What Is Palliative Care?

Palliative care, sometimes called “comfort care,” is person- and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness addresses physical, intellectual, emotional, social and spiritual needs and facilitates patient autonomy, access to information and choice in care.¹

How Does Medical Aid in Dying Improve Palliative Care Outcomes?

Medical aid in dying — one option on the palliative care spectrum — enhances palliative care in several ways. Prior to providing a medical aid-in-dying prescription, physicians are required to confirm that their patient is fully informed of all their care options.

Palliative care physicians report that a patient’s questions about medical aid in dying prompt in-depth conversations between doctors and patients about the full-range of end-of-life care options, including hospice, pain management and emotional support in addition to aid in dying.

Numerous studies in Oregon and Washington, along with a host of national surveys, link the availability of medical aid in dying as a palliative care option to a number of positive outcomes for end-of-life care. A few of these findings are summarized below:

> Research conducted in Oregon suggests that having medical aid in dying as an option relieves worries about future discomfort, pain and loss of control. A study of hospice nurses and social workers in Oregon reported that symptoms of pain, depression, anxiety, extreme air hunger and fear of the process of dying were more pronounced among hospice patients who did not request aid-in-dying medication,² indicating a strong palliative care benefit for having an aid-in-dying prescription on hand. University of Pennsylvania’s Center for Bioethics director Arthur Caplan has said, “...the Oregon law probably has benefited many more people than have actually used it.”³

> **Medical aid in dying promotes appropriate hospice use.** A Journal of Palliative Medicine report on patterns of hospice use noted that Oregon was in both the highest quartile of hospice use and the lowest quartile of potentially concerning patterns of hospice use.⁴ Vermont, where medical aid in dying was authorized in 2013, was in the lowest quartile of all three potentially concerning patterns of hospice use examined.⁴ Posited the researchers, “...it is possible that the Oregon Death With Dignity Act has resulted in or at least reflects more open conversation and careful evaluation of end-of-life options.”⁵ Indeed, 30 percent of Oregon doctors responding to a 1999 survey said that after voters approved medical aid in dying, the number of patients they referred to hospice increased.⁶ Some hospice programs in Oregon, according to the Annals of Internal Medicine, reported a 20 percent jump in referrals since the vote.⁷
> Medical aid in dying helps family caregivers prepare for and accept a terminally ill person’s death. Respondents to the previously cited Oregon hospice nurse/social worker study reported family caregivers of patients who chose medical aid in dying “were more likely to find positive meaning in caring for the patient and were more prepared for and accepting of the patient’s death” than family caregivers of patients not requesting medical aid in dying. A mental health survey of 95 Oregonian families whose loved ones chose medical aid in dying after exhausting other palliative care options yielded similar results.

> Medical aid in dying has resulted in better physician palliative care training. The Journal of Palliative Medicine article referenced above also suggested that medical aid in dying in Oregon has resulted in “more appropriate palliative care training of physicians,” and a New England Journal of Medicine article likewise noted that 88 percent of responding Oregon doctors who had cared for terminally ill patients reported actively improving their knowledge of pain management for those patients.

> Terminally ill people who choose medical aid in dying are overwhelmingly in hospice care and able to die at home. In Oregon, 93 percent of adults who used medical aid-in-dying prescriptions in 2014 were enrolled in hospice care, and 90 percent died at home. In Washington state, 69 percent were enrolled in hospice care, and 92 percent were able to die at home.

> Since the authorization of aid in dying, Oregon hospitals have expanded palliative care for individuals with terminal and life-threatening illnesses. The Annals of Internal Medicine reported a number of Oregon hospitals had developed or expanded the scope of hospice-modeled “comfort care consultation teams” in the wake of Oregon’s Death With Dignity Act’s passage. According to the Annals article, “These interdisciplinary teams act as consultants to enhance comfort care not only for terminally ill patients but for other patients who have life-threatening illnesses in various inpatient and outpatient settings.”

> Adults in Oregon and Washington, where medical aid in dying is authorized, are more knowledgeable about palliative, end-of-life and hospice care. A poll conducted by National Journal and Regence Foundation found that both Oregonians and Washingtonians were more familiar with the terminology “end-of-life care” than the rest of the country and residents of both states are slightly more aware of the terms palliative and hospice care.
Resources

1An Explanation of Palliative Care. Available from http://www.nhpco.org/palliative-care-4


5ibid., p.778.


