

Can Your Doctor *Talk about* Dying?

MEDICAL EDUCATORS ARE BRINGING END-OF-LIFE CARE ISSUES OUT OF THE CLOSET AND INTO THE CURRICULUM.

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“A hundred years ago, people didn’t talk about sex but felt comfortable talking about death and dying,” observes Jerry Vannatta, executive dean of the OU College of Medicine. “Then we started talking openly about sex but whispering about or denying death.”

People used to die at home, with dying more of a family event than a medical one. “But over the last century, especially in the years since World War II, people started dying in hospitals, and we began the process of institutionalizing dying,” Vannatta says.

Also since World War II, technology in all its various forms exploded onto the medical scene. Americans, especially, began to believe that technology would prolong life indefinitely.

Americans have evolved a sense of entitlement about this technology. “In this country, we believe that we are entitled to have everything possible done so that we don’t have to die,” Vannatta says.

Denying death is practiced by American society as a whole—and by the medical profession, which tends to view death as a defeat and not a normal or acceptable part of medical care.

“The way we practice medicine helps that implicit message get carried along,” says Vannatta, an internal medicine specialist. “We put very sick people in hospitals where there is access to lots of technology, so the normal response by physicians is to use all that technology to keep patients from dying.

“There’s nothing wrong with that up to a point,” he adds, “but there is a time in every person’s life when—if that person doesn’t die suddenly of unexpected causes—it doesn’t matter how much technology a doctor applies because it isn’t going to help.”

Vannatta is one of a growing number of people—both healthcare professionals and lay individuals—who believe that it is time to bring dying out of the closet and deal with it more rationally and humanely.

With the financial and philosophical support of the Hospice Foundation of Oklahoma, Vannatta has initiated a palliative care program in the OU College of Medicine to raise the awareness of end-of-life issues among medical students and practicing physicians. (The word “palliative” in the medical



profession has come to mean “end-of-life care.”)

“Physicians have a difficult time deciding when to stop using technology and concentrate instead on helping a patient die well,” Vannatta says. “We need to be willing to acknowledge when the further application of technology isn’t going to help and start helping our patients die with dignity and without pain.”

Vannatta believes that patients have a right to know they are dying and be allowed to make decisions about the process. “One of the precepts of medical ethics is that patients must be informed,” he points out.

He admits, however, that this precept is not always practiced. “What happens in reality is there’s so much

dialogue between patient and physician about the disease itself that the doctor doesn’t have to talk about dying.

“Being explicit when the prognosis is death is uncommon in the medical profession,” he says.

“One of the goals of our palliative care program is to encourage practicing physicians to have this dialog with their patients. We are going to train physicians so that they ‘grow up’ doing this in their profession.”

Vannatta contends that physicians need to discuss end-of-life issues with their patients. How do they want to spend the last weeks or months of their lives? What technology do patients want to be accessed in their behalf? Do they want to be put on a ventilator? If their heart stops beat-

ing, do they want to be revived?

The OU educator pauses before adding, “Of course, it’s not uncommon for a patient to say, ‘I don’t want to talk about this.’ It’s not just the doctors who have a problem talking about death.”

Vannatta remembers very well his first encounter with death as a first-year medical student. He found it frightening—so frightening that he wondered if he should continue his medical education.

And indeed, research has shown that first-year medicine students are more uncomfortable with the topic of death than their age-related peers.

“It’s probably a little bit Freudian why we go to medical school in the first place,” Vannatta speculates. “Maybe we are trying to overcome our



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anxieties about illness and death and dying.”

Freudian overtones or not, he firmly believes that medical schools need to do a better job of helping students deal with their anxieties and to graduate physicians who are dedicated not only to preserving health and life but also, when the time comes, to helping their patients die well.

OU’s medical dean sees the hospice movement in this country as a very positive development. Not only does it provide compassionate care for the dying in their own home or a homelike setting, it has brought the topic of end-of-life care to the forefront and helps give structure to the process that was missing before. By entering into hospice care, people acknowledge that they are dying,

and usually they have had some sort of explicit discussion with their caregiver and family members.

