

2nd ANNUAL SYMPOSIUM FOR CATHOLIC MEDICAL PROFESSIONALS

***End of Life Care
and the
Catholic Medical Professional***

FAITH IN PRACTICE

F. Michael Gloth, III, MD, FACP, AGSF, CMD

Associate Professor of Medicine
Division of Geriatric Medicine & Gerontology
Johns Hopkins University School of Medicine

Adjunct Associate Professor of Medicine University of Maryland School of Epidemiology and Preventive Medicine
Adjunct Associate Professor of Medicine University of Maryland School of Medicine

Corporate Medical Director
Mid-Atlantic Health Care



www.cathmed.org/

www.SeniorHealthCare.org

Objectives

- Describe the current state of living and dying in America
- Contrast this with the way people wish to live until they die
- Discuss the role of the caregiver
- Provide insight into physician-assisted suicide and misconceptions about medicine
- Provide insight into the physician's role in end-of-life care

Do Not Go Gentle Into That
Good Night...

Why not?

How Americans died in the past . . .

- Early 1900s
 - average life expectancy 50 years
 - childhood mortality high
 - adults lived into their 60s

. . . How Americans died in the past

- Prior to antibiotics, people died quickly
 - infectious disease
 - accidents
- Medicine focused on caring, comfort
- Sick cared for at home
 - with cultural variations

