HOSPICE NEWS NETWORK

Recent News On End-of-Life Care

Volume 19, Number 4 February 3, 2015
A Service of State Hospice Organizations

DO RELIGIOUS BELIEFS DRIVE OPPOSITION TO PHYSICIAN-ASSISTED SUICIDE?

A recent *Medscape* analysis by Leslie Kane, MA, indicates that the faith commitments of practicing physicians may be the principal reason that many clinicians are resolutely opposed to the practice. With the "death with dignity" movement growing by leaps and bounds in response to the story of Brittany Maynard, Kane analyzes the results of the *Medscape* study to discover what reasons doctors give for their disagreement with physician-assisted suicide (PAS). He also examines what this might mean about the future of the practice.

Medscape's 2014 Physician Ethics Report surveyed more than 21,000 practicing physicians. They were asked their opinions on a variety of controversial health care issues, ranging from abortion and physician-assisted suicide, to palliative care practices and respecting patient's end-of-life wishes. Among the results of this study, **researchers for *Medscape* found that 54% of physicians said that PAS should be allowed. Of the 46% of remaining respondents, 15% percent said, "It depends" (which, *Medscape* points out, may be another way of saying "yes"). The remaining 31% of respondents gave a clear "no" as their response to the question.**

This is a big change over only a few years ago, when the majority of physicians did not support PAS. Nevertheless, the issue is by no means settled among doctors. **Survey respondents gave a variety of reasons for their opposition to physician-assisted suicide, which Kane lays out in order of prevalence. First and foremost among these reasons is the religious faith of the physicians.** "The majority of physicians who were against PAS talked about God and religion." For example, surveyors received responses like, "God has said that it is a sin to kill," or "I believe it is God's will that we do everything possible to preserve life, not to take it."

Despite a recent decline in religious commitment in the United States, faith in God is still prevalent. A Harris poll of 2250 adults in 2013 found that 74% of American adults believe in God, a marked decrease from 82% in 2009, but still an overwhelming majority. A 2014 study conducted by Pew Research Center reported that 53% percent of Americans feel that "belief in God is necessary in order to be considered a moral person."

Of course, this does not mean that opposition to PAS and religious belief are synonymous. Many physicians who support physician aid in dying also base their decision in terms of faith convictions. For example, one respondent stated, "God would not want me to witness terrible suffering and not do what I could to try to relieve that suffering for the patient."

In addition to their personal religious beliefs, physicians noted several other reasons for their opposition to PAS. One of the most popular of these was the physician's support for palliative care. "A number of doctors noted that suicide should be unnecessary; palliative care could alleviate pain and discomfort." These doctors seemed to operate under the assumption that palliative care is (or should be) available and effective for all people in all situations. Kane does not agree that this is always true.

Another reason commonly mentioned by those who opposed physician-assisted suicide is the possibility that patients may suffer from treatable depression, and that this mental condition should be addressed, rather than allowing patients to kill themselves. Kane objects that this concern is misguided, since the Death With Dignity Act says, "Depression must be considered before moving ahead with any suicide activity." Still other doctors responded that they opposed PAS because of the limitations of prognosis. They see it as unethical to help patients end their lives when there is always a possibility for recovery. "Who is to say what is terminal and when death may come?"

Kane also gives the top three reasons supporters of PAS believe physicians should be allowed to aid dying patients in ending their lives through lethal medication. The top reason given is the reality of unmitigated suffering at the end of life. "Physicians who have had more direct or more frequent exposure to patients suffering from not-always-controllable pain, inability to breathe or move, reliance on years of dialysis, loss of all control, etc., talked about the patient's profound misery and the concomitant suffering of the helpless family members." One respondent stated that she came to support PAS after watching her mother suffer terribly at the end of life.

The second reason that PAS proponents give is that patients should not be put in the position of figuring out how to end their lives on their own. Because patients may try to kill themselves one way or another, doctors should be permitted to help them do this in the most humane, painless, and legally responsible way possible. Kane asks, "Why shouldn't terminal, suffering patients be able to choose their time and situation of death, surrounded by family, in a warm loving situation?"

Finally, advocates of PAS sometimes argue that dogs and cats are often treated with more dignity than human beings. When pets or livestock are suffering from terminal disease or incurable pain, euthanasia is the common response. Why not for people? Kane points out that what is right for other animals might not be best for humans.

