

End-of-Life Care

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In 2016, California, Colorado, and Washington, DC, followed the examples of Washington, Vermont, Montana, and Oregon in passing aid in dying legislation. According to a recent *New York Times* article, “it is now estimated that close to 20% of Americans live in jurisdictions where adults can legally end their lives [by choice] if they are terminally ill and meet eligibility requirements.”¹ To honor the intent of these laws while providing the best possible care for our patients, it is imperative that end-of-life decision making be included in the skill set for every physician and healthcare provider.

In this issue of *Forum*, we asked palliative care experts to share their insights regarding end-of-life decision making in the 21st century. How can we encourage patients and families to have meaningful discussions among themselves about end-of-life planning? How can we guide patients toward care that honors their values and expectations? How can we avoid the futility of one more test, one more surgery, or one more treatment?

As I read the article (in this issue of *Forum*) by Dr. Martin illustrating the last month of caring for her patient, Dr. B-, I found my thoughts transported back in time to March 1991, when then SGIM member Dr. Timothy Quill published his story of Diane, a candid account of a terminally ill patient and her physician partnering in physician assisted suicide at a time when such practice was universally taboo.² This publication triggered debates throughout the medical world as well as in the courts and continues to be referenced as a seminal moment in the national dialogue on this important

topic. A grand jury was convened to review the events of the case and consider initiating criminal indictment of Dr. Quill, but in the end decided against doing so. As I reflect on these two stories, I marvel at how far we have come in 25 years! And yet, for physicians and patients, the challenges remain largely the same.

For some patients, it is extremely difficult to know when to let go. As physicians, we are aware that the prior probability of a poor outcome increases with advancing age and frailty, yet we often fail to include these risks in our discussions with patients as we discuss long-term plans of care. Our seniors have witnessed amazing things in their lifetimes: the invention of penicillin and eradication or control of many infectious diseases, cardiac surgery, hemodialysis, cancer cures, and organ transplantation.... Is it any wonder that at no matter what stage of life, no matter how grave the prognosis, the first question is always, “*What’s the next treatment?*” It is an irony of chronic disease management that when we do it right, patients arrive at the “last quarter” of their lives never truly comprehending how sick they really are!

In addition, organizational changes in the way we practice medicine and the current systems for referral of care often lead to fragmented care. In situations when they are at their most vulnerable, patients are regularly cared for by providers who have just met them and have not witnessed their personal life trajectory or come to know them as autonomous individuals. Despite our best intentions, questions such as, “*Who is this person and what is important for him (or*

her)?” often get lost in the midst of, “*What’s the new diagnosis and how do we fix it?*”

How can we effectively evaluate the relative risks and benefits of treatment for an aging cohort? How can we individualize these risks for the patient in front of us? And how can primary care physicians impact the lives of our patients when they are often transitioned to inpatient, intensive care, or even long-term care settings that exclude us from participation in goal setting and end of life decision making?

I hope this issue of *Forum* sheds some light on these questions and contributes to our national dialogue on end-of-life care. As always, we welcome your feedback on this important issue.

References

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