NHMS Policy
Physician Care at the End of Life

Our role as physicians is to preserve life when possible and reasonable, and to comfort always. The obligation to relieve pain and suffering continues when the possibility of curing disease is past. The experience of dying is the last phase in the experience of living. Patients have a right to expect their needs for physical, psychological and spiritual comfort to be addressed in the course of any illness, including terminal illness.

Physicians may provide such care directly, or may transition care to other providers, as is in the best interest of each patient. Those of us who elect to care for patients in their final illnesses are obligated to establish and maintain competence in end of life care, and to be aware of consultative resources, including clinicians with expertise in pain management, palliative care and hospice.

Some patients faced with terminal illness, declining bodily function, increasing dependence on others and/or the experience of suffering, understandably wish to control the time and nature of their deaths. Beliefs about the beginning and end of life are intensely personal. It is unlikely that science or human experience will ever bring about consensus on these issues. However, our society has traditionally recognized a fundamental difference between allowing death to occur as a natural process, and actively taking life.

It is reasonable, and consistent with these widely held societal values, that physicians may, in accordance with the wishes of a patient (or the patient's legitimate representatives), take steps to allow death to occur as a natural process.

There are many actions that a patient may elect in order to allow natural death to occur:

-Artificial means of support, such as ventilators, feeding tubes, intravenous hydration, dialysis or pacemakers may be disconnected.
-Medications that prolong life may be discontinued.

-Infections, such as pneumonia or sepsis, may be allowed to evolve without active treatment.
-A patient may discontinue eating and drinking.
-Combinations of these actions, or others, may be appropriate.

As a patient moves through the process of dying, it is appropriate for physicians to

aggressively treat pain and other distressing symptoms, such as anxiety, respiratory distress, agitation, nausea and others.

Physicians may use whatever treatments are required to provide relief of suffering, even if such treatments hasten death, as long as the treatment is not provided for the purpose of causing death, but for the purpose of relieving suffering. The hallmark of this intention is the titration of treatment according to effect. Sedation to unconsciousness may be legitimately employed for the relief of otherwise intractable symptoms.

In making end of life decisions, it is important that the physician determine that the patient is relating his or her own wishes, is not suffering from a treatable depression or other psychological disturbance that might influence decisions, and is not inappropriately influenced by other persons, or by considerations extraneous to his or her own well-being.

In patients with cognitive impairment, physicians may rely on existing advanced directives, legally designated guardians, those with durable power of attorney, family members, significant others, and/or on their own best judgment in determining care.

When difficult decisions or conflicting inclinations between involved parties arise, it may be helpful to consult with a standing ethics committee, or ad hoc team, to weigh the issues from different perspectives.

The physician's obligation in the setting of end of life care is uniquely, and above all else, to the patient. The physician should work with the patient, and/or his or her legitimate representatives, to provide the best possible quality of life for the patient through the final moments of life.
Societal issues of expediency, such as those related to health care financing, rationing of resources, or political influence, must never factor into decisions regarding what is best for an individual patient.

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