

- Contribute tools that they have found to be helpful that can be included with the other tools on the CHA website. The goal is to put together a robust library of tools that can be accessed by all those doing ethics within the ministry.
- Contribute, also for posting or linking on the Excellence in Ethics section of the CHA website, *curricula* for ethics committee and ethics consultation team education, **and** on-line *modules* or *PowerPoints* for implementing the curricula.
- Volunteering to conduct a 12 – 18 month study on the effectiveness of “Striving for Excellence in Ethics.” CHA-member systems and facilities from across the ministry are invited to participate. Participants would agree to conduct the “assessment” that is part of the resource, develop a work plan that addresses the results of the assessment and some opportunities for improvement, and conduct the assessment again at six months with adjustments to the work plan if necessary. Additional follow-up assessments would take place at 12 and 18 months, with written reports at the time of each assessment. Findings from across the ministry will be reported in a series of articles. Additional options may

include a presentation at a future CHA Assembly and/or meeting of the American Society for Bioethics and Humanities.

Please contact Ron Hamel at rhamel@chausa.org regarding any of these.

The release of this resource provides an opportunity for all of us in the ministry to redouble our efforts to truly make strides in achieving excellence in ethics in our organizations.

RH

End-of-Life Issues: Part Two

In the spring issue of HCEUSA, we noted the attention being given to end of life issues in the popular press and in professional medical journals. That was only a partial listing. Here are several additional contributions.

- Gallup’s 2011 Values and Beliefs poll found that Americans are almost evenly divided over whether or not doctor-assisted-suicide is morally acceptable. Forty-five percent believe it is morally acceptable and 48 percent believe it is morally wrong. No other issue divides the country so closely. (See www.gallup.com/poll).
- According to new research published in the *Archives of*

Internal Medicine, health care costs at the end of life continue to rise. We still spend approximately one third of overall health care resources in the last year of life. On the hopeful side, the use of hospice has increased. For example, the use of hospice by dying prostate cancer patients increased from around 30 percent in 1992 to over 60 percent in 2005. However, the timing of entry into hospice has not changed much. One quarter of patients are in hospice for seven days or less which is too short a time to maximize the benefits of enrollment (See, Bergman, "Hospice Use and High-Intensity Care in Men Dying of Prostate Cancer," *Archives of Internal Medicine* 171, no. 3 [February 14, 2011]: 204-10.

In another study of 230,000 Medicare patients (Unroe et. al., "Resource Use in the Last Six Months of Life among Medicare Beneficiaries with Heart Failure," *Archives of Internal Medicine* 171, no. 3 [February 14, 2011]: 196-203), researchers found that the use of hospice dramatically increased from 19 percent in 2000 to nearly 40 percent in 2007, but rates of hospitalization in the last six months of life held steady at around 80 percent. Use of the intensive care unit was up from 42 percent in 2000 to 50 percent in

2007. Average time spent in the ICU increased from 3.5 days to nearly 5 days. Costs rose from about \$28,000 per patient in their last six months in 2000 to \$36,000 in 2007. The researchers conclude that while there seems to be an increased use of hospice, it does not seem to be substituting for institutional care, and large numbers of patients are in hospice for short periods of time. The authors of the study also emphasize the need for talking with patients about their wishes for end of life care.

- In a fairly recent study, researchers at the Dartmouth Atlas Project found that the proportion of cancer patients who die in the hospital and who get hospice care varies considerably from one part of the country to another. They analyzed the medical records of 235,821 Medicare patients who died between 2003 and 2007. They found that one-third of patients spent their last days in hospitals and intensive care units. However, in Manhattan, 46.7 percent died in the hospital, while in Mason City, IA only 7 percent of cancer patients died in the hospital. On average, 6 percent of patients received chemotherapy in their last two weeks of life, but it was as high as 10 percent in some areas. More than 18 percent of cancer patients had a feeding tube or received CPR in their last two

weeks of life in Manhattan, while in Minneapolis it was fewer than 4 percent. Researchers also found less use of hospice in at least 50 academic medical centers and referrals to hospice very close to the day patients died, thereby minimizing the benefit of hospice. The lead analyst, David Goldman, noted that the findings suggest that too many cancer patients are not receiving adequate palliative and hospice care and that the care of cancer patients has less to do with what they want and more to do with the hospitals and physicians they obtain their care from. One of the take-aways from this report is that physicians need to do more to determine what patients want at the end of their lives and to discuss patient's wishes with them much earlier. (A link to this study can be found at www.dartmouthatlas.org).

- A study of 700 people that appeared in an October, 2010 issue of the *Journal of Clinical Oncology* found that cancer patients who died in a hospital or ICU suffered more physical and emotional distress than those who died at home with hospice services. According to the study's author, Alexi Wright of Boston's Dana-Farber Cancer Institute, where cancer patients die also affects their loved ones. When patients die in an ICU, their loved ones often experience more lasting

psychiatric problems or prolonged periods of disabling grief. (See

Wright, et al., "Place of Death: Correlating Quality of Life of Patients with Cancer and Predictions of Bereaved Caregivers' Mental Health," *Journal of Clinical Oncology* 28, no. 29 [October 10, 2010]:4457-64).

- Palliative sedation continues to receive attention. Two examples are B. Broeckaert, "Palliative Sedation, Physician-Assisted Suicide, and Euthanasia: 'Same, Same but Different,'" *The American Journal of Bioethics* 11, no. 6 (June 2011): 62-64 and B. Henry at al., "To 'Sleep until Death,'" *Hastings Center Report* 41, no. 1 (January-February 2011): 4. Both articles, responding to articles by other authors, make important observations. In the first, the author writes: "The point of palliative sedation is not to reach a certain level of consciousness (e.g., coma); its point is finding a solution for a refractory symptom and therefore lowering the level of consciousness only as much as needed. Proportionately is thus an essential ingredient of palliative sedation." In order to achieve symptom control during palliative sedation the right medication is given in the right dosages (i.e., not more than is necessary). In the

case of palliative sedation, terminally ill patients die as a result of their illness; nobody is killing or is being killed, not at the level of intention, nor at the level of the action itself, nor at the level of its results” (63-64). The authors of the second piece echo something quite similar: “[O]ur working group proposes the creation of a guideline that considers palliative sedation therapy as a proportionate response to the clinical symptoms being managed. Sedation to unconsciousness happens only in cases where this level of sedation is required to effectively palliate symptoms, but the degree of sedation cannot and should not be predicted from the onset. Any request to forgo consciousness until death obligates a sensitive and thorough search to find and mitigate, so far as possible, the reasons for such a request.” (4). (See Resources for a select bibliography on palliative sedation. The articles by Dr. Sulmasy et al. are particularly important).

R.H.