H438-A/17 END OF LIFE CARE – POLICY STATEMENT ON

The American Osteopathic Association (AOA) approves the attached white paper on end of life care and (1) encourages all osteopathic physicians to maintain competency in end of life care through educational programs such as the web-based osteopathic Education for Professionals on End of Life Care (Osteopathic EPEC) modules; (2) supports the development, distribution and implementation of comprehensive curricula to train medical students, interns, residents and physicians in end-of-life issues; (3) urges osteopathic medical schools, and appropriate training programs to support innovative approaches to instruction in geriatric medicine and end-of-life care; (4) encourages all osteopathic physicians to stay current with their individual state statutes on end of life care; (5) supports public policies which uphold a patient’s right to a “Do Not Attempt Resuscitation” (DNAR) and/or allow natural death (and), designation, determined by the patient or, if the patient is incompetent, by the family, attending physicians, patient advocate, and/or Durable Power Of Health Care Attorney (DPOA); (6) encourages all osteopathic physicians to engage patients and their families in discussion and documentation of advance care planning regarding end of life decisions; (7) will work to implement policies to ensure hospice and palliative services for all individuals, including the developmentally challenged, children, and other special populations; and (8) urges that osteopathic physicians recognize the importance of cultural diversity in perspectives on death, suffering, bereavement and rituals at the end of life, and incorporate cultural assessment into their comprehensive evaluation of the patient and family; the AOA will work to identify sources of culturally appropriate information on advance directives, palliative care, and end of life ethical issues in populations served by osteopathic physicians. 2005; revised 2010; reaffirmed as amended 2015

AMERICAN OSTEOPATHIC ASSOCIATION
END OF LIFE CARE

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. Osteopathic palliative care improves the quality of life of patients and their families facing serious illness, through prevention and relief of physical, psychosocial and spiritual suffering. Osteopathic palliative care utilizes many modalities of treatment including osteopathic manipulative medicine.

End of life decisions should be the result of the collaboration and mutual informing of the patient, the patient’s family and health care professionals, each sharing his or her own expertise to help the patient make the best possible decision.

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, proxy directives (Durable Medical Power of Attorney -DMPOA) and Physician Orders For Life Sustaining Treatment (POLST) will be honored to guide others in delivering their health care. It should be noted that the term “physician” may also mean “medical” in this context. 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 over-riding 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 and be able to fully understand the circumstances, what decisions would the patient make? 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 Durable Medical Power of Attorney) is to be encouraged advance of a life threatening situation with the assistance of trusted professionals. Persons holding the DMPOA/legally designated 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/legally designated proxy has been selected and there is no state approved surrogate available and the patient has not executed an advanced direct or expressed preferences for care at end of life, then 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.

**Palliative care** is always appropriate when patients and families are facing a life threatening illness. 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** although 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 treatment 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 from a primary illness or injury, or 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. CPR efforts that involve a deliberate decision not to attempt aggressively to bring a patient back to life are not appropriate and a clear ethical violation.

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, e.g., inability to cope, fear of being a burden, or lack of control. The 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 should be made available to all patients. Hospice and palliative care principles do not support physician assisted suicide and euthanasia remains an illegal practice.

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 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 wellbeing and includes the family in the palliative plan of care.

Patients living with a life threatening illness as well as those who are terminally 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 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 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.

At the end of life, the goal is comfort for the patient and psychosocial support of the family. Osteopathic physicians, through their holistic approach, are well suited to provide quality end of life care. DO's 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.

Current AOA resolutions related to the Policy on End of Life Care:
H264-A/07 PHYSICIAN ASSISTED SUICIDE--AOA POSITION
H202-A/07 ADVANCE DIRECTIVES
H228-A/08 HOSPICE AND PALLIATIVE CARE, SUPPORT FOR