An Educational Response To Assisted Suicide

Catholic Systems Reach Out To Advance Compassionate Care of the Dying

BY LAWRENCE A. PLUTKO

Mr. Plutko is director, Office of Theology and Ethics, Sisters of Providence Health System, Seattle. He is also chairperson of the Committee on Care of the Dying of the Franciscan, PeaceHealth, and Providence Health Systems.

This past November Oregon voters inadvertently offered Catholic healthcare providers an excellent opportunity to advance the Church's healing mission to persons and communities. They approved Ballot Measure 16, making it legal for physicians to prescribe lethal doses of drugs for their dying patients. Even though the once unthinkable reality of legalized assisted suicide is now "at our door" in Oregon, a spirit of collaboration in care at the end of life is reshaping the future of the Catholic healthcare ministry.

The future of "The Oregon Death with Dignity Act" is uncertain since a preliminary injunction blocking the law's enactment has been granted. Still, three Catholic healthcare systems with facilities in the Pacific Northwest are quite clear about their commitment to providing optimal care to persons at the end of life. Bellevue, WA–based PeaceHealth; Seattle-based Sisters of Providence Health System; and Aston, PA–based Franciscan Health System have formed the Committee on Care of the Dying of the Franciscan, PeaceHealth, and Providence Health Systems. The three organizations have collaborated to develop and offer comprehensive educational outreach on compassionate care of the dying throughout Oregon.

Goals

Twenty system representatives met in Portland, OR, in January 1995 and developed a vision statement, "Care at the End of Life" (see **Box**, p. 20). In addition, a steering committee of 12 representatives, which is leading the overall collaborative effort, then identified four goals for its work:

- Clarify, communicate, and implement an ethical, clinical, and spiritual paradigm of compassionate care.
- Assess the current level of care and, using expertise and resources primarily within the Catholic provider and greater Oregon community, identify and share delivery models pertaining to all dimensions of care for the suffering and dying.
- As part of the compassionate/comfort care

Summary The future of "The Oregon Death with Dignity Act" is uncertain since a preliminary injunction blocking the law's enactment has been granted. Still, three Catholic healthcare systems in the Pacific Northwest are quite clear about their commitment to providing optimal care to persons at the end of life.

Bellevue, WA–based PeaceHealth; Seattle-based Sisters of Providence Health System; and Aston, PA–based Franciscan Health System have formed the Committee on Care of the Dying of the Franciscan, PeaceHealth, and Providence Health Systems. The three organizations have collaborated to develop and offer comprehensive educational outreach on compassionate care of the dying throughout Oregon.

Twenty system representatives met in Portland, OR, in January 1995 and developed a vision statement, "Care at the End of Life." In addition, a steering committee of 12 representatives has identified the goals of the Committee on Care of the Dying. The steering committee has also identified seven "Organizational Commitments and Common Elements" to ensure quality and excellence in compassionate care of the dying.

Recently, the Daughters of Charity National Health System, the Carondelet Health System, and the Catholic Health Association—all based in St. Louis—have joined this collaborative effort to educate healthcare providers and the public.

delivery models, develop standardized educational modules for the care-giving community, as well as modules for the community at large.

• Foster relationships and networking between care givers in the same organization and within the entire Catholic and state healthcare community on the issue of compassionate care; identify resources that can be regionalized and shared.

Work Groups

The Committee on Care of the Dying held a planning retreat in March, at which it formed three work groups (each with 15 members), comprising representatives from the three systems:

• The Clinical Care Giver Work Group will develop standards and guidelines for optimal care at the end of life, identify mentors to model such care in facilities and programs, and create educational modules for physician and care-giver education.

• The Patient/Member/Community Education Work Group will educate patients, members of health plans, and targeted populations in Oregon communities on end-of-life issues and care.

Michelle Barnes

• The Public Policy Work Group will identify legislative and administrative changes to improve the environment in Oregon for optimal care of its suffering and dying citizens.

Work group leaders see a need for a radical shift in our attitudes toward death and dying, both individually and corporately. To be credible, successful advocates for compassionate care of the dying in society, Catholic healthcare must also actively tend to its own internal reform on this issue. It must address key structural problems such as fragmentation of care, inadequate pain management, and lack of care-giver competencies in and accountabilities for care of the dying.

Leaders see a need for a radical shift in attitudes toward death.

Compassionate Care

Integrating the value of compassionate care and relief of suffering in facilities and health plan benefit packages will require much time and patience, as well as creating permanent structures and programs to support delivery models and the education of care givers, patients, and communities. The steering committee has further identified seven "Organizational Commitments and Common Elements" to ensure quality and excellence in compassionate care of the dying:

1. Ensure that the focus on compassionate care includes:
   - A patient-focused approach
   - A multidisciplinary team
   - Pain and symptom management
   - Physical, emotional, and spiritual components
   - Evidence of management staff and budget support
   - Attention in each organization's strategic plan and other decision-making processes
2. Ensure that the compassionate care position of Oregon Catholic healthcare providers is made known to every patient and family member at time of admission, as well as to members of our health plans at enrollment.
3. Ensure that our position on compassionate care is a part of facility and health plans staff and physician orientation programs.
4. Ensure that all policies and procedures are

Continued on page 22

VISION STATEMENT: CARE AT THE END OF LIFE

Catholic healthcare providers in Oregon have rich heritages and histories of providing compassionate care to all individuals, with a special emphasis on the poor, the elderly, and the dying.

