

End of Life Care Planning:

***Advanced Directives, Physician-Assisted Suicide and
Pain Management***

2.5 Contact Hours

Presented by:

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End of Life Care Planning

Advanced Directives, Physician-Assisted Suicide and Pain Management

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OBJECTIVES:

After completing this course, the learner will be able to:

1. Explain the origins of the Patient Self-Determination Act (PSDA)
2. Discuss the need for cultural awareness in dealing with patients and their families
3. Identify resources for learning more about patients and organizing information in order to provide the most holistic and competent care possible
4. Discuss issues relating to physician-assisted suicide
5. Explain pain management strategies in the elderly

Background Information on the Patient Self-Determination Act

When faced with the choice of where they would like to die, most patients say that they would prefer to be at home; however, statistically only 23% of the population is able to achieve this wish (Giger, 4).

The Patient Self-Determination Act (PSDA) was first implemented in 1991, in part, as a means for containing the skyrocketing costs of healthcare in this country. PSDA also has roots in the consumer rights movement that found its footing in the late 1970s and early 1980s. One of the early, Western thinkers on the subject of the dying process was the Swiss-born psychiatrist, Elizabeth Kubler-Ross. Kubler-Ross published the first widely-distributed text on death and the experiences of the dying, appropriately titled, On Death and Dying, in 1969. In her work, Kubler-Ross outlined a model of stages in the dying process, based on her personal interviews with hundreds of dying patients. Kubler-Ross's work and other stage models have been commonly used in the U.S. healthcare system to try and better understand the patient experience when confronted with terminal illness. Her work provided the dying with a voice for the first time in Western medicine and marked the beginning of our efforts to develop a systematic response to this experience. In part as a result of these models, policies such as the American Hospital Association's Patient's Bill of Rights, and the PSDA, have brought about a shift in the decision-making process in the care and treatment of terminally ill patients. Prior to the late 1960's, medical personnel and family made choices about a patient's care.

Subsequent to this period of change, the U.S. healthcare system has shifted to represent greater patient authority surrounding the experience of death and dying.

One of the principle goals of the PSDA is to provide terminally and seriously ill patients with the option of completing an advanced directive. Advanced directives are based on four connecting values. The first is the patient's autonomy over their end-of-life care. The second is the patient's right to information for making an informed decisions about that care. The third is the patient's right to hear the truth about their condition and prognosis from medical personnel. The fourth is the patient's right to exercise full control over their dying process.

Under PSDA, healthcare providers are required to give patients written information about advanced directives. Providers are also required to ask patients whether they have existing advanced directives. Furthermore, healthcare providers are required to have institutional policies relating to the administration and management of advanced directives, and they are also responsible for educating staff and their community about these policies, and about advanced directives in general.

PSDAs are based on four primary values. These include the patient's autonomy over all end-of-life decisions, the right to accurate and understandable information when making these decisions, the right to be told the truth regarding prognoses and treatments, and finally, the right to control their dying to the greatest extent possible.

Laws pertaining to PSDAs vary from state to state, and often include regulations relating to living wills and durable power of attorney. A living will is a legal document that is commonly drafted before any invasive medical treatment, allowing or rejecting medical personnel to use life-sustaining measures in the event that they are required during the course of care. Durable power of attorney is the authorization for someone other than the patient to act on the patient's behalf in making any healthcare-related decisions, in the event that they are unable to do so.

Cultural Considerations of Advance Directive Planning

According to the U.S. Department of Commerce's Bureau of the Census, by 2020, only 53% of the United State's population will be of European descent (Giger, 3).

For some people who die without an advanced directive, there may have been problems in planning and foresight. For others, dying without an advanced directive may be a choice based on differing cultural attitudes and beliefs. Culture is an expression of who we are as individuals and communities, which guides our thinking, doing and being.

Most of the public is familiar with the ongoing debate over the issues of euthanasia and assisted suicide; however, it is still not clear where the majority stands on either issue. A recent Gallup Poll survey suggested that 75% of all Americans are in favor of euthanasia

as an option for terminally-ill patients. Additional research suggests that there are large-scale differences across both social and, by extension, cultural groups, regarding the degree of support for euthanasia in healthcare. Individual attitudes have gotten more attention lately by practitioners and researchers, because they could influence future legislation on this topic, regarding how patients are cared for in hospitals, hospice and long-term care settings (http://en.wikipedia.org/wiki/Assisted_suicide#United_States).

