Health Promotion Through Life Promotion and the Fallacy of Right to Choose

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As nurses, we want to promote health, but what is health? If our goal in nursing is fact-based care, we need to make sure all our defining terms are not merely bumper stickers. Of course, health promotion has different goals throughout our lifespan. Hence, how we promote health will be determined by our definition of life itself, or so-called "quality of life." It cannot be denied that the *quality of life* idea frames our health promotion process. But what is "quality of life"? Though a term used daily in healthcare, when you ask the user of the term to define it, we see the proverbial *deer in the headlights* response. This is not surprising since organizations like the NIH state that there is no uniform definition for *quality of life* (NIH, 2023).

The thesis of this paper follows: the term *quality of life* is a bumper sticker. What do we mean when we use the term "bumper sticker" in this context? Good bumper stickers are short statements that sound profound, but usually promote an agenda that goes far beyond the short statement. These short statements can be handy shortcuts for dealing with life. When confronted with a difficult situation, we can say "stuff [sic] happens" or "it is what it is" and move on. Usually, however, bumper stickers exhibit a short statement that few people can disagree with on face value, but in fact, represent a larger body of beliefs that may be controversial. In other words, bumper stickers garner widespread support for an idea while those making the bumper stickers have a much broader and deeper agenda.

Furthermore, the *quality of life* bumper sticker is always accompanied by the *right to choose* bumper sticker. Indeed, the NIH states that, for the most part, since the *quality of life* idea is subjective, it should be defined by the individual's perception, or in other words, how the individual determines quality of life for herself or himself (NIH, 2023). Those who defend the

quality of life idea point to this definition, that is, *right to choose*, but is that definition really honored in healthcare? For the most part, no.

Assumed Definitions

Undefined truisms mean different things to different people while people assume a unified meaning when they hear the truism spoken. When we hear "quality of life," we assume everyone knows what that means and is talking about the same thing. This is the unfortunate power of bumper stickers, which do not take science into consideration. Water happens when you have two atoms of hydrogen and one atom of oxygen or H_2O. The *quality of life* formula should have at least 200 different expressions that look something like this: Nqol. In this formula, quality of life is determined by nihilism. Or you could have a formula that looks something like this: Sqol. This is quality of life determined by socialism, which defines quality of life as a person's sole ability to contribute to the state or the "greater good." When we hear someone speak about quality of life, we have no idea what they mean unless we know their worldview—we have no idea what they mean unless the term is qualified.

By way of example on this point, the World Health Organization defines health promotion as supporting governments and communities for "building healthy public policies" (WHO, 2024). Even though support and education for the individual is interwoven in the statement, "building healthy public policy" is really a soft term for mandating health "choices" through the legislation of laws. This is where we begin to see the fallacy of *right to choose*.

The Right to Choose and Dying Incorrectly

Unfortunately, most people driven by a worldview are zealots—zealots struggle with someone's right to choose because invariably, if the choice does not align with their worldview, it

is deemed a choice driven by some inequitable standard based on their opinion. This is a huge problem in healthcare as exemplified by the documentary *Death Land* narrated by Leah Green, a journalist with The Guardian (Guardian, 2019).

In episode II of the documentary, Green interviewed Dr. Sunita Puri, director of palliative care at Keck Hospital in LA, California, and shadows her during visits with some of her patients. During the interview, Dr. Puri shared her philosophy of palliative care as reflected in her book, *That Good Night: Medicine in the 11th Hour*. The framework that guides her counseling to terminally ill patients follows: "No matter where you are in the dying process you are still living, so what does it mean to live well?" (Guardian, 2019). According to Dr. Puri, that means "respecting the limits that your body imposes" and acknowledging "the limits of biology" (Guardian, 2019). Puri suggests that "prolonging the death process" inflicts harm in the dying process, and therefore violates the principle of dying well and living well while you are still alive. Puri also comments to Green, "it's not really about them, but about the limitations of their body."

