and **Medicare**. These plans dramatically increased the profits available to hospitals. This in turn led both to a rise in for-profit hospitals and to increasing mergers of hospitals into ever-larger for-profit and voluntary hospital chains (such as Humana and Sisters of Charity, respectively).

As hospital profits grew, so did costs to the federal government via Medicaid and Medicare. As a result, the government for the first time developed a vested interest in controlling hospital costs. Ironically, the resulting price-control programs (described in Chapter 8) such as **diagnosis-related groups (DRGs)** have pressured voluntary hospitals (which remain the core of the hospital system) to focus more on the bottom line and thus to act more like for-profit hospitals (Stevens, 1989:305).

More recent cost-containment programs at the state and federal level have especially squeezed funding for public hospitals. Under any circumstances, it is difficult for these hospitals to make ends meet because so many of their patients go to public hospitals only because they cannot afford to pay. To cover these costs, public hospitals rely on funding from state and local governments. This funding, however, has declined substantially in recent years, forcing hospitals to cut staff, reduce services, or close altogether.

Concern about costs and profits also has affected the mix of services offered by hospitals. Rather than fighting **managed care** insurers over which treatments and services the insurers will cover, hospitals now increasingly offer extra

services that patients are willing to pay for out of pocket, such as yoga, meditation, and massage (Abelson and Brown, 2002). Similarly, because insurers (including Medicare under the DRG system) typically pay hospitals only preset amounts for inpatient surgery but will negotiate prices with hospitals for outpatient surgery (that is, surgery given without formally admitting the patient to the hospital or requiring an overnight stay), hospitals now offer **outpatient surgery** whenever technically feasible. As a result, **outpatient surgery** increased from 20% of all hospital surgeries in 1981 to 60% in 2010 (American Hospital Association, 2010). At the same time, the competitive market environment has encouraged hospitals to offer new, technologically intensive treatments and tests even if evidence of their benefits is weak and other nearby hospitals already offer them. The result has been a proliferation of expensive technologies such as magnetic resonance imaging machines, intensive care units, and open-heart surgical suites. Finally, an increasing number of hospitals have closed or shrunk money-losing units such as obstetrics wards, emergency departments, and psychiatric units. Because of these changes, hospitals now treat an older and sicker mix of patients, most of whom suffer from the acute complications of chronic illnesses.

Conversely, as hospitals have shifted toward providing more intensive care for middle-class Americans, some (especially public hospitals) have moved, if unwillingly, toward becoming **primary care providers for the poor**. Patients who have neither health insurance nor money to pay for care sometimes turn to hospital outpatient clinics and emergency departments not only for treatment of acute problems, such as gunshot wounds, but also for chronic problems, such as backaches.

The Hospital-Patient Experience

Although hospitals no longer terrify and endanger patients as they did in the nineteenth century, a hospital stay still can be alienating and frightening. The bureaucratic nature and large size of modern hospitals, coupled with the highly technological nature of hospital care, often mean that the patient as an individual person, rather than just diseased body, gets lost.

The reasons behind this are obvious and, to some extent, unavoidable. First, increasingly, patients enter hospitals needing emergency care. Often, **health care workers must respond immediately to their needs and have no time to talk with them to ascertain their preferences**—which many are physically incapable of expressing in any case. Second, the highly technical nature of hospital care encourages staff to focus on the machines and the data these machines produce rather than on the patient as a whole person. In the modern obstetric ward, for example, workers often focus much of their attention on the electronic fetal monitor rather than on the laboring woman (Simonds, Rothman, and Norman, 2007). Third, and as we will see in Chapter 11, medical training encourages doctors to focus on biological issues much more than on patients' psychological or social needs. Fourth, as large institutions necessarily concerned with costs and profits, hospitals must rely on routines and schedules, with little leeway for individual

needs or desires. Hence the common stories of nurses awakening patients from needed sleep to take their temperature or blood pressure.

NURSING HOMES

From the start, American hospitals focused on caring for acutely ill persons and assumed that families would care for chronically ill persons. During the course of the twentieth century, however, average life expectancy increased; families grew smaller, more geographically dispersed, and less stable; and women less often worked at home. As a result, more and more Americans needed to seek long-term care from strangers, and **nursing homes**—facilities that primarily provide nursing and custodial care to groups of individuals over a long period of time—became part of the American landscape.

The number of nursing homes has more than tripled since 1980. Currently, there are about 16,000 skilled nursing homes in the United States, the majority run for profit (U.S. Bureau of the Census, 2010).

Gender, Age, Ethnicity, Class, and Nursing Home Usage

About 1.4 million Americans currently live in nursing homes (National Center for Health Statistics, 2010b). Some groups, however, are more likely than others to find themselves in a nursing home.