The U.S. healthcare system is based on three core values. They are, firstly, that life is sacred and must be protected; secondly, decisions about our health are our own; and thirdly, no one should be subjected to needless suffering in the name of medicine. While these values are held by our healthcare system, that system is there to serve a much more broadly defined population, with its own set of cultural values and beliefs (Giger, 3).

Perhaps the most commonly shared cultural belief is that life is revered. Beyond this belief, there is not always as much common ground. In some cultures, the belief in personal autonomy is less developed. Instead, some cultures place a higher value on family, or community-centered decision making in matters such as healthcare and the dying experience. Similarly, the value placed on the patient's right to know about their medical condition and prognosis is not shared by all cultures. In some cultures, telling a patient about the seriousness of a condition, or the terms of a prognosis, is thought to be an unnecessary burden on the patient, which is better handled by the family, or community.

So, as a practitioner, how are you to know who holds what values when dealing with patients and their families? There is no single, 'right' way to learn about patients' cultural values; however, one resource used to help organize information about cultural values is the Giger-Davidhizar Transcultural Assessment Model. This model has been used since the early 90s in a variety of settings to collect patient data that may be used to better understand how patients and their families connect to the core values expressed in the U.S. healthcare system. The model includes questions in six domains: communication, time, space, social organization, environmental control and biological variations. The model concludes with a nursing assessment, which guides users in incorporating collected patient information into a nursing care plan. Utilizing this or another assessment model that looks carefully at patients' cultural variables can greatly impact care givers' knowledge and understanding of different views of death and dying (Transcultural Nursing, 13).

The American Association of Colleges of Nursing, in connection with the Robert Wood Johnson Foundation, has made recommendations concerning the content areas where nursing competencies should be developed by all practitioners. The End of Life Nursing Education Consortium (ELNEC) offers nine modules covering these content areas, which are offered regularly throughout the U.S. These modules include: "An Introduction to Palliative Care"; "Learning Pain Assessment and Management"; "Teaching Symptom Management in End of Life Care: The Didactic Content and Teaching Strategies" "Ethical and Legal Issues in End of Life Care"; "Teaching Cultural Considerations at the End of Life"; "Communication Skills for End-of-Life Nursing Care"; "Strategies for

Teaching Loss, Grief, and Bereavement”; “Achieving Quality Care at the End of Life”; and “Preparation and Care at the Time of Death”. As a practitioner, you also have the combined right and responsibility to determine your own comfort level with the wishes of those in your care. If you are not comfortable with a patient, or patient’s families’ requests, you have the right to request a referral to another practitioner who is better equipped to work with the patient’s wishes.

Researching Death and Dying

It is important that each healthcare practitioner find out more about the communities, in which they work, in order to make better informed decisions about managing their patients’ requests, regarding end of life care. *MedLine* is one of the most commonly referenced resources for medical information, and is often used to keep up to date on current research and best practices. However, a recent analysis of *MedLine*’s retrieval of articles on religious traditions and end-of-life care showed a serious deficit in information related to death and dying in the three major world religions.

Out of 66 retrieved articles, twelve focused on Christianity, with the highest concentration on Catholicism. Eight of the 66 focused on Judaism and only four focused on Islam. Looking through the lens of these three monotheistic religious traditions, these researchers wanted to see if their *MedLine* search would provide information about what medical practices were either prohibited or expressly permitted by any of these three faiths (Rodriguez & Fins, 3). However, none of these articles provided information on the rich theological debate over such questions as pain management, artificial nutrition and hydration, or other quality of life considerations.

Researchers noted in comparison that a check of the search engine *Google* showed a greater return in the numbers of articles concerned with these widely debated issues: Christian (38,400); Jewish (19,500); Islamic (11,200). (Del Pozo & Fins, 2-5). What this suggests is that while *MedLine* is an invaluable resource for scientifically-based healthcare information, it is not as representative of the resulting religious implications and debate, generated by the major world religions, as a commercial search engine, such as *Google*. This is important information for healthcare practitioners trying to better understand different perspectives, by seeking out information on their patients’ religious backgrounds, and the resulting attitudes towards death and dying. What this research suggests is that investigating commercial resources for information may be more productive than simply relying on established medical databases.

Physician-Assisted Suicide

Physician-assisted suicide has been a hotly debated topic in the U.S. healthcare system, with great attention being focused on select high-profile cases in the media over the past several years. These cases have helped shape legislation and public opinion on the topic, as well as establishing the public's perception of the medical communities' response to patients seeking physician-assisted deaths.