One thing that all physicians seem able to agree on is that the Hippocratic Oath is important, though there are varying interpretations. The statement "First, do no harm" was cited by both advocates and opponents of PAS. But what does "harm" mean? For proponents of PAS, allowing a person to remain alive when in terrible pain and desiring to die could be construed as "harm." For many who oppose physician aid in dying, however, killing another human being - for whatever reason - is the very definition of "harm." As one respondent expressed, "There is no greater harm done than to kill a person." (*Medscape*, 1/27, www.medscape.com/viewarticle/838571_4)

GAWANDE AND VOLANDES AGREE THAT PHYSICIAN EOL CONVERSATIONS ARE CRUCIAL

What would the US medical system be like if physicians were as well trained in the human aspects of patient care as they are in the technical aspects of medicine? In a recent article published in *The Atlantic*, James Hamblin highlights the work that Atul Gawande and Angelo Volandes are doing to raise awareness of end-of-life issues, and the important role that physicians can play in fostering healthy end-of-life conversations.

Did you know that the human brain shrinks as we age? "At 30 years old, a person's brain weighs about three pounds. In its capaciousness it wears the skull like a well-tailored suit." By age 70, however, there is usually around an inch of space between the brain and the skull! While this loss of brain matter doesn't necessarily mean that the aging are any less "brilliant," it is an example of how the body slowly wears down - losing mass and resiliency - as we age.

Atul Gawande, author "Being Mortal", which was published this past October, says that doctors are trained to resist and fight this process, treating the process of aging as a battle to be fought, rather than a natural progression to be understood and planned for. Of course, if old age is a war, nobody ever emerges victorious. Death always has its way in the end.

In Gawande's view, death is simply not discussed often and openly enough in American society. Death is shunned and denied, rather than openly discussed and accepted. Patients often suffer agony at the hands of well-meaning doctors who have been trained to see death as the greatest evil that can befall their patients, failing to perceive that there are fates worse than death.

Harvard physician Angelo Volandes has recently come out with his own book, which is in many ways complementary to Gawande's. In "The Conversation," Volandes delivers a wake up call to a country where far too many are receiving care that they did not ask for and do not desire. "I think too many people don't know what's going on behind those closed doors in hospitals," he says. "But if they did, they'd be outraged. So many people are getting - not costly care - I'm talking about unwanted care."

Much of this stems from a lack of real conversations about what patients want at the end-of-life. These conversations often never occur because physicians are not taught how, when, and why to have them. Dr. Volandes points out that, in order to become a board-certified physician in his residency training at the University of Pennsylvania, "I was required to prove my competence with inserting central line catheters, leading Code Blues, performing lumbar punctures, drawing blood, and obtaining arterial blood-gas samples. **But not a single senior physician needed to certify that I could actually speak to patients about medical care."**

Volandes sees his book as a sort of "part two" to Gawande's. In it, he "goes an extra step to tell people exactly how to raise the subject of death - in a context of personal values and life priorities - with their doctors." At this point, he says, training patients to initiate these conversations is critical. **If a patient doesn't start the conversation, it is unlikely to happen at all.**

Rather than "die fighting", both Gawande and Volandes are urging Americans to re-embrace the more gentle ways of dying that were more prevalent only a few generations ago. Gawande points out that in the 1940s almost everyone died at home. By the late 1980s, only 17% did. "This shift was partly due to tremendous scientific advances that transformed the hospital from a place of very few effective treatments, to a place that had intravenous antibiotics, heart surgery, and kidney transplantation. By the latter part of the century, a doctor could do something for almost anyone..."

In an age of powerful modern medicine, the question is no longer simply whether someone can be kept alive, but also what conditions the individual will experience while still living. At what point is allowing death preferable to the "life-saving" alternative? When are health care providers missing the point altogether? Is there a point at which medical care becomes torture?