Most strikingly, **women are far more likely than men to become nursing home residents**. Indeed, women now comprise about three-quarters of residents, partly because women more often live long enough to become enfeebled by age and partly because they more often survive their spouses, leaving no one to care for them if they need help.

Not surprisingly, **older people are far more likely than others to live in nursing homes, and residents overwhelmingly are older than age 75**. However, the numbers of nursing home residents younger than age 65—indeed, younger than age 30—has grown significantly in the past decade because of the rise in diabetes and in gang violence, among other factors (Persson and Ostwald, 2009). Many young people stay in nursing homes only temporarily while recuperating from a serious illness or accident, but others stay for years. Still others find themselves in nursing homes because they have a mental illness or disability and have no one who can help them with basic daily tasks (such as preparing food or dressing themselves).

Regardless of why young people find themselves in nursing homes, life for them can be grim and isolating: Few have interests in common with their elderly co-residents, and many are in nursing homes in part because they have limited contact with their families (Persson and Ostwald, 2009).

Historically, nursing homes residents overwhelmingly were white, but this is shifting as the U.S. population shifts. Usage of nursing homes by African Americans and Hispanics increased significantly from 2000 to 2007, whereas usage by white Americans decreased, probably because whites increasingly can

afford alternatives that allow them to stay in their homes or in other, less restrictive environments (Feng et al., 2010). In addition, African Americans and Hispanics far more often find themselves in lower quality nursing homes, primarily because of their lower incomes (Fennell et al., 2010; Smith et al., 2007). The same is undoubtedly true for poorer white Americans, although data on this is unavailable.

Importantly, nursing home residents these days are considerably sicker on average than were residents 20 years ago. This change stems from the economic incentives built into DRGs, which have encouraged hospitals to discharge patients “sicker and quicker”—physically stable but still ill—once their bills and lengths of stay exceed the limits set by Medicare. Those who cannot care for themselves at home often are discharged directly to nursing homes.

Financing Nursing Home Care

Currently, nursing homes charge about \$200 per day for a room (National Clearinghouse for Longterm Care Information, 2010). Few Americans can afford these costs. Nor can most afford insurance coverage for nursing home care which typically is very expensive. As a result, at least initially, most residents rely on Medicare to pay their bills. However, Medicare pays only for skilled nursing care and at most for the first 150 days. As a result, most individuals who need only custodial care or need more than 150 days of care must turn to Medicaid to pay their bills. To be eligible for Medicaid, however, they must first sell all of their assets (minus their houses if they are married) and spend all of their savings (minus the cost of burial expenses and minimum living expenses for their spouses). Thus, long-term nursing homes residents (and their spouses) usually end up impoverished. Moreover, because Medicaid reimbursement for nursing homes is often less than the homes' usual charges, nursing homes often either move residents who are on Medicaid to lower quality areas of the nursing home or discharge them to other, cheaper homes.

to receive Medicaid, most must bankrupt themselves (& spouses)

Working in Nursing Homes

Nursing home care is extremely labor intensive. To provide this care, nursing homes rely almost solely on nursing assistants (who often have no training) augmented by licensed practical nurses (who have completed approximately one year of classroom and clinical training).

Nationally, nursing assistants (half of whom work in nursing homes and one-quarter in hospitals) form one of the largest and fastest growing health care occupations (Bureau of Labor Statistics, 2010b). Almost all are women, and most are nonwhite. Many come from Africa, Asia, or Latin America and are not native English speakers. These characteristics leave them particularly vulnerable in today's shrinking job market, with little ability to fight for better working conditions. Indeed, in August 2010, the federal government announced a new crackdown on employers that pressured nurses at all levels to work unpaid overtime and noted that the pressures on nursing assistants were especially severe

* limited training + poor working conditions

(Pear, 2010). Currently, nursing assistants who work in nursing homes earn a median income of \$10.91 per hour (Bureau of Labor Statistics, 2010b).

To understand the life of nursing home residents and the nursing assistants who care for them, sociologist Timothy Diamond (1992) became certified as a nursing assistant and worked for several years in a variety of nursing homes. He soon concluded that the core of working as a nursing assistant is caregiving but that those who train nursing assistants do not recognize this basic fact. Instead, his instructors taught him to recite biological and anatomical terms, measure vital signs, and perform simple medical procedures. Instructors divorced these skills from any social context or any sense that their patients were people rather than inanimate objects. Moreover, the skills Diamond most needed were never taught, such as exactly how do you clean an adult who has soiled a diaper in a manner that preserves the individual's sense of dignity? Only by labeling this caregiving as mere physical labor could those who hire nursing assistants label them "unskilled" and treat them so poorly.

