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The Final Transition: End of Life Care

I recently had the opportunity to participate in a panel on end-of-life care jointly sponsored the Charles E. Smith Life Communities in Rockville MD, Suburban Hospital in Bethesda, MD,, and Sibley Hospital in Washington, D.C. The session was part of a day-long program on care transitions and highlighted the special importance of caring for the dying.

My fellow panelists and I brought a wide range of perspectives. I represented the views of patients and their families. Rabbi Jim Michaels is a chaplain who serves residents and patients at the Charles E. Smith continuing care community; Dr. Thomas Smith is an oncologist and director of palliative care at Johns Hopkins; Steven A. Widdes is a noted elder care attorney; and Dr. Richard Alcorta is an emergency room physician, the Maryland State EMS medical director, and the man who plays a key role in implementing the state's MOLST program.

MOLST, or Medical Orders for Life-Sustaining Treatment, is a form that allows people to make their medical wishes known to health professionals. In some states, it is called a POLST, or physician order. (Peter Kote comment – In CA it is called POLST and is in bright pink color)

Despite our very different backgrounds and perspective, we all ended up delivering a similar message: It is essential that everyone involved with a dying patient communicate. This is important for all patients—and rarely done well. But when it comes to the highly emotional and complex issues surrounding end of life, it is especially key.

That means physicians should honestly and compassionately discuss what is happening with a patient and her family. When someone is diagnosed with a fatal disease, they must be told.

Not long ago, doctors rarely had these conversations. That is changing, but not fast enough. There are still physicians who won't give patients the "bad news" because they

believe people will “lose hope.” In fact, many dying patients already suspect they are dying. Often, they want to talk about it. They need a doctor willing to have the discussion.

If a doctor is not comfortable talking about death, he can turn to others for help. Palliative care teams are invaluable, though attending physicians need to request their assistance much sooner than they often do. Clergy and chaplains can provide special assistance. And, often, hospice can play a big role (full disclosure: my wife is a hospice chaplain).

These discussions should also involve the family. Often relatives disagree about end-of-life issues. But when they can, the patients themselves should make the decisions. That’s one reason why advance directives such as MOLST forms are so important. They encourage families to talk.

And usually, if family members are able to air their disagreements, these disputes can be resolved. Not always, of course. But surprisingly often.

Health and personal care in the 21st century is complicated. It often provides multiple providers—primary care doctors, specialists, nurses, physical therapists, pharmacists, and others. And it takes place in a wide range of settings—home, hospital, nursing home, and assisted living facilities. Getting those care transitions right is critically important but all the more so when a patient is dying.

The hospital and nursing home administrators, care managers, nurses, doctors, and other health professionals who came to this conference cared enough to take a day out of their schedules to listen to what we had to say. I hope they take some of it to heart.