The tide is beginning to turn on the way people die in America. By 2010, 45% of Americans were dying in hospice care - which for the most part meant a home death. Gawande calls this a "monumental transformation" in just a couple of decades of the way dying happens in America. Nevertheless, the work of change is far from over. "We have begun rejecting the institutionalized version of aging and death, but we have not yet established our new norm." (*The Atlantic*, 1/25, www.theatlantic.com/health/archive/2015/01/dying-better/384626/)

HOSPICE NOTES

*** NHPCO is drawing attention to an error on the Library of Congress website, which contains incorrect information about the hospice face-to-face requirement of the IMPACT Act of 2014. The erroneous message indicates that the face-to-face requirement was repealed, when in fact it was retained.** "Instead, the IMPACT Act did make changes to another provision of the law, which was passed at the same time as the face-to-face visit requirement and appears in the same area of the statute, that requires CMS to undertake medical review of claims for certain long stay patients in hospices that have a high percentage (to be specified by CMS) of long stay patients." **NHPCO has requested that the error be corrected.** (*NHPCO Newsbriefs*, 1/29)

*** An article in an Illinois paper highlights the stress experienced by doctors who work in hospice care. "**Our work is really seeing [patients] at their most vulnerable times at the end of their lives," says Dr. Phillip Olsson, Executive Director of the OSF Richard L. Owens Hospice Home. (*CIProud.com*, 1/21, www.centralillinoisproud.com/story/d/story/working-with-the-critically-ill/22510/bf-2pJ0ttUCq1Q_KkIwg7w)

*** The Department of Veterans Affairs is redoubling its efforts to provide end-of-life care as more veterans are entering hospice.** Roughly half a million veterans will need end-of-life care every year for the next 5 years. One story is online at *NPR's "Morning Edition*." (*NPR*, 1/28, www.npr.org/blogs/health/2015/01/28/381938804/va-steps-up-programs-as-more-veterans-enter-hospice-care; *IdeaStream*, 1/27, www.ideastream.org/news/npr/381938804)

*** Why has Vermont been slow to adopt hospice care?** Vermont currently ranks 48th in the nation in terms of hospice utilization, with 1736 Vermonters of about 5500 who die each year

being served by hospice**.** Hypotheses of why the number choosing hospice is so low include the fierce independence of Vermonters and misconceptions about hospice. (*Insurance News Net*, 1/28, insurancenewsnet.com/oarticle/2015/01/28/no-48-why-vermont-has-been-slow-to-adopt-hospice-care-a-588057.html#.VMudRWjF9KJ)

*** A proposed law in Wyoming would allow hospice providers to assist long-term caregivers in that state. The bill in question would allow hospice care to include short-term respite care to non-hospice patients.** (*Casper Star Tribune*, 1/28, trib.com/news/state-and-regional/govt-and-politics/bill-allows-wyoming-hospice-providers-to-assist-long-term-caregivers/article_19942dbc-e880-5007-8770-eef28db488ab.html)

*** Learning about hospice should begin long before the onset of illness, writes Caroline E. Mayer for *Kaiser Health News*.** (*Kaiser Health News*, 1/27, kaiserhealthnews.org/news/learning-about-hospice-should-begin-long-before-you-are-sick/)

END-OF-LIFE NOTES

*** The "Choosing Wisely" initiative is "working to spark conversations between providers and patients to ensure the right care is delivered at the right time."** Their website includes resources, survey data, and updates from the field. (*Choosing Wisely*, www.choosingwisely.org)

*** Doulas, trained caregivers who traditionally aid women in the process of childbirth, are finding that end-of-life care is another life transition for which they can provide support.** (*The New York Times*, 1/24, www.nytimes.com/2015/01/24/your-money/death-doulas-help-the-terminally-ill-and-their-families-cope.html?_r=1)

*** *The Vancouver Sun* has just published a three-part series on "A Better Death", which has been highlighted by Georgetown University's Bioethics Research Library.** The series is available online. (*Georgetown University*, bioethics.georgetown.edu/a-better-death-end-of-life-care-doctors-machines-and-technology-can-keep-us-alive-but-why/)

*** *NPR's* "All Things Considered" highlights the special care that war veterans need at the end of life.** "Caring for vets isn't always the same as caring for others: as veterans approach the end of life, old traumas can resurface or appear for the first time." (*NPR*, 1/28, www.npr.org/2015/01/28/382218316/end-of-life-care-can-be-different-for-veterans)

*** *US News* provides tips on how to ensure health care providers understand and respect your end-of-life wishes.** (*US News*, 1/21, health.usnews.com/health-news/patient-advice/articles/2015/01/21/honoring-your-end-of-life-treatment-wishes)

PALLIATIVE CARE NOTES

*** What was 2014 like for the world of palliative care?** Both *The KB Group* and *Pallimed* share link-rich reflections on the major happenings of the last calendar year. Check out the following links for a wealth of resources on the progress that palliative care has made in 2014.