Those are not unreasonable suppositions, but clearly, as shown in Green's documentary, Puri is counseling patients to avoid any treatments that may prolong life if the treatments are painful. In other words, rather than supporting the patients in their choice, she overtly counsels them against it while suggesting that they are violating moral principles against self-inflicted pain (and thereby dying incorrectly) and showing disrespect to the limitations of one's body and biology, whatever that means. This is not therapeutic, and borderlines on being confrontational with terminally ill patients because they do not share her wisdom regarding bodily limitations and biology, and our supposed moral obligation to respect such.

The various reasons for fighting death, even in terminal situations, are not unreasonable suppositions as insinuated by Dr. Puri. If a patient is not ready to die, they may attempt to prolong life regardless of the pain. Dr. Puri, like many in our profession today, do not see treatments to prolong life as a process that some people need for their own purposes. Many terminally ill patients fear death far more than they fear the sufferings that may result from treatments. If it is truly their right to choose, they should be supported in that decision. Many people simply want more time in the process of death to come to terms with it. Whatever those concerns might be, pain may not be at the top of the list.

Defining Quality of Life

The idea of quality of life is useless and non-therapeutic because, as mentioned earlier, in every case, the term must be qualified to determine the version. Again, for example, the socialist would judge quality of life solely on one's ability to contribute to the state or the "common good." Altruism, or an altruist, would determine quality of life based on one's ability to contribute everything they are to others. If a person in a total-care situation can only receive from others and not give, the altruist would deem their quality of life as being very low, but in addition, it is an unavoidable conclusion that this also puts a value on the person's life. Hence, the *quality of life* idea flirts with putting a value on life itself, which historically has never turned out well. We get a sense of this when we consider the words of George Bernard Shaw, awarded the Nobel Prize for Literature in 1925:

> You must all know half a dozen people at least who are no use in this world; who are more trouble than they are worth. Just put them there, and say, now sir or madam, now will you be kind enough to justify your existence? If you can't justify your existence; if

> you're not pulling your weight in the social boat; if you're not producing as much as you consume or perhaps a little more, then clearly we cannot use the big organization of our society for the purpose of keeping you alive, because your life does not benefit us, and it can't be of very much use to yourself (Rose, 2019).

In addition, we can consider that many philosophers in the world would go much further than Bernard and reject quality of life altogether because they come from an anti-humanity point of view. Here is where we have a perfect example of bumper stickers. Few are against protecting the environment and most people would agree with the pithy truisms displayed about environmentalism on the bumpers of cars. But that has to be qualified. We may agree with the statement based on face value, but who produced the sticker? Being pro-environment can also mean you believe that humans need to be extinguished from the earth altogether. In other words, humans are destructive earthly usurpers that have invaded the only valid life in metaphysics; e.g., trees, fish, air, water, or the environment in general. Lighter forms of anti-humanity philosophies focus on so-called "overpopulation" and the supposed problem of too much life and too many people.

The quality of life idea is like a cell floating around that has receptors for a myriad of different cells that produce different actions in the one cell. Health promotion is qualified by one's definition of life quality, which determines nurse action. The complexity of the issue is supposedly rectified by "right to choose," but what is that right? Does the aforementioned Dr. Puri think patients have the right to put her in a position where she is violating the Hippocratic oath to "do no harm." Clearly, Puri believes that any kind of suffering in the process of dying is harmful. In her aforementioned book, she decries medical treatments that "prolong the dying process" for the sake of keeping people alive regardless of the suffering and the inevitable end

result. In her book, that is not living well or dying well, and clearly, she counsels terminally ill patients accordingly.

But if she is foisting her philosophy into her counseling, is that therapeutic? No, because therapeutic communication establishes rapport through empathy, elicits a list of all concerns, and negotiates a shared agenda (Chou, Cooley, 2018). Though Puri emphasizes listening in her book, all of the data she is collecting is set against the agenda of "living well and dying well." Entering care with a set agenda is not therapeutic and does not seek a shared agenda. (Chou, Cooley, 2018). In the aforementioned documentary video, neither does Puri collect data in a therapeutic way. Statements about fighting the disease "for my family," fear of death itself, and not being "ready to die" are not explored with open-ended questions. Rather than continuing to explore why people want to fight terminally ill diseases with open-ended questions, a situation that she says she encounters often, she feels compelled to teach them that "it's not about them, but their bodies."

