



American Osteopathic Association's Policy Statement on End-of-Life Care

Council on Palliative Care Issues*

The following policy statement was adopted by the American Osteopathic Association's House of Delegates in 2005. This statement was drafted by the association's Council on Palliative Care Issues, which at that time was called the End-of-Life Care Committee.

This statement has been modified to adhere to the house style of JAOA—*The Journal of the American Osteopathic Association*.

The osteopathic approach to care can be particularly beneficial at the end of life. Attending to the patient and family holistically is a key principle of osteopathic medicine. When there is nothing more that can be done to cure, there is always something that osteopathic physicians can do to comfort: management of a symptom, a treatment, a repositioning, a touch, a commitment to caring.

End-of-life decisions should be the result of the collaboration and mutual informing of the patient, the patient's family, and the physicians, each sharing his or her own expertise to help the patient make the best possible decision, often in the worst possible circumstances.

Adults with decision-making capacity should be informed of their

choices and that they have the legal and ethical right to make their own decisions about their end-of-life care, including the right to receive or refuse recommended life-sustaining or life-prolonging medical treatment. This position honors the patient's autonomy and liberty as guaranteed in the United States Constitution and the Patient Self-Determination Act. This right exists even when the physician disagrees with the patient's decisions.

Patients without decision-making capacity have the right to assurance that their previously executed instructive advance directives, such as living wills, and proxy directives (durable medical power of attorney [DMPOA]), will be honored to guide others in delivering their healthcare. Advance directives delineate treatment options selected by an individual and enable decisions to be made by reviewing these documented wishes. The principle of "substituted judgment"

allows for a proxy to speak for an individual who is unable to do so, based upon close personal knowledge of the incapacitated person. The principle of "best interests" (what the reasonable and informed patient would select) is invoked if the individual's wishes are not known. The overriding issue is not what the family or friends want for the patient at end of life, but rather what would the patient want for himself or herself. If the patient were to awaken for only 15 minutes and be able to fully understand the circumstances, what decisions would the patient make? If the answer is unclear, society should choose life. If the answer is clear, it is unethical, except in extraordinary circumstances, not to follow the patient's wishes.

Creating **advance directives** (living wills or designating a DMPOA) is to be encouraged with noncrisis timing, preferably in the setting of osteopathic primary care. Persons holding the DMPOA/proxy should make decisions in accordance with the patient's previously expressed preferences. Living wills document the desired treatments but leave much room for interpretation when the situation doesn't match the directives, so a combination may be best. If no DMPOA/proxy has been selected and no patient preference has been documented or expressed, decisions should be made based on the principle of "best interests." When there is disagreement, confusion, or a request for another opinion, the use of an ethics committee is to be encouraged. Quality of life should be viewed from the patient's perspective in all these decisions because quality of life can only be self-determined. Extreme caution must be exercised when trying to determine what constitutes quality of life for another person as research has shown that patients consistently assess their quality of life to be better than their caregivers think the patients do. Unfortunately, no documentation or proxy designation can definitively prevent or curtail disagreements between family members.

*For 2004-2005, the members of what is now the American Osteopathic Association's Council on Palliative Care Issues, were Karen J. Nichols, DO, chair (AOA Board of Trustees); Katherine E. Galluzzi, DO, vice-chair; Bruce P. Bates, DO; Benneth Ann Husted, DO; Jimmie P. Leleszi, DO, Cleanne Cass, DO; and Dennis Lavery (National Associations of Osteopathic Foundations' observer). Kenneth Simon, DO, was a 2000-2004 member.

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Palliative care is always appropriate at the end of life. The osteopathic physician understands that physical suffering from pain, dyspnea, and other end-of-life symptoms can be relieved with good osteopathic medical management. The patient may also need psychosocial and spiritual assistance to address suffering in those domains as well. Hospice and palliative care services provide invaluable benefits to families and patients. The earliest possible involvement of hospice in the end-of-life care of patients should be encouraged.

The existence of a medical technology does not mandate its use. A physician is not required to provide **futile medical care**. It may be difficult to determine that a requested treatment is actually futile. A life-prolonging treatment may allow a terminally ill patient to achieve an important life goal, such as

seeing a grandchild, but in other cases, aggressive therapies serve only to prolong suffering and expense associated with the dying process. The physician should employ full disclosure and compassionate honesty in discussing a treatment's likely benefits and burdens. If agreement cannot be reached, a consultation with an ethics committee is appropriate. If an ethics committee is not available, it may be necessary to seek the assistance of a court-appointed guardian. When a patient and physician cannot align their goals and treatment approaches, a congenial transfer of care may be necessary. Patient abandonment is unethical.

Withholding or withdrawing life-sustaining treatments are considered morally, legally, and ethically identical because the end results are the same. When the benefit of a palliative treat-

ment is uncertain, a time-limited trial is frequently advisable to help clarify prognosis. Offering treatment and then withdrawing it if it proves to be ineffective or burdensome is preferable to not offering the treatment at all.

Artificial nutrition and hydration may actually prolong the dying process. The use of artificial nutrition and hydration involves invasive medical procedures with potential side effects and complications. A decision to not provide or to discontinue this intervention may pose significant challenges to professional caregivers, as well as to families. Physicians need to assist patients and families to understand the role of artificial nutrition and hydration at the end of life. Research has shown that dying patients do not experience hunger or thirst.