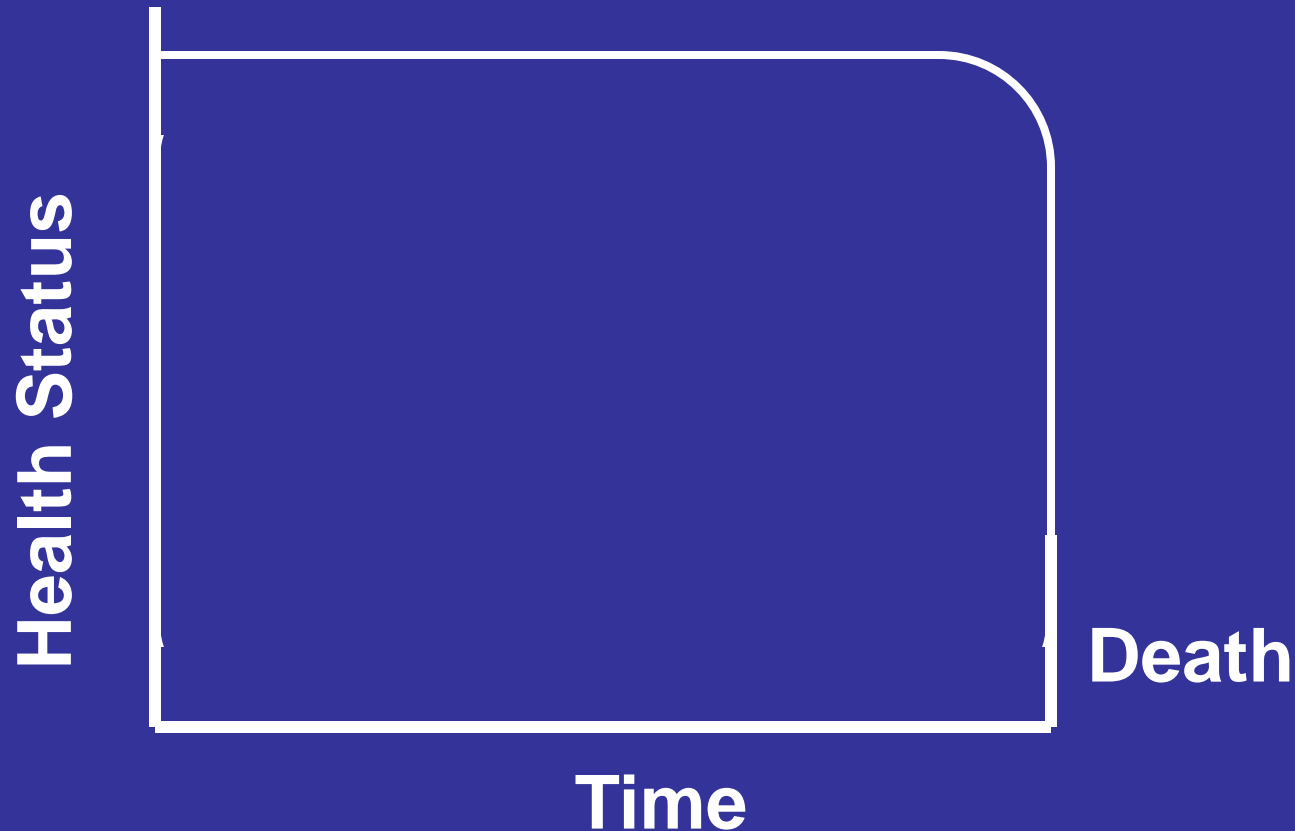


. . . . Medicine's shift in focus

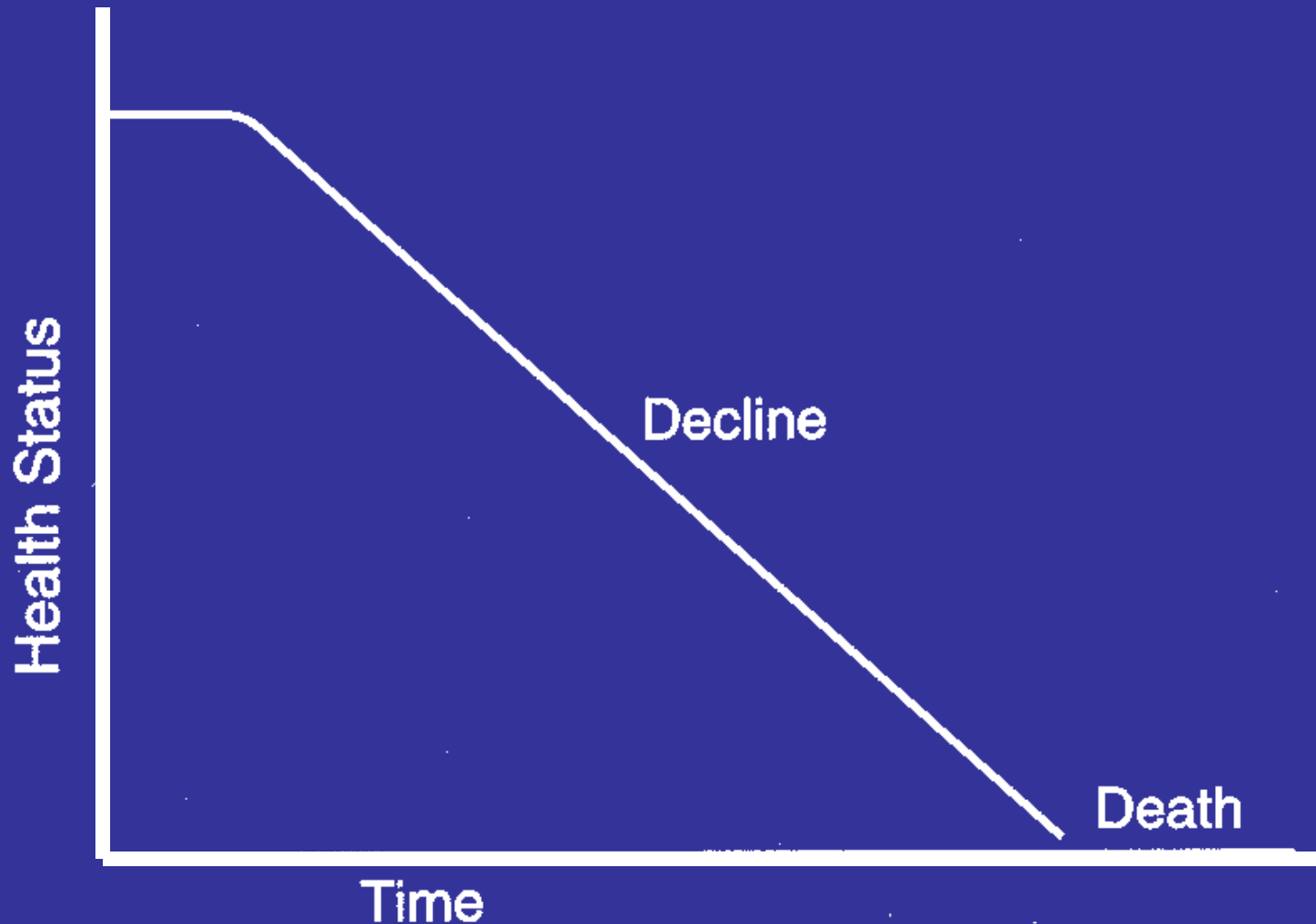
- Death “the enemy”
 - organizational promises
 - sense of failure if patient not saved