Dr. Puri herself is a great example of a bumper sticker. Though her *living well and dying well* framework for palliative care seems reasonable, if we want to make sure there isn't a much deeper and wider agenda behind the bumper sticker, the findings are disappointing. Dr. Puri's framework is not medical, but is patterned after the philosophy of her mentor, a journalist and practicing Buddhist by the name of Katy Butler (Puri, 2020 p.297). Butler wrote a book about the death of her father who suffered a stroke, and from her viewpoint, excessive medical procedures to prolong his life resulted in undue suffering. However, the details of her view are interesting to say the least.

> In time, she saw her father's suffering prolonged by an advanced medical device, one of a panoply of recent inventions capable of prolonging "life" beyond its natural end (Mesa, 2024).

The device that Butler refers to is a pacemaker. Apparently, Butler believes that this pacemaker was responsible for prolonging her father's life and enabling him to live long enough to later suffer with dementia. However, Butler, a devout Buddhist, would be strongly influenced by the Buddhist idea that medical devices can interfere with the "natural cycle of life" (Emblem, 2024). In fact, Buddhist ideas concerning natural death, peaceful death with emphasis on lack of pain, good death, and "dying well" are peppered throughout her writings.

Butler's suggestion for changing the "prolonged disaster" (The Sun, 2014) problem of terminal care is a focus on how palliative care is performed. Butler notes something that she sees as a problem:

> I don't think people ever were free of fear of death, but clinging to life and being so unprepared for it is a modern experience. Our ancestors actually read books about how to prepare for death. It was considered your moral obligation to be prepared for your deathbed and to able to face it with equanimity. We offer such false hopes to people that every medical problem can be fixed even when you're starting to deal with an 80- or a 90-year-old body that is breaking down in multiple ways and doesn't have that resilience. And so it doesn't surprise me that someone who is completely unprepared for death may say, "Doc, do everything" (Mother Jones, 2013).

Butler's remedy for this problem is to begin preparing the elderly through education for a "good death." The word she used in a Mother Jones interview was "equanimity," which means, poise,

calmness, composure and self-control. As seen in the demeanor of Dr. Puri while counseling patients, Butler considers this to be a "moral obligation." Butler believes this preparation should dominate palliative care and should be the focus of all siblings caring for their parents at home. In other words, *right to choose* is great if your choices come from the so-called right education. Otherwise, your choice to fight a disease is immoral. Butler also stated in an interview with The Sun:

> It's a question of the appropriate use of technology. When quality of life is high, the decisions are different. It's when quality of life is low and inexorably declining that you need to consider whether the cure is worse than the disease (The Sun 2014).

The primary problem with the *quality of life* idea follows: who decides what quality of life is, and should the philosophy of the person deciding either qualify them or disqualify them? And what are the social consequences if the assessment, whatever it might be, becomes law? And what would those laws look like if George Bernard Shaw set the standard for the definition?

Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs is a primary standard for priority setting frameworks in healthcare. *Priorities* and *quality of care* should be ideas that nurses are comfortable with. *Quality of life* is subjective, and in nursing, subjectivism is in the venue belonging to the patient, not the nurse. Nursing should be fact-based care. This is why the patient alone should judge what their quality of life is, and even if the patient thinks their quality of life is low, that doesn't necessarily mean they want to die. Again, the patient, for many different reasons, may deem staying alive a higher priority than an escape from suffering, especially when they do not know

what happens after death. It also makes sense that a terminally ill patient may want to go down fighting, so to speak, rather than passively accepting the inevitable outcome.

Furthermore, if there is any merit to Elisabeth Kübler-Ross' five stages of death, why not let the patient work through those stages on their own time? Oddly, clinicians like Dr. Puri fail to recognize a correlation between wanting to fight a terminal illness and Kubler-Ross' initial stages of denial, anger, and bargaining. Instead, Puri, in an almost scolding demeanor, accuses the patients of not respecting the limitations of the body and biology, and thinking it is about them.

According to Maslow's priority framework commonly accepted in healthcare, it is about them. Nurses can fairly ask themselves, "What are the priorities in caring for this terminally ill patient?" Then, the priorities can be executed with best practice, or with the best quality possible. This makes sense, not judging the patient for how they are facing death. Nurse judgement should be confined to clinical applications. As stated by the Journal of Palliative Medicine:

> Although the widespread implementation of hospice in the United States has led to tremendous advances in the care of the dying, there has been no widely accepted psychological theory to drive needs assessment and intervention design for the patient and family (JoPM, 2006).

