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Medical Ethics

Meeting Physicians' Responsibilities in Providing End-of-Life Care*

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Despite many clinical examples of exemplary end-of-life care, a number of studies highlight significant shortcomings in the quality of end-of-life care that the majority of patients receive. In part, this stems from inconsistencies in training and supporting clinicians in delivering end-of-life care. This review describes the responsibilities of pulmonary and critical care physicians in providing end-of-life care to patients and their families. While many responsibilities are common to all physicians who care for patients with life-limiting illness, some issues are particularly relevant to pulmonary and critical care physicians. These issues include prognostication and decision making about goals of care, challenges and approaches to communicating with patients and their family, the role of interdisciplinary collaboration, principles and practice of withholding and withdrawing life-sustaining measures, and cultural competency in end-of-life care.

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While prevention of premature death has always been a primary goal of medicine, provision of a comfortable and peaceful death has been widely acknowledged as an important end in itself only in the last several decades.[1] Even with widespread professional acknowledgment of the importance of palliative care, many patients die in moderate or severe pain,[2] physicians are often unaware of patients' wishes regarding end-of-life care,[3] and interventions are often inconsistent with patients' preferences.[2] Providing high-quality end-of-life care is difficult and complex. Figure 1 shows the diverse skill set necessary for providing high-quality end-of-life care, as derived from the perspectives of patients with chronic and life-limiting illnesses, family members, physicians, and nurses.

In this review, we describe the responsibilities of pulmonary and critical care physicians in providing end-of-life care to patients and their families. Although many of these responsibilities are common to all physicians caring for patients with life-limiting illness, we focus on issues most relevant to pulmonary and critical care settings. We also focus on practical aspects of providing this care, such as prognostication and decision making about goals of care, approaches to communicating with patients and family, the importance of interdisciplinary collaboration and addressing conflicts, principles of withholding and withdrawing life sustaining measures, and the role of cultural competency in end-of-life care.

End-of-life care is frequently cited as an area of particular relevance to medical professionalism, both in concert with and in addition to medical ethics.[4] Perhaps never more than in dealing with end-of-life issues will the physician's culture, spiritual beliefs, and personal values influence decision making and

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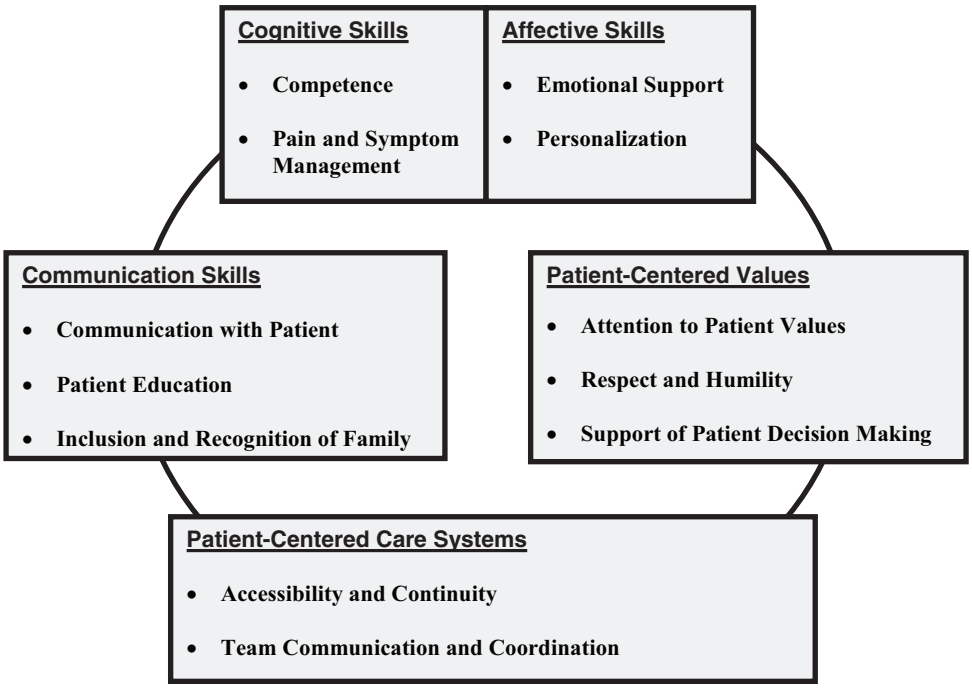

FIGURE 1. Conceptual model of the domains of physicians' skills at providing high-quality end-of-life care based on analyses of focus group transcripts.[7]

therefore have the potential to compromise or test professionalism.[5] The hospital setting, and particularly the ICU setting, compounds these challenges to physicians' professionalism. The ICU setting, a strange, stressful, and often seemingly hostile environment to patients and families, increases vulnerability to the opinions, influences, or preferences of clinicians. Variable and conflicting approaches to care may be more pronounced and more common than in other health-care settings.[6] In the context of these challenges, maintaining awareness of one's personal values and simultaneously understanding and respecting the values of others becomes especially important. The key components of professionalism, including respect, integrity, honesty, and compassion, provide a foundation for the skills needed to provide competent and compassionate care at the end of life.

Unique Aspects of End-of-Life Care in Pulmonary and Critical Care Medicine

Approximately 20% of all deaths in the United States, or 540,000 deaths per year, occur in the ICU.[8] The majority of ICU deaths involve decisions to withhold or withdraw life-supporting therapies,[9–18] which require specific skills in end-of-life care. Outside of the ICU, pulmonary physicians and cardiologists also care for many patients with chronic and life-limiting diseases, such as COPD, pulmonary fibrosis, and heart failure. Some studies[19,20] suggest that the quality of end-of-life care for patients with chronic lung or heart disease is poorer than for patients with cancer. For example, compared to patients with cancer, patients with COPD were more likely to die in the ICU, receiving mechanical ventilation, and with dyspnea.[21–23] These differences occurred despite the treatment preference of most patients with COPD for comfort over prolonging life; in fact, one US study[21] found that patients with cancer and patients with COPD were equally likely to prefer forgoing intubation and receiving cardiopulmonary resuscitation. A British study[23] also found that patients with COPD were much less likely to die at home and to receive palliative care services than patients with lung cancer. Health care for patients with chronic lung or heart disease is often initiated in response to acute exacerbations rather than being proactively based on a previously developed plan for managing disease.[22,24]

In meeting the responsibilities of end-of-life care in the ICU or for patients with chronic lung or heart disease, several important challenges arise. ICU care frequently uses the most technologically advanced medical care to restore health and reverse injury or illness; transitioning to a palliative focus can be especially difficult in this setting.[25] The gravity and acuity of critical illness can lead to conflicts among family members and between patient, family members, and the medical team, which can complicate communication and decision making.[26,27] Navigating