Life in Nursing Homes

Diamond's research underlines how the fates of nursing assistants and nursing home residents intertwine and how even in the best nursing homes, the economics of a profit-driven system produce difficult conditions for both. According to Diamond, within nursing homes

caregiving becomes something that is bought and sold. This process involves both ownership and the construction of goods and services that can be measured and priced so that a bottom line can be brought into being. It entails the enforcement of certain power relations and means of production so that those who live in nursing homes and those who tend to them can be made into commodities and cost accountable units (1992:172).

In this process of **commodification**, or turning people into commodities, "Mrs. Walsh in Bed 3" becomes simply "Bed 3." To keep down the price of this "commodity," only the most expensive homes provide private rooms or separate areas for residents who are dying, smelly, or psychologically disturbed. Privacy, then, also becomes a commodity that few residents can afford.

Nursing assistants, meanwhile, become budgeted expenses, which homes try to keep to an absolute minimum. Largely as a result, federal regulators in 2008 cited *more than 90%* of nursing homes for health and safety violations (Pear, 2008). Such violations can place residents at risk of bedsores, malnutrition, pneumonia, and other avoidable health problems.

To justify their low staffing levels, nursing home administrators and owners narrowly define the caregiving that assistants provide and residents need (Diamond, 1992; Foner, 1994). For example, managers may hire only enough assistants to hurriedly spoon feed residents rather than enough to allow assistants to chat with residents while feeding them or to help residents retain their dignity by feeding themselves. Similarly, managers can keep residents drugged, strapped

to chairs, on a strictly regimented schedule, and in a single central room during the day so that a few assistants can supervise many residents; one recent study found that 71% of new residents received psychiatric drugs even though most had neither been diagnosed with a psychiatric problem nor received such drugs before admission (Molinari et al., 2010).

Although all these problems also can occur in nonprofit nursing homes, a review of federal data from all U.S. nursing homes found that both quality of life and quality of care were significantly worse in for-profit homes (Harrington et al., 2001). One reason for this is that within the profit-driven system, managers constantly stress to staff that providing care is less important than documenting care. As a sign proclaimed in one nursing home where Diamond worked, “If it’s not charted, it didn’t happen.” For example, state regulations where Diamond worked required homes to serve residents certain “units of nutrition” each day. Consequently, each day Diamond collected the cards placed on residents’ food trays that named the foods and their nutritional content. Every few months, state regulators would inspect the cards and certify that the homes met state nutritional requirements. Yet these cards bore little relationship to reality because the appetizing-sounding names given to the foods rarely matched the actual appearance or taste of the food. Nor did the cards note if a resident refused to eat a food because it was cold, tasteless, or too hastily served. Similarly, sanitation regulations required homes to shower residents regularly but did not require that the showers be warm. Nor did they require the homes to hire enough nursing assistants so that residents who used diapers could be cleaned as soon as needed or so that residents could get the help they needed in using the toilet and thus avoid the indignity and discomfort of diapers.

Ironically, in top tier nursing homes, the same process of commodification is now leading nursing home owners to encourage nursing assistants to emphasize caring and, indeed, to think of residents as their kin (Dodson and Zinbavage, 2007). By so doing, nursing homes can both charge higher prices for their “family atmosphere” and get more work from assistants for the same low wages. But this “purchased intimacy”—similar to that offered by massage therapists, beauticians, and others—is a one-way transaction: Nursing assistants may treat residents like family, but residents still often sling racist slurs at nonwhite nursing assistants. And even in these “higher quality” nursing homes, owners rarely allow nursing aides time off to deal with problems in their own families or to grieve when residents they cared about die.

HOSPICES

Origins of Hospice

Whereas nursing homes emerged to serve the needs for long-term care not met by hospitals, hospices emerged out of growing public recognition that neither of these options provided appropriate care for the dying.

Only in the past few decades has institutional care for the dying become a public issue. At the beginning of the twentieth century, few individuals

experienced a long period during which they were known to be dying. Instead, most succumbed quickly to illnesses such as pneumonia, influenza, tuberculosis, or acute intestinal infections, dying at home and at relatively young ages. Now, however, most Americans live long enough to die from chronic rather than acute illnesses. In addition, as doctors and scientists have developed techniques for detecting illnesses in their earliest stages, they now more often identify individuals as terminally ill long before death occurs. Thus, dealing with the dying is to some extent a uniquely modern problem and certainly has taken on a uniquely modern aspect.