Recent adaptations of Maslow's theory to palliative care is a welcomed advancement.

> The five levels of the hierarchy of needs as adapted to palliative care are: (1) distressing symptoms, such as pain or dyspnea; (2) fears for physical safety, of dying or abandonment; (3) affection, love and acceptance in the face of devastating illness; (4) esteem, respect, and appreciation for the person; (5) selfactualization and transcendence. Maslow's modified hierarchy of palliative care needs could be utilized to provide a

> comprehensive approach for the assessment of patients' needs and the design of interventions to achieve goals that start with comfort and potentially extend to the experience of transcendence (NIH, 2024).

In addition, Elisabeth Kübler-Ross' five stages of death can be considered and applied along with Maslow's hierarchy. If Maslow's theory is a primary framework for setting priorities in nursing, and it is, then quality of life is far less subjective. Obviously, according to Maslow's theory, the level of self-actualization achieved determines quality of life. And if Maslow's theory can be applied to palliative care, quality of life can be achieved, even in the dying process.

In contrast, Puri's framework for palliative care is derived from a nonmedical source and is not therapeutic. The length of the death process should be determined by the needs and desires of the terminally ill patient without a concern for "lengthening the process of dying" and failing to recognize the limitations of the body and biology. Confrontation by a clinician does not make the patient feel safe or loved, and certainly does not bolster self-esteem.

Hard Cases Make Bad Law

There are commonalities shared by all those who make bumper stickers for some cause. First, their wider agenda is hidden by a pithy truism that most people would agree with. Secondly, they are exercised by the idea of defending a person's right to choose, which is pretense on their part. Thirdly, they cite awful cases that are certain to illicit righteous indignation from people and thereby supposedly ending the argument. Who could possibly defend a situation where a patient screamed in agony for days so greedy healthcare professionals can make more money? And lastly, they are zealots.

When discussing so-called quality of life (bumper sticker number one), a discussion of euthanasia is not far behind, defended by bumper sticker number two, the right to choose, and supported by dreadful cases that should end the argument. But remember, those who make the bumper stickers are endeared to some logic that drives them, and they are zealots. Hence, the right to choose is predicated on making the right choice based on the zealot's wisdom. Right now, in the U.S., the zealots can only make patients feel guilty for the immoral decision to "prolong the dying process," but historically, societies that are duped into validating subjective concepts like *quality of life* end up with healthcare systems that revoke care (NIH, 2017).

It all starts with some philosophical movement that sells their ideology with a truism while hiding their larger agenda, and defending their argument with the hard cases. But, where are these hard cases? Katy Butler, while bemoaning the exploits of technologies that prolong life, acts as if there is little progress in comfort care. As far as prolonging life and providing comfort, today's medical technology can do both. Also, when the likes of Butler and others speak of "suffering," we must remember that they are conflating actual suffering with their perception of life quality.

> Hard cases make bad law is an adage or legal maxim meaning that an extreme case is a poor basis for a general law that would cover a wider range of less extreme cases. In other words, a general law is better drafted for the average circumstance as this will be more common (Hayek, 2013).

An inability to manage pain with contemporary medical resources is not a common circumstance in our day. Yes, some pain medications do cloud the mind, which would figure into Butler's palliative philosophy as a practicing Buddhist, and for that matter, Dr. Puri as well.

Again, it is not enough to consider any position on face value, but listening to the perspectives of others must also include an understanding of their logic that drives their desires for particular actions. As historian John Immel has noted, there is a logic that drives every action (Immel, 2011). And again, fact-based research should always determine nurse action.

Slippery Slope

Few people would disagree that a culture that does not value life will eventually become a barbaric society. The word, "quality" denotes value, and when you put that word together with "life," it is really a statement concerning the value of life. Then, the *quality of life* idea is thrown into a batter of subjectivity. The term is very common in healthcare, but is completely undefined and completely subjective. Nevertheless, incredibly, everyone assumes the term is defined objectively and this is the reason it is an accepted term in healthcare. From there, it begs the question: who determines what quality of life is, and what is their criteria? Are those who determine *quality of life* socialists? Are they Buddhists? Are they the ones who control cost overhead at a health insurance company? Or is it George Bernard Shaw?