Sudden death, unexpected cause

- < 10%, MI, accident, etc



Steady decline, short terminal phase



Slow decline, periodic crises, sudden death



Place of death . . .

- 90% of respondents to NHO Gallup survey want to die at home
- Death in institutions
 - 1949 – 50% of deaths
 - 1958 – 61%
 - 1980 to present – 74%
 - 57% hospitals, 17% nursing homes, 20% home, 6% other (1992)

. . . Place of death

- Majority of institutional deaths could be cared for at home
 - death is the expected outcome
- Generalized lack of familiarity with dying process, death

Public expectations

- AMA Public Opinion Poll on Health Care Issues, 1997
 - “Do you feel your doctor is open and able to help you discuss and plan for care in case of life-threatening illness?”
 - Yes 74%
 - No 14%
 - Don't know 12%

Barriers to end-of-life care . . .

- Discomfort communicating “bad” news, prognosis
 - misunderstanding
- Lack of skill negotiating goals of care, treatment priorities
 - futile therapy

Physician training . . .

- No formal training, physicians feel ill equipped

“They said there was ‘nothing to do’ for this young man who was ‘end stage.’ He was restless and short of breath; he couldn’t talk and looked terrified. I didn’t know what to do, so I patted him on the shoulder, said something inane, and left.

At 7 am he died. The memory haunts me. I failed to care for him properly because I was ignorant.”

. . . Physician training

- 1997-1998: only 4 of 126 US medical schools require a separate course
- By 2005 most, if not all, US medical schools offered end-of-life training
- Not comprehensive, standardized
- Most practicing physicians lack end-of-life training

Symptoms, suffering . . .

- Multiple physical symptoms
 - many previously poorly examined
 - Ex. pain, nausea / vomiting, constipation, breathlessness, weight loss, weakness / fatigue, loss of function

Reasons for Inadequate Pain Management

Physician Reasons

- Insufficient Assessment (>70%)
- Fear of using some medication, esp. opioids (>60%)
- Inadequate knowledge (>50%)

Patient Reasons

- Inadequate Reporting
- Fear of stigma of opioids

Social isolation

- Americans often live alone
- Americans often live as working couples
 - If older one or both are often frail or ill
- Other family
 - live far away
 - have lives of their own
- Friends have other obligations, priorities



Caregiving

- 90% of Americans believe it is a family responsibility
- Frequently falls to a small number of people
 - often women
 - ill equipped to provide care

Financial pressures

- 20% of family members quit work to provide care
- Financial devastation
 - 31% lost family savings
 - 40% of families became impoverished

Coping strategies

- Vary from person to person
 - Spiritual people cope better
- May become destructive
 - suicidal ideation
 - premature death by PAS or euthanasia

End of life in America today continues to change

- Modern health care
 - only a few cures
 - live much longer with chronic illness
 - dying process also prolonged
- Physician-assisted suicide (PAS)

Physician-assisted Suicide

- Would Physician-assisted Bank Robbery be O.K.?
- Is Physician-assisted Murder acceptable?
- Why is Physician-assisted suicide more acceptable than suicide?
- Do things always go as the physician plans?
- Do medications always work as the physician expects?

