

Editorial

Caring for the Dying Patient: Family Medicine's Expanding Role

Grube D^{1*} and Pratt DS²¹Medical Director, Compassion & Choices, Denver, CO, USA²Consulting Medical Director, Care Choices, Schenectady, NY, USA***Corresponding author:** David Grube, Medical Director, Compassion & Choices, Denver, CO, USA**Received:** September 27, 2016; **Accepted:** October 03, 2016; **Published:** October 05, 2016

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“To cure sometimes, relieve often and comfort always.” –Anon.

Some call it the silver tsunami - America's baby boomers (those born between 1946-1964) are rapidly aging. The children who overcrowded classrooms in the 1950s will fill waiting rooms in coming decades. By 2030, the U.S. Census Bureau estimates we will have 72 million seniors over 65; almost 1 in 5 citizens, with a life expectancy of more than 20 years. According to the U.S. Social Security Administration the median age at death by 2030 will be over 80 for men and women [1]. By 2050, more than 8 million of us will be age 90 or older [2]. If demography is destiny, family medicine practitioners will be seeing older, more complex patients from now well into the mid century.

The baby boomers are often assertive with clear ideas about their care. Many have seen their parents through illness and death. They recognize the value of technology and also see the limitations of current treatment options. Most want to control their situation socially and medically. We must ask-how can family medicine better serve these patients?

Family physicians are uniquely qualified to discuss all end-of-life options and to provide end-of-life care for their patients. Family physicians are ideally positioned to integrate palliative medicine and end-of-life planning, from advance directives to hospice and the more recent topic of medical aid in dying into their patients' lives. Because family medicine, by definition, is connected to all elements of the life of a terminal patient, family physicians are able to encourage the appropriate use of palliative care and hospice services, as well as to provide them from time to time. Exploring all options at the end of life is an act of palliative care in and of itself.

Presence, compassion, and pain medication at times fall short of our desire to fully relieve suffering, especially for those at the end of life. For these particular patients one other option is gaining support. Today, medical aid in dying (sometimes referred to as death with dignity) is available to 1/6 of all Americans. Oregon [3], Washington [4], Montana [5], Vermont [6] and California [7] authorize terminally ill individuals with a prognosis of six months or less to request a prescription medication from their physician to end their

suffering on their terms, in a time and place of their choosing. Should Colorado's 2016 ballot referendum pass and New York's legislative measure be signed into law, nearly ¼ of all American's would have access to medical aid in dying. Family physicians need to be aware of this growing trend and be prepared for questions and the needs related to medical aid in dying from patients.

Recent polling data from New York [8] and Colorado [9,10] revealed that about 70% of those surveyed support medical aid in dying. Support crossed political party and demographic lines as well as ethnic and religious identities. Conversations with seniors reveal that many of them have thought about the value of medical aid in dying, should they develop an agonizing fatal illness. Many too, had cared for dying loved ones and generally praised hospice but stated it sometimes fell short when it came to complete relief of protracted suffering.

In 1997, Oregon was the first state to authorize medical aid in dying. Data has been collected by the state public health division and published annually since then. Medical aid in dying accounts for approximately 0.3% of deaths each year [11]. Approximately, 1/3 of those who complete the process and obtain a prescription for aid-in-dying medication, never take it. For many, simply having the prescription provides a significant palliative effect and peace of mind. Patients only take the medication when they determine that their suffering has become unbearable.

Though some raised fears that the law would expand or changes in the indications for medication would lead to the so-called “slippery slope” of overuse - this has failed to materialize. In the 18 years since the law was enacted, there has been no evidence of abuse or misuse of the act, particularly in regard to the poor, elderly or disabled. The reasons given for using medical aid in dying show that individuals who use this option do so (in rank order) because of loss of autonomy, anhedonia, and loss of dignity. Importantly, multiple studies have concluded that hospice and palliative care have improved and are more appropriately utilized in authorized states because of medical aid in dying [12].

Thus, the family physician should be prepared for such requests; she or he should have full knowledge of local laws and regulations, tools for evaluation for depression or other mental illness that could impede mental capability, and an understanding of the role of hospice and its policies in regard to a medical aid in dying requests. The practitioner should become familiar with the Clinical Criteria for Physician Aid in Dying [13] and the protocol for medical aid in dying medications, including an anti emetic and a large dose of a short acting barbiturate.

Terminally ill individuals who request medical aid in dying must receive a prompt and thorough evaluation. If a family physician is unwilling or unable to participate, she or he should make a timely

referral. This thorough evaluation is completed to prevent any impulsive or premature action by the patient, and to establish whether the request is volitional and reflects full decisional capacity. The physician should explore the physical, psychological, spiritual, financial, and social issues influencing the request. The practitioner must be convinced there is no coercion or external pressure from family members or loved ones and ensure that the patient has considered all of their end-of-life options including palliative and hospice care.

Ethical concerns are often raised in thinking about medical aid in dying. In all states with the law, safeguards are in place to protect the patient and the doctor. Dr. Timothy Quill, a palliative care specialist from New York, has studied this topic for decades. He has written of physicians' obligations for those who have unrelieved suffering stating, "The question is, how we can respond to those kinds of sufferings? Part of our job, in my opinion, is to help people die better. I say that in a direct way because it irks me when we say that doctors should not help people die. We need physicians who are committed to caring for people all the way through to their death as if they were family members, committed to relieving suffering. Sometimes that requires helping people to die [14]". In states where medical aid in dying is authorized, this end-of-life care option does not result in more deaths, but does result in less suffering.

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