Initially, right to choose is merely a ploy to put the decision in the hands of people other than the patients, usually the government, doctors, or health insurance companies. Most, if not all euthanasia movements are spearheaded by the *right to choose* mantra, but the real goal is to take away the decision from those who do not "respect the limitations of our bodies" and "disrespect the limitations of biology." The real goal is to put the decision in the hands of those who supposedly know best...always.

How do we know this? In reality, people already have the right to choose. Yes, technically, suicide is against the law, but obviously, those who violate this law are not prosecuted, even

when they are unsuccessful. Planning and painless methods are also readily available via books like *Final Exit* (Humphry, 2011). Furthermore, terminal sedation, or the softer term, palliative sedation, have been legally practiced in every state and every country for years. When people are in end-of-life care, or “actively dying,” it is considered a last resort for refractory symptoms.

> Palliative sedation encompasses a broad range of activities aimed at relieving distress in terminally ill patients. It involves therapy targeted at resolving or alleviating refractory symptoms at the end of life. The most common refractory symptoms for palliative sedation are delirium, intractable pain, and shortness of breath. Despite clear palliative benefits in patients, the use of palliative sedation remains quite controversial. This is partly due to the lack of consistency in defining "refractory symptoms" and lack of adequate knowledge in patients, family members, and health care workers alike regarding the issue of palliative sedation. Additionally, ethical and legal issues surrounding this topic as it appears, at least superficially similar to the process of physician-assisted suicide or euthanasia, discourage physicians from initiating conversations or planning for palliative sedation in patients (NIH, 2022).

In other words, obviously, there is already a solution in place for the “hard cases.” Though pain levels are subjective, the final determination of pain level is decided by the patient. A common rule in nursing follows: the level of pain is whatever the patients say it is. In dementia care, orders for palliative sedation can be obtained according to nurse judgement and if POAs are in agreement. Don’t miss the point here: there is already a solution for undue suffering in the end-of-life process. The real concern is how long it is taking people to die. And if you are not ready, you are taking too long and lack “poise, calmness, composure, and self-control.”

Lastly on patient choice and technology, the hope of longevity certainly has merit because today's technologies can easily come up with treatments that can decrease symptoms or even cure symptoms in a short time span. In the case of this nurse's brother, he was given about five years to live, and fought ALS in hopes that new treatments could improve his condition or even cure it. As nurses, we are called to support that choice and collaborate with the patient accordingly. Right to choose is always framed within the context of ending the dying process, while for years terminally ill patients were prevented from trying experimental treatments that had not yet been approved by the FDA. Oddly, the American government allows for people to end their lives through assisted suicide, but prevented people from trying experimental treatments that might prolong their lives. This might be telling. This changed in 2018 through the Right to Try Act (Right to Try, 2018), and is indicative of why life and death decisions must be truly the choice of the individual, not a pretense for a philosophical agenda.

Conclusion

"Quality of life" terminology should be eradicated from nursing dialogue. It is not fact based and is not therapeutic. In addition, it places a value on life according to subjective notions. Acceptance of the *quality of life* idea will result in distorted healthcare promotion, and distorted care plans that violate best practice.

Furthermore, there is no need for nurses to become useful idiots for philosophical agendas disguised as medical care. For us, the end-of-life issue is settled; life, in and of itself has value, and the venue of subjectivism belongs to the patient. Therapeutic communication requires us to establish rapport through empathy, elicit a list of all concerns, and negotiate a shared agenda, not our agenda formed by listening to subjective opinions posing as fact-based care. Our care is

based on accepted nursing principles and nothing else. It is not enough to merely listen to various care theories, we must insist that we know the rationales behind the theory.

Once we have elicited all concerns through open-ended questions, our care plan must be based on patient-centered care and relationship-centered care. Our aim is mutual respect, legitimization of the patients concerns and feelings, and support (Chou, Cooley, 2018), not the legitimation and support for various and sundry philosophies outside of the patient's realm.

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