(*The KB Group*: the-kb-group.com/2015-pc/; *Pallimed*, 1/25, www.pallimed.org/2015/01/results-of-2014-stories-of-year-in.html)

*** Training the next generation of doctors in palliative care techniques will be critical for the future of medicine in America, writes Bill Frist for *Forbes Magazine*.** "Palliative care is part of the solution to the healthcare crisis in our country, but integrating it into the current system requires a lot of change from all sides: social culture, insurance reform, and the delivery of care." (*Forbes*, 1/22, www.forbes.com/sites/billfrist/2015/01/22/training-the-next-generation-of-doctors-in-palliative-care-is-a-key-to-the-new-era-of-value-based-care/)

* **Mitch Kaminski, family practice physician, says physicians "forget to ask patients what their goals are."** He shares a story of how he learned the value of doing this. Not only did this help him as a physician, but it also resulted in positive outcomes for the patient. (*KevinMd*, 1/29, http://www.kevinmd.com/blog/2015/01/forget-ask-patients-goals.html)

*** Ira Byock, writing an opinion in *New York Times, says,* "Our health care system is well honed to fight disease, but poorly designed to meet the basic safety needs of seriously ill patients and their families. We can do both. We must."** *(New York Times,* 1/31, http://opinionator.blogs.nytimes.com/2015/01/31/dying-shouldnt-be-so-brutal/?_r=1)

PAS NOTES

*** *Seven Days* published a write-up on Maggie Lake, the third person to end her life under Vermont's new "Death with Dignity" law.** (*Seven Days*, 1/28, www.sevendaysvt.com/vermont/last-rights-a-putney-woman-becomes-the-third-vermonter-to-end-her-life-using-new-law/)

*** New Mexico might become the 5th state to legalize physician-assisted suicide.** Judges of the New Mexico Court of Appeals are examining a case that could allow the practice in the state. (*UPI*, 1/27, www.upi.com/Top_News/US/2015/01/27/New-Mexico-could-be-fifth-state-to-legalize-physician-assisted-suicide/6801422377996/)

*** Lawmakers in Colorado have introduced their own version of "Death with Dignity" legislation, which would provide similar rights to terminally ill residents as those granted under Oregon law.** (*KWGN*, 1/27, kwgn.com/2015/01/27/death-with-dignity-legislation-introduced-in-colorado/; *KRCC Radio*, 1/27, krcc.org/post/physician-assisted-suicide-bill-introduced)

*** Lawmakers in California have introduced the End of Life Option Act, which would allow PAS statewide.** The bill would provide for a system similar to that found in Oregon. (*New Times*, 1/29, www.newtimesslo.com/news/11954/california-lawmakers-introduce-the-end-of-life-option-act/)

*** "Assisted suicide raises too many moral dangers," says Tim Rutten, writing for *The Los Angeles Daily News*.** With the cost of assisted suicide being much lower than high-quality palliative care, will financial pressures soon come to bear on those who choose to live their final

months rather than taking their lives? (*Los Angles Daily News*, 1/23, www.dailynews.com/opinion/20150123/assisted-suicide-raises-too-many-moral-dangers)

*** A California version of Oregon's assisted suicide law should move ahead, say the editors of the Monterey Herald.** The "End of Life Options Act" would allow "anyone with a terminal disease and a prognosis of death within six months to obtain a prescription for a lethal dose of medication." (*Monterey Herald*, 1/23, www.montereyherald.com/opinion/20150123/editorial-assisted-suicide-bill-should-move-ahead)

*** California has tried (and failed) to pass a PAS bill before, but much has changed since then.** "One of the big hurdles to passage has been ongoing opposition by the California Medical Association. So far, the CMA has not taken an official stance on this most recent proposal." (*California Healthline*, 1/22, www.californiahealthline.org/capitol-desk/2015/1/much-has-changed-since-legislature-last-tried-to-pass-an-endoflife-bill)

*** Physician-assisted suicide is a complex issue, different for every individual, says Bud Hebeler.** (*The Wall Street Journal*, 1/23, blogs.wsj.com/experts/2015/01/23/physician-assisted-suicide-every-case-is-different/)

Thanks to Don Pendley for contributions.