Consistent with this strong common foundation and in a spirit of collaboration, our systems make a firm commitment to recognizing the many dimensions of pain and suffering experienced by those whom we serve. We believe that pain extends well beyond the physical dimension and encompasses spiritual, emotional, and relational needs as well.

We wish to be known as organizations that are progressive in promoting palliative care and compassionate relief of suffering and pain management with adequate interventions for both acute and chronic needs. We will integrate these efforts within standards of care and continuous quality improvement activities, within ongoing education for physicians, nurses, pharmacists, and other appropriate care givers, and within mission, ethics, and pastoral care. Structures for evaluation and accountability will be created.

We are committed to providing high-quality care in a way that alleviates pain and suffering consistent with the wishes of patients and family members. We believe that patients have a right to maximal comfort regardless of the stage of their disease or their life expectancy.

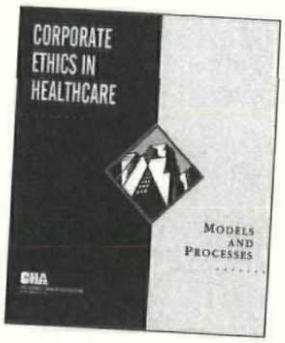
We are committed, as well, to establishing and maintaining those standards whereby physicians and other members of the healthcare team will be held accountable in working toward this goal. Interdisciplinary clinical teams are an effective antidote to fragmentation of care, while they also promote accountability. As values-based organizations, we are committed to focusing our energies and to providing resources to further enhance the visibility of this issue within our healthcare systems.

We recognize that budgets and staffing may well be affected by these goals. We also understand the need to build deeper partnerships with physicians and the communities we serve to accomplish our objectives. Patient education and community education will be important in this regard.

Principal strategies will include education, funding/staffing priority, policies and protocols, interdisciplinary clinical teams, hospice and home care, and accreditation.

C H A

BOOKS



Corporate Ethics in Healthcare: Models and Processes

66 pages/8½ x 11/1991

Catalog No. 210/$7

Corporate Ethics in Healthcare: Models and Processes

Corporate Ethics in Healthcare offers models of analysis that facilitate analyses of corporate ethics issues. It also provides models of several values implementation processes.

The models can be used to help:

- Executive teams review the value dimensions of a major strategic decision
- Boards assess management proposals
- Planners structure a process to build consensus among board members and executive staff
- Leaders ensure that strategic planning initiatives are consistent with the organization's mission and values
- Planning and marketing staff integrate values and ethics into their business plans
- Mission leadership staff develop a framework for assessing how well the organization's mission and values are integrated

CHA

THE CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES

Influence Model

Continued from page 17

The optimal role of religious sponsorship has not been fully defined.

tion's leaders as they assist employees in coping with rapid change.

This experiment in religious sponsorship through influence is today meeting one of the most severe tests it will undergo. Certain staff, especially those outside clinical care areas, view the continued religious sponsorship of Saint Marys Hospital as largely sentimental. However, there is a counterbalance to this passive view of sponsorship. It is the feeling of a large number of staff members that a significant dimension of the vigorous culture that supports and directs this medical undertaking derives from religious origins.

The optimal role of religious sponsorship in the still-evolving restructuring of the Mayo Medical Center has not been fully defined. The sponsorship's influence may continue to be limited to Saint Marys Hospital—or it may come to affect the entire Mayo Medical Center. Its current advocates will—through their ability to capture the imagination, understanding, and conviction of their colleagues—determine the degree to which future patients, their families, and the Mayo Foundation staff will be beneficiaries of the "added dimension" of care that religious sponsorship brings. □

Persons interested in learning more about the influence model of sponsorship may call Sr. Ellen Whelan, OSF, executive director of the Sponsorship Board, 507-255-4277.

Assisted Suicide

Continued from page 20

reviewed for consistency of approach to our vision statement on compassionate care. Develop policies and procedures that address at least the following:

- Management of acute and chronic pain
- Management of symptoms associated with pain, including nausea, vomiting, bowel care, weakness, and emotional and spiritual suffering
- Organizational philosophy on care of the dying, with an emphasis on a description of comfort care services
- Use of advance directives
- Administration of narcotics for the dying patient

5. Establish a multidisciplinary study that involves monitoring of at least one aspect of compassionate care as part of the quality assurance program.

6. Develop and implement an organizational-based training program that addresses the following audiences:

- Clinicians
- Management staff
- Members of governing boards (foundation, community)
- Mission leaders

7. Seek information via patient satisfaction surveys and community surveys that identifies to what degree pain and suffering were addressed and/or controlled during a procedure, physician office visit, or hospitalization.

Collaboration Increases

Recently, the Daughters of Charity National Health System, the Carondelet Health System, and the Catholic Health Association—all based in St. Louis—have joined this collaborative effort. □

For more information, call Lawrence A. Plutko, 206-464-3392.