JAOA

Editorial

Needed! Knowledge and skills to care for survivors of terrorist attacks and dying patients

No man is an island entire of itself; every man is a piece of the Continent, a part of the main.... Any man's death diminishes me because I am involved in Mankind: and therefore never send to know for whom the bell tolls; it tolls for thee.

John Donne, "Devotions Upon Emergent Occasions," Meditation 17 (1625)

These words, written more than 400 years ago, ring ever true today, especially in light of the horrific events of September 11. The terrorist attacks on the twin towers of the World Trade Center on the island of Manhattan in New York City and on the Pentagon in Washington, DC, are cruel reminders of our vulnerability and mortality. Certainly, osteopathic physicians, being definitely "involved in Mankind," must focus on their patients, providing them with comfort and support during this most tragic time in the history of the United States. Each and every American and every citizen of the world—"a part of the main"—are grieving at this time. We are not only sad, but we are concerned and even careful. It is our obligation as physicians to study once again, to refamiliarize ourselves with what suddenly may be required of us. Anyone of us at any time could be involved in the management of patients suffering trauma—be it physical or emotional. In the aftermath of such devastation, we will need to be increasingly vigilant to recognize depression and posttraumatic stress disorder in our patients. Therefore, it is incumbent on us to review just how we should deal with such situations. Also, we may wish to spend some time reviewing what we must do at times of chemical and biological assault. Numerous infectious agents are available which, in the hands of terrorists, may be released on our society. We must be prepared.

The reality of such threats prompted my colleagues and me to meet and review what we must do if an actual attack using an infectious agent such as anthrax were to strike our community. We found a great deal of information in the literature rapidly at hand to help us understand this issue. One has only to peruse the Internet to find a wealth of obtainable information. I encourage every osteopathic physician who is not only interested but, more important, who may also be involved in the care of victims of such an attack to pursue these important areas of medical education.

The October issue of *The DO* magazine carefully describes what many osteopathic physicians have done so far to assist the world community during this time of crisis. John B. Crosby, JD, executive director of the American Osteopathic Association (AOA), writes an outstanding column devoted to all these issues. He relates how numerous osteopathic physicians have been working in the trenches helping patients at "ground zero." The November issue of *The DO* will look in greater detail at the various ways in which osteopathic physicians contributed to the total effort at both sites of devastation.

In June, the *JAOA* committed to producing in October a special section focusing on end-of-life issues. Special Focus Section Editor Thomas A. Cavalieri, DO, and colleagues have put together an outstanding resource that is not only extremely attractive but also extremely interesting and important for osteopathic physicians. The AOA End-of-Life Care Advisory Committee, chaired by AOA Trustee Karen J. Nichols, DO, has obtained the AOA House of Delegates' endorsement of 13 "Principles for Care of Patients at the End of Life."

In her article in the special section, Dr Nichols addresses the issues, options, and challenges of providing optimal care at the end of life. She explores the barriers to good end-of-life care and what patients and families expect during this process. She also discusses financial restrictions, inadequate caregivers and community support, legal issues including legislation, and the training needs and care transitions for both patients and their families.

Anita Chopra, MD, looks at communication at the end of life. Her article focuses on practical approaches for conducting such discussions. She includes such issues as do-not-resuscitate orders, artificial nutrition and hydration, initiating hospice care, and advance care planning. Of particular note is her look at cross-cultural considerations and communication issues concerning elderly patients.

Kenneth M. Simon, DO, and Shannon A. Miller, PharmD, provide a guide to managing the pain that afflicts some dying patients. It is the primary care physician who must pursue the majority of such pain management and therefore must have a strong familiarity with pain medications and clinical and ethical concerns regarding the use of narcotics. To effectively treat patients who have varying degrees and types of pain requires adequate assessment. This article walks the physician through that important process.

During the dying process, patients have a variety of symptoms that can be painful or, at the least, uncomfortable. If not managed appropriately, these symptoms are bothersome to patients and their families. Correct handling of these symptoms relieves psychological, social, and spiritual suffering and enhances the overall quality of life. Such relief, if possible,

makes the dying process more tolerable and perhaps acceptable. Charlotte A. Paolini, DO, thoroughly reviews these issues and provides many helpful suggestions for interventions for such symptoms as constipation, delirium, anorexia and cachexia, weakness and fatigue, dyspnea, and nausea and vomiting.

In the concluding article, Dr Cavalieri reviews the most important ethical issues that physicians encounter while providing end-of-life care. To provide good care for dying patients, physicians must have a strong knowledge of all the ethical issues that are pertinent at the end of life. Patient autonomy can be maintained with effective advance care planning. Dr Cavalieri's article explores medical futility, withdrawing and withholding interventions, physician-assisted suicide, and the double effect of proper pain management.

Also in this month's issue of the *JAOA* is a relevant original contribution article, titled "End-of-life decisions: physicians as advocates for advance directives." Jeri Katherine Cooper, PhD, RN, and colleagues report the findings of their study to determine the effect of an individual's age, gender, and attachment to the decision maker with regard to life support choices.

We need to address many of these issues with our patients before the end-of-life process begins. Advance care planning can occur with any patient at any time, and this issue of the *JAOA* can be helpful to osteopathic physicians in planning the strategy for end-of-life care. A recent survey tells us what matters most for many patients at the end of life.[1] Patients ranked their concerns in the following order:

- ☐ freedom from pain,
- ☐ peace with God,
- ☐ presence of family,
- ☐ mental awareness,
- ☐ treatment choices followed,
- ☐ finances in order,
- ☐ feeling that life was meaningful,
- ☐ resolution of conflicts, and
- ☐ dying at home.

Osteopathic physicians can work to make sure that the majority of these concerns are addressed for all patients so that all, despite the admonition of poet Dylan Thomas,[2] may "go gentle into that good night" when the "bell tolls" for them.

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References

1. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000;284:2476-2482.

2. Thomas D. Do not go gentle into that good night. *In Country Sleep.* 1952.