Oklahoma has 75 hospice programs, the largest number of programs per capita in the country, Vannatta points out.

The American Medical Association also is actively promoting changes in end-of-life care. The AMA has developed the Education for Physicians on End-of-Life Care (EPIC) program for physicians. The AMA Liaison Committee on Medical Education, which is the accrediting body for U.S. and Canadian medical schools, has given medical schools one year to incorporate end-of-life care into their curriculum.

Vannatta believes that economic issues have played a role in the nation’s evolving willingness to deal with end-of-life issues. A seemingly disproportionate percentage of healthcare expenditures is spent treating people in the last six months of life.

“We had a huge national debate about health care in 1992,” he recalls. “I believe that some of the end-of-life care issues now being raised boiled up out of that debate, which asked, ‘What should we pay for?’ ”

He says the answer to that question is another question. *What works?*

“We should not be paying for what does not work. We need to focus on when palliation should begin and lifesaving treatment end.”

At a time when medical science is making such tremendous strides, it is perhaps ironic that how we die is becoming an important medical and societal issue.

Vannatta believes, however, that advancing medical science and learning to die well are not mutually exclusive concepts. “Society will benefit best if we in medicine make room for both issues and as physicians embrace scientific advancement and humanistic dying with equal grace.”

Palliative Care Training: Part of OU Medical Preparation

A 1998 survey showed that only five of the nation's medical schools had a course on care of the dying, points out Sheila Crow, director of the Palliative Care Program in the OU College of Medicine.

This statistic will change now that the American Medical Association has mandated that palliative care become a part of medical school curriculums, she adds.

OU is ahead of the curve. Its palliative care program is already under way.

"The program is now in its second year," says Crow, a College of Medicine faculty member who has completed a training course for teaching the AMA's Education for Physicians on End-of-Life Care curriculum.

"With the support of Dean Vannatta and the Hospice Foundation of Oklahoma, we have made great progress in developing a national model to train healthcare professionals to meet the care needs of dying patients," Crow says.

The OU program offers instruction in each of the four years of medical school.

"Instead of implementing a whole new course in each of the four years, we are incorporating palliative care issues into existing courses," Crow explains.

- The Human Behavior course required of all first-year medical students now includes sessions on death and dying and palliative care.
- The issues of medical futility and withholding or withdrawing therapy have been added to the second-year course on Professional Ethics. This course includes small group sessions with students interviewing patients and learning their views on the topic under discussion.

- Sessions on communicating bad news will be included in a third-year program on Advanced Interviewing.

- A palliative medicine elective will be offered to fourth-year students. The one-month rotation will assign students to hospice patients. The students will be required to keep a journal chronicling their experiences with patients and family members and with the hospice medical directors, social workers and nurses.

Crow anticipates that for many students the elective will be their first prolonged contact with a dying person. "I think they will learn a great deal," she says.

In addition, OU Health Sciences Center students, residents and faculty take part in lectures, seminars and grand rounds dealing with end-of-life care that are scheduled throughout the year and during Palliative Care Week.

In April, Crow coordinated the College of Medicine's second annual Palliative Care Week, which included public lectures at the OU

Health Sciences Center and other sites. Also scheduled during the week was a two-day Continuing Medical Education program, which was the third CME session the OU Palliative Care Program has held for practicing physicians.

Crow believes the Palliative Care Program is addressing the issues raised in the wake of Jack Kevorkian. People saw assisted suicide as a way to avoid the indignity, pain and loneliness often associated with dying.

"When physicians address the fears of people who are depressed, in pain and worried about being a burden, when a patient has been told, 'we will help you through this, you're not going to die alone, you're not going to die in pain,' the issue of suicide goes by the wayside," Crow says.

The OU Palliative Care director predicts that patients will start expecting their physicians to be competent and capable in end-of-life care. "We want OU-trained physicians to be ready to meet the challenge." ■

—Judith Wall