"Do not resuscitate/DNR" status is appropriate for patients who are dying

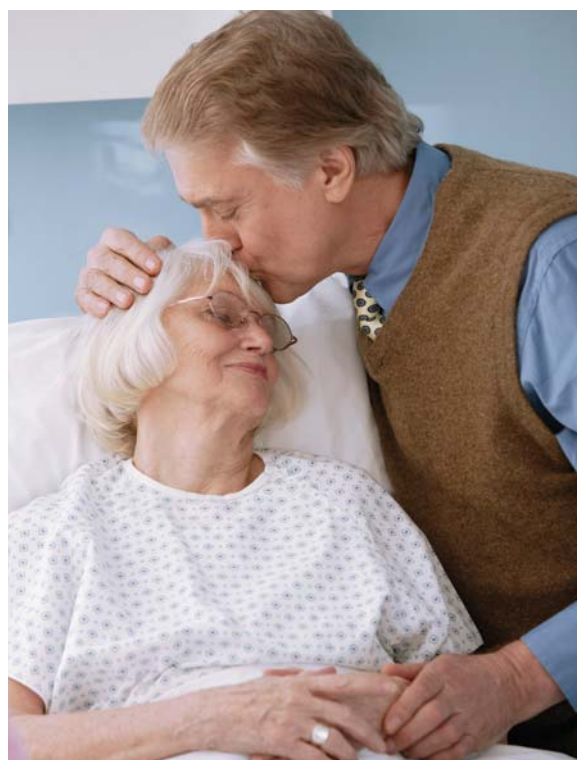


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from a primary illness or injury, for whom cardiopulmonary resuscitation (CPR) would not be effective or for whom the burden of treatment outweighs the benefit. It is important to ensure that patients with DNR status receive all comfort care and appropriate treatments. A DNR status does not preclude treatment of correctable conditions. "Slow codes" (when full resuscitative efforts are not expended with the pretense that they are) are not appropriate as they represent an attempt to misrepresent, which is an ethical violation.

Irreversible loss of consciousness is particularly challenging. Patients determined to be in a persistent vegetative state are unconscious but do not meet the criteria for brain death. They are not aware of nor are they able to meaningfully respond to their environment. The diagnosis can be difficult to determine and is usually made after the patient has been in this state for several (possibly as long as six) months. These patients may live extended periods of time. Whether or not this "life" is considered acceptable to the patient determines the type of support that is appropriate. The decision-making approach is the same as that described for patients without decision-making capacity. The patient's constitutional right to self-determined life closure as expressed by an instructive advance directive or through a legally designated proxy must be upheld.

Physician-assisted suicide is generally defined as a patient obtaining the assistance of a physician to secure the means to cause his/her own death. Physician-assisted suicide is legal only as determined by specific state law. The request for physician-assisted suicide is frequently a call for help. Individuals may request physician-assisted suicide for reasons other than pain, eg, inability to cope, fear of being a burden, or lack of control. The best alternative to physician-assisted suicide is physicians who are committed to providing excellence in end-of-life care and continuing to attend their dying patients. Community resources such as hospice programs



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should be made available to all patients. Hospice and palliative care principles are incongruent with physician-assisted suicide and euthanasia.

Legal involvement to resolve end-of-life conflicts is sometimes inevitable but is usually not the approach of choice. Legislative "remedies," including single-person and single-situation laws, are also inappropriate. By far, the best approach to prevention/resolution of conflict is by documented advanced planning, good communication, and the assistance of an ethics committee. Collection of "clear and convincing evidence" of the patient's wishes as cited in a US Supreme Court decision as well as the principles of "substituted judgment" and "best interests" discussed above apply to the decision-making process.

Families of patients living with a terminal illness also have needs: the need to understand the dying process, the need to have cultural and religious differences understood and respected, the need to process grief. The osteopathic physician understands the important contribution of the family to the patient's overall well-being and includes the family in the palliative plan of care.

Patients living with a life-threatening illness as well as those who are termi-

nally ill have a right to **relief of pain**, as well as relief of other physical symptoms. Fear of regulatory scrutiny should never be a deterrent to the prescription of adequate doses of analgesic medications. State licensing boards of medicine and pharmacy should provide assurance to physicians that this care is appropriate and protected under the law. Osteopathic [medical] colleges and graduate medical education programs are encouraged to review curricula in order that adequate education in osteopathic pain management is provided to osteopathic trainees at all levels of their education. Physicians in practice will want to avail themselves of educational opportunities such as Osteopathic-EPEC [Education for Osteopathic Physicians on End-of-Life Care] to stay current

in pain management and other aspects of end-of-life care. Osteopathic physicians should always assure their patients that they will provide safe and comfortable dying. Alternatively, patients may elect to suffer significant pain so that they remain alert and engaged until death. In every circumstance, patient autonomy for decision making must be upheld.

The **overriding principle at end of life** is the same as at all other decision points in life: cure sometimes, comfort always. Osteopathic physicians, through their holistic approach, are well suited to provide quality end-of-life care. DOs are in a unique position to provide important leadership in enhancing end-of-life care in the United States. There is no finer gift that osteopathic physicians can give than to provide excellent care through all phases of life, and no one is better suited to the task.

Nota bene: In an area as sensitive as end of life, no white paper can address all scenarios and permutations. It should be understood that this white paper presents general guidelines, and osteopathic physicians will always tailor appropriate management to the needs of their individual patients and families.