Physician-assisted Suicide

- Fifty percent of patients became unconscious within five minutes of ingestion of the lethal medication and the same percentage died within 26 minutes of ingestion. The range of time from ingestion to death was from five minutes to 9.5 hours.
- One recipient, who ingested the prescribed medication in 2005, became unconscious 25 minutes after ingestion, then regained consciousness 65 hours later.
- This person did not obtain a subsequent prescription and died 14 days later of the underlying illness (17 days after ingesting the medication).

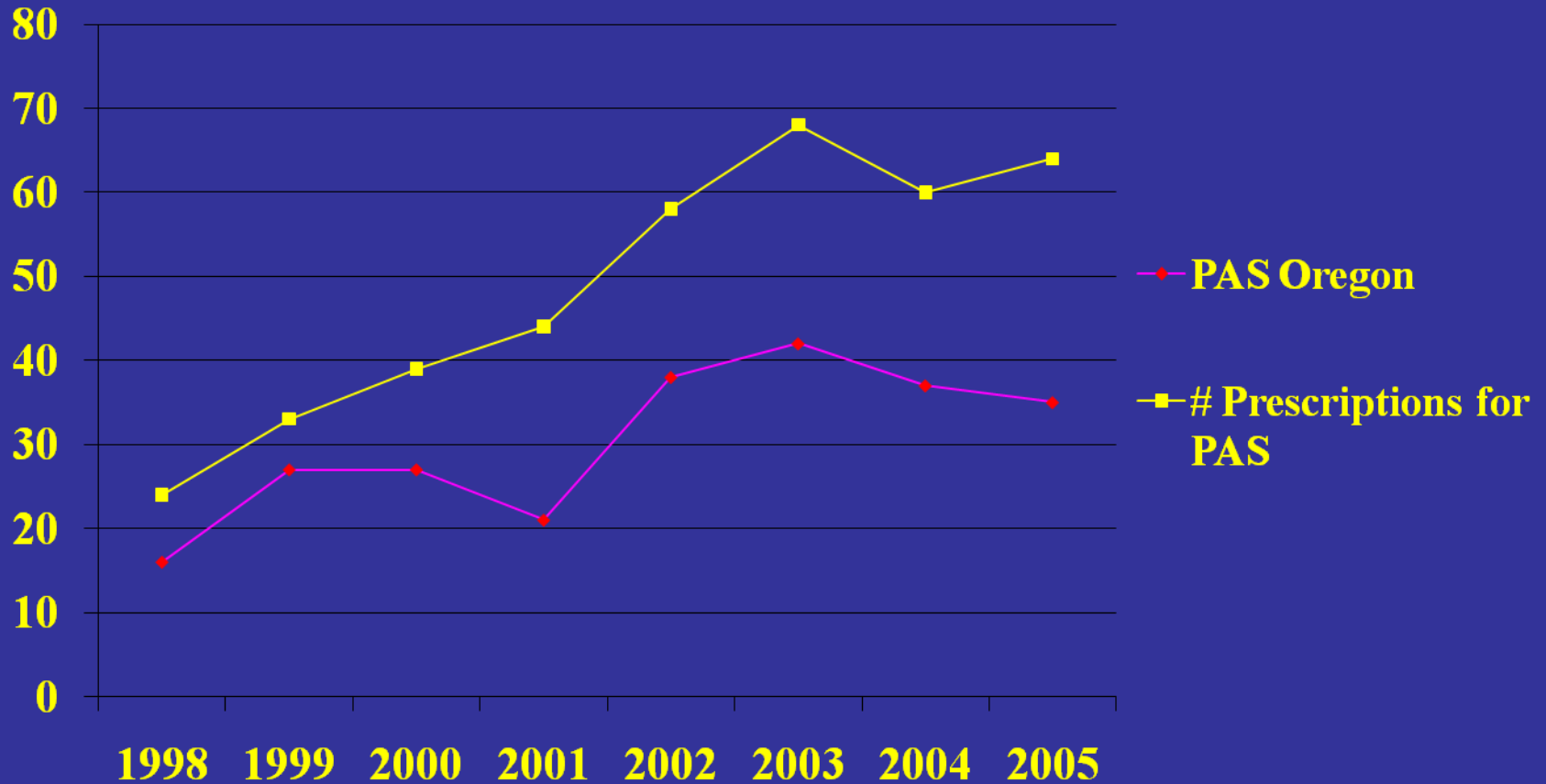
Physician-assisted Suicides in Oregon

- About 12 PAS per 10,000 deaths
- 1 in 800 deaths among Oregonians in 2005 resulting from physician-assisted suicide.
- 8 in 10 patients having at least three concerns, the most frequently mentioned:
 - a decreasing ability to participate in activities that made life enjoyable
 - loss of dignity
 - loss of autonomy

Physician-assisted Suicides in Oregon

- The law states that "actions taken in accordance with [the statute] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law."
- ...would refer to the terminally ill patients who ask physicians to help them die as "persons who use the Oregon Death With Dignity Act."

Physician-assisted Suicides in Oregon



ADDRESS OF JOHN PAUL II
TO THE PARTICIPANTS IN THE INTERNATIONAL CONGRESS
ON "LIFE-SUSTAINING TREATMENTS AND VEGETATIVE
STATE:
SCIENTIFIC ADVANCES AND ETHICAL DILEMMAS"

- **Encyclical *Evangelium Vitae*:**
 - "by euthanasia in the true and proper sense must be understood an action or omission which by its very nature and intention brings about death, with the purpose of eliminating all pain"
- ...such an act is always "a serious violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person."

American Medical Association Code of Ethics: *E-2.211 Physician-Assisted Suicide*

- “However, allowing physicians to participate in assisted suicide would cause more harm than good.”
- “Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.”

(I, IV) Issued June 1994 based on the reports "Decisions Near the End of Life," adopted June 1991, and "Physician-Assisted Suicide," adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.

Misconceptions...

- Fears, fantasy, worry driven by
 - experiences
 - media dramatization

Misinformation . . .

- related to
 - primary illness
 - adverse effects of medications, therapy (tube feeding)
 - intercurrent illness
 - The impact of interventions e.g. CPR, Feeding Tubes

Artificial Feeding & CPR . . .

- Artificial Feeding

- No studies show benefit in conscious patients
- Aspiration (Crogan et al; Cogan et al.)

- IV hydration

- More complication than benefit

- CPR

- < 5% MI patients survive CPR
- <<1/1000 survive CPR in nursing home or out in community

Role of hospice, palliative care . . .

- Hospice started in US in late 1970's
- Percentage of total US deaths in hospice
 - 11% in 1993
 - 18% in 2003
 - 36% in 2006

Source: National Hospice and Palliative Care Organization

Role of hospice, palliative care . . .

- Median length of stay remains low
 - 20 days in 1998
 - 25 days in 2000
 - *21 days in 2006*