Although modern medical care has proved lifesaving for many, its ability to extend life can turn from a blessing to a curse for those who are dying. (*Ethical Debate: A Right to Die?* discusses this issue in more detail.) For various reasons, including legal concerns about restricting care, financial incentives for using highly invasive treatments, and a medical culture (described in the next chapter) that emphasizes technological interventions, thousands of Americans each year receive intensive, painful, and tremendously expensive medical care that offers little hope of restoring quality of life or extending lives. In nursing homes, on the other hand, the emphasis on profit making and cost cutting often results in dying persons receiving only minimal and depersonalized custodial care.

This lack of appropriate care for the dying led to the development of the hospice movement. The first modern hospice, St. Christopher's, was founded in England in 1968 by Dr. Cicely Saunders to address the needs of the dying and to provide an alternative to the alienating and dehumanizing experience of hospital death. The hospice admitted only patients expected to die within six months and offered only palliative care (designed to reduce pain and discomfort) rather than treatment or mechanical life supports. The hospice provided care both in St. Christopher's and in patients' homes.

The first American hospice, which closely resembled St. Christopher's, opened in 1974 in New Haven, Connecticut. Other hospices soon followed, emerging from grassroots organizations of religious workers, health care workers, and community activists seeking alternatives to hospitals and nursing homes. Public support for hospices was so immediate and so great that in 1982, only eight years after the first American hospice opened, Congress approved covering hospice care under Medicare.

Modern Hospices

The U.S. hospice movement has proved enormously successful, growing from one hospice in 1974 to about 5,000 hospices serving 1.6 million clients annually by 2009 (National Hospice and Palliative Care Organization, 2010). With that success, however, there have been changes. Whereas the original hospices were independent, free-standing institutions, these days most hospice care is received in homes and nursing homes. In addition, the original hospices were nonprofit organizations, primarily staffed by volunteers, that emphasized individualized care and patient participation. Now that hospices are primarily funded by insurers, they have had to reconfigure their staffing and practices to meet standards for care based on hospital protocols.

ETHICAL DEBATE**A Right to Die?**

In 1983, 26-year-old Elizabeth Bouvia, who lived with almost total paralysis from cerebral palsy and near-constant pain from arthritis, presented herself for admission to Riverside General Hospital. In years past, and despite her physical problems, Bouvia had earned a degree in social work, married, and lived independently. However, after her efforts to have children failed, her husband left her, and the state stopped paying for her special transportation needs, she lost interest in living. Her purpose in coming to the hospital, she told the hospital staff soon after her admission, was to obtain basic nursing care and pain-killing medication while starving herself to death, cutting short what might otherwise have been a normal life span. The hospital's doctors took her case to court and won the right to force-feed her on the grounds that, although individuals have the right to commit suicide, they cannot force health care workers to commit passive euthanasia (i.e., to allow patients to die through inaction).

In 1990, Janet Adkins, 54 years old and living with Alzheimer's disease, killed herself with the assistance of Dr. Jack Kevorkian—a process known as assisted suicide. Kevorkian had designed a machine that allowed people with severe disabilities to give themselves a fatal dose of sodium pentothal and potassium in the privacy and freedom of their homes. Over the next decade, Kevorkian provided doctor-assisted euthanasia to more than 100 people. In 1999, he was convicted of second-degree homicide and sentenced to 10 to 25 years in prison after he administered a lethal injection himself rather than having his client do so and sent a videotape of the death to CBS-TV. He was released from prison in 2007 on the condition that he not assist in any further deaths.

In the Netherlands, meanwhile, doctors legally can practice active voluntary euthanasia (i.e., actively end a patient's life) for patients who are mentally competent, incurably ill, suffering intolerable and unrelievable pain, and who authorize their doctors to do so in writing. Although so far only Oregon has legalized doctor-assisted suicide, at least two-thirds of Americans believe that terminally ill people have both a right to die and a right to their doctors' assistance in so doing (Contexts, 2004).

Those who support a "right to die" argue that competent adults have the right to make decisions for themselves, including the ultimate decision of when to die. They argue that death sometimes can be a rational choice and that it's cruel to force individuals to suffer extreme physical or mental anguish (Seale, 2010).

If we accept that death can be a rational choice, then harder questions follow. Why is it rational only if one's condition is terminal? Doesn't it make even more sense to end the life of someone like Elizabeth Bouvia, whose agonies may continue for another 50 years, than to end the life of someone who will die soon regardless?

Moreover, about half of all hospices are now run on a for-profit basis (National Hospice and Palliative Care Organization, 2010). For all of these reasons, hospice care is now more cost oriented and less individualized or patient centered.

Use of Hospice

The number of Americans served by hospices tripled in the past decade (National Hospice and Palliative Care Organization, 2010). Currently, about 40% of persons who die in the United States use hospice services, for a median of 21 days.