Striving for Excellent End-of-Life Care

To the Editor:

The editorial in CHEST (November 2004) by Wood and Mark regarding how to improve end-of-life care in the ICU was welcome and timely, well-supported, and well-written. I believe that their first two points regarding customizing care and incorporating post-hospital discharge planning into ICU care are right on the mark.

But I believe that they are shy of the mark on their third point about “educating the public.” I think that this is where we as intensivists and all of medicine have failed the public through our own lack of training and education in the delivery of end-of-life care. Much of the problem with providing futile intensive care lies far “upstream” from the ICU, in the offices of physicians who are taking care of patients with chronic, progressive, and ultimately fatal diseases such as cerebrovascular disease, congestive heart failure, dementia, COPD, and cancer, among others.

End-of-life care has been a hot topic in medicine for at least 10 years now. The Robert Wood Johnson Foundation and other charitable organizations have poured huge sums of money into efforts to improve end-of-life care. Much has been learned in these years, but I think the most important lesson can be summed up as follows fairly simply: most physicians and nurses are inadequately trained to provide high-quality, compassionate end-of-life care. Most of us have had no formal training in advance care planning, communicating bad news, communicating about and identifying the goals of care, pain management, medical futility, and legal, spiritual, and social issues of patients nearing the end of life. Is it any wonder that the public is not educated?

We have failed to educate ourselves to be capable of educating the public.

I do not mean to imply that there are not thousands of physicians who are excellent and well-trained in these areas. There are. But I do not have to tell the readers of this journal that, first, we are not as well trained as we would like to be, and, second, that those who are upstream from us are even less likely to be as attuned to these issues and are more uncomfortable in dealing with them. And above and beyond these issues are the economic disincentives that provide pressure against doing the right thing, even when the medical team is well-trained.

Education in Palliative and End-of-Life Care (The EPEC Project) is a training program that was developed by the American Medical Association with support from the Robert Wood Johnson Foundation to bridge the gap in training in end-of-life care that the vast majority of physicians have experienced. It was designed as an intensive 2-day educational experience to bring competence to physicians in all of the major aspects of end-of-life care. It does not turn physicians into palliative care experts any more than advanced cardiac life support turns us into cardiologists, but it does provide a solid foundation and basic competencies in end-of-life care, and it allows us to teach and learn with primary care physicians, specialists, nurses, clergy, social workers, and others. It is a powerful course, one that can lead to tears of recognition or uneasiness when we recognize ourselves in others eyes, and to joy when we rediscover many of the profoundly human reasons why we are so privileged to be physicians.

I strongly support the advocacy by Mark and Wood for better...
educating the public in end-of-life care and advance care planning, but I advocate that the American College of Chest Physicians make it our business to work with our membership to improve our education in end-of-life care in a comprehensive manner. I presuppose that we cannot do this ourselves. The American College of Chest Physicians already has an electronic EPEC program, and the AMA sent out the EPEC Program on CD-ROM several years ago when the program was first developed. Some organizations have presented the full, live program in various places around the country. And the American Association of Colleges of Nursing has developed a corresponding program, the End-of-Life Nursing Education Consortium. But I would argue that until every reader of this journal is aware of these programs and has participated in at least one, and until it is unacceptable for a physician to not be competent in these areas, we are failing in our responsibility to educate ourselves. And when we get our house in order, then we will be better able to educate the public.

Wood and Marik have asked, “how best should we select which patients are likely to derive the most benefit from admission to the ICU?” This is an important question, but I would like us to ask a different set of questions well before we are faced with that one. Let us get our professions to be competent in helping our patients answer the difficult questions that they will almost certainly be faced with long before they come to us. If we do this, we may not have to ask their question as often.

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References


To the Editor:

We find it difficult to disagree with Dr. Hughes’ thoughtful letter and concur that most physicians and nurses are inadequately trained to provide high-quality, compassionate end-of-life care. Furthermore, as highlighted by Dr. Hughes, the failure of upstream physicians to discuss end-of-life issues with patients who have “terminal” diseases frequently results in the inappropriate use of life-sustaining interventions in dying patients.

Most undergraduate as well as postgraduate medical training programs provide little or no formal training in dealing with the dying patient and end-of-life issues. Rabow and colleagues reviewed the end-of-life care content of 50 major medical texts. An astonishing 76% of the texts provided no or inadequate information on the care of the dying patients, with those texts devoted to AIDS, surgery, and oncology providing the least amount of information on end-of-life care. It has been suggested that residents learn most of their skills in dealing with dying patients from watching commercial television.

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Prediction of Pulmonary Artery Pressure

To the Editor:

We read with great interest the article by Chemla et al (October 2004) on predicting mean pulmonary artery pressure (mPAP) from the systolic pulmonary artery pressure (SPAP) and have a few comments. We believe that correlation coefficients are not the best way to determine whether two measurement methods are clinically interchangeable. While the correlation coefficient for the measured SPAP and the calculated mPAP is not the best way to determine whether two measurement methods are clinically interchangeable. While the correlation coefficient for the measured SPAP and the calculated mPAP is