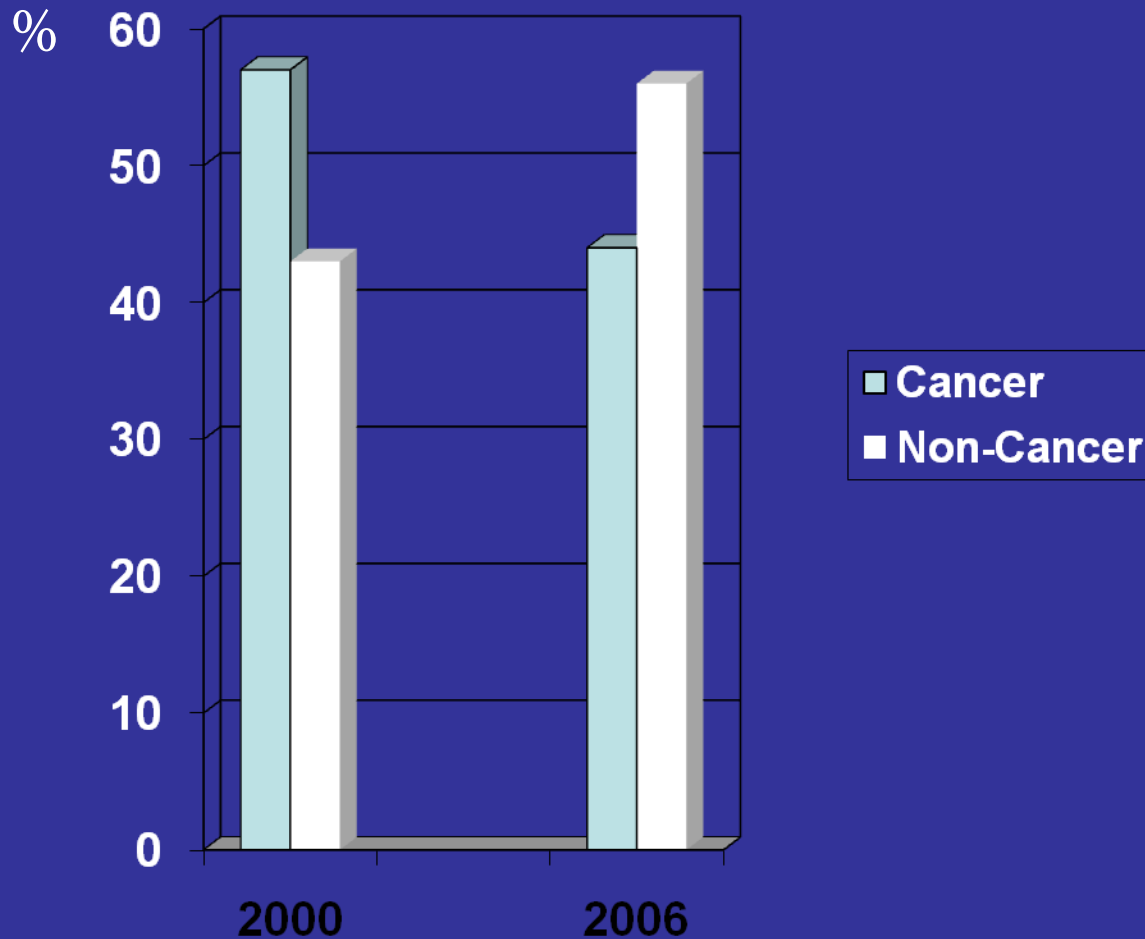
Source: National Hospice and Palliative Care Organization
and Hospice & Palliative Care Network of MD

. . . . Role of hospice, palliative care

- Palliative care programs / consult services evolving
 - earlier symptom management / supportive care expertise
 - possible impact on life expectancy
 - spiritual component

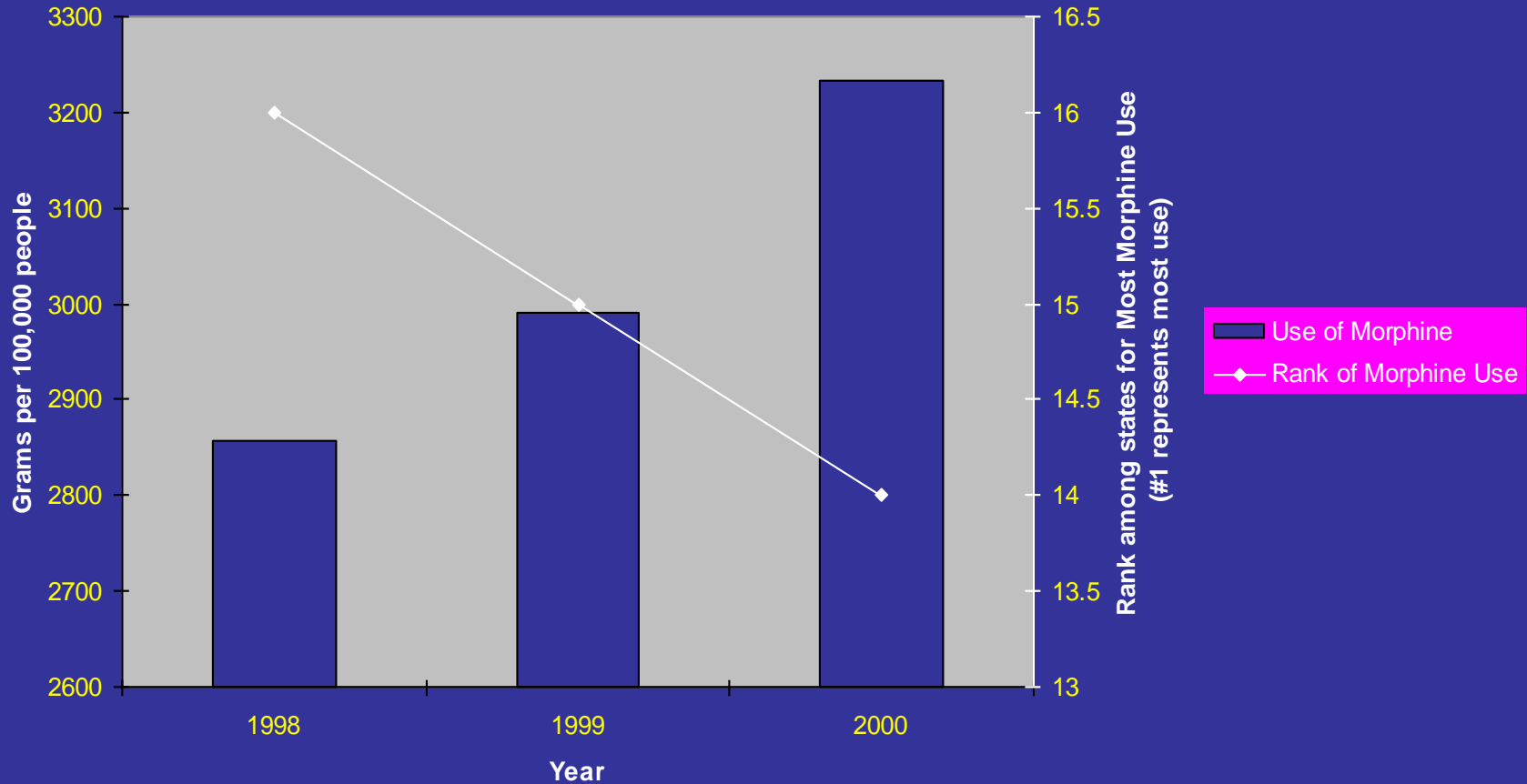
Diagnoses in Hospice

- More non-cancer diagnoses are being referred to hospice.



NHPCO data

Change in Morphine Consumption for Maryland Since 1998 Ban on Physician-assisted Suicide









Sea Fever...

John Masefield

Ah, but remember that Dylan Thomas also wrote another poem...

And Death Shall Have No Dominion

*End of Life Care
and the
Catholic Medical Professional*

FAITH IN PRACTICE

F. Michael Gloth, III, MD, FACP, AGSF, CMD

Associate Professor of Medicine
Division of Geriatric Medicine & Gerontology
Johns Hopkins University School of Medicine

Adjunct Associate Professor of Medicine University of Maryland School of Epidemiology and Preventive Medicine
Adjunct Associate Professor of Medicine University of Maryland School of Medicine

Corporate Medical Director
Mid-Atlantic Health Care