One of the most famous names related to the physician-assisted suicide debate is Dr. Jack Kevorkian. On March 26, 1999, Kevorkian was charged with second-degree homicide for his role in delivering a controlled substance, via lethal injection, to a terminally-ill patient. Kevorkian had been involved in previous trials for aiding in patient suicides; however, this trial centered on the premise of homicide, rather than assisted suicide.

Kevorkian discharged his attorneys and represented himself and the judge ordered a criminal defense attorney to remain available at trial for information and advice. Despite this, the Michigan jury found Kevorkian guilty of second-degree homicide. The plaintiff proved that Dr. Kevorkian had killed his patient, because the patient was not physically able to administer the injection to kill himself. As a result of this ruling, Kevorkian is currently serving a 10-to-25-year sentence in Michigan (Retrieved from http://en.wikipedia.org/wiki/Jack_Kevorkian).

In the last 25 years, several states have faced voter ballot initiatives and "legislation bills" attempting to legalize euthanasia and assisted suicide. Washington state introduced Ballot Initiative 119 in 1991, California put Proposition 161 on the ballot in 1992, and Michigan included Proposal B in their ballot in 1998. The public's opinion on the issue is becoming more and more important because nationwide support could very well facilitate the legalization of these policies in other states (http://en.wikipedia.org/wiki/Assisted_suicide#United_States).

Perhaps the most carefully watched state is Oregon, where Ballot Measure 16 established Oregon's Death with Dignity Act in 1994. The Death with Dignity Act legalized physician-assisted suicide, under specific restrictions. The Act makes Oregon the first state with governmental recognition for physicians to exercise their right to help terminally-ill patients die. Under the Act, anyone aged 18 or older, who is deemed competent to make decisions on their own behalf and has been diagnosed with one or more terminal illnesses by a physician may ask for a prescription for a lethal dosage of medication in order to end his or her own life. The request must be made in writing, signed by the patient and confirmed by two witnesses. At least one of these witnesses cannot be related to the patient or be a beneficiary of the patient's estate. The witness also cannot be the patient's physician or an employee of a health care facility where the patient is currently receiving care. Once the request is made, a separate physician must examine the patient's medical records and confirm the same diagnosis as the primary physician. Additionally, the patient must be evaluated by a mental health professional to guarantee that he or she does not suffer from any mental condition that might have adversely affected their judgment in making this request. Pending the approval of all

involved parties, the patient's request may then be authorized; however, they must wait a minimum of fifteen days and make a second verbal request before the prescription can be written by the original physician.

The Act protects physicians and any team of associated healthcare professionals from liability for managing the care of an assisted suicide patient. It also recognizes the right of physicians to not participate in any assisted suicide. Finally, it states that the patient's decision to die will not affect any life, health, or accident insurance or annuity policies held by the patient or family members (http://en.wikipedia.org/wiki/Oregon_Ballot_Measure_16_%281994%29).

Recent studies based on interviews with terminally ill patients have begun looking at the reasons patients may seek out a physician-assisted death. One survey found 8.5% of 200 patients with terminal cancers expressed a persistent desire to die. This desire was related to the patient's reported experience of depression, pain, poor social supports, or a combination of these three factors. A different study reported that 27% of patients with terminal cancers had experienced thoughts of physician-assisted suicide, with only 1.9% having had a discussion on the subject with their physician. This study also found that patients who were depressed, were not religious, were physically-dependent on others for their care, and were perceived as affluent were more likely to have discussed the option of physician-assisted suicide with their physician (Drickamer, 147).

The Patient- Healthcare Provider Relationship

Discussions on the subject of physician-assisted suicide make the assumption that every patient has an ongoing relationship with a primary care physician; however, an estimated 35 million U.S. residents live in geographic areas where there is a shortage of primary care options. This reality makes physician-assisted suicide more of an option for those living in locations where the supply of primary care professionals meets the demand for these services. (Drickamer, 149).

Assuming a patient lives in a geographic area where there is an adequate supply of primary care professionals, other issues in the relationship between the patient and healthcare professional must be considered. One of the key issues with the current physician-assisted suicide legislation is the label of "terminal illness." The definition of a terminal illness, according to Oregon law, is "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months" (Ibid., 152). At issue with this definition is the reality of recognizing the terminal phases of a patient's disease process. Different patients experience different disease processes. For example, a patient infected with HIV meets the criteria of experiencing a terminal illness; however, the rate at which that illness may progress is not as easily known. According to one estimate, 10-17% of HIV patients are alive without secondary signs of immunodeficiency at 20 years post-infection. Recognizing when a patient's right to request an assisted suicide meets the outlined

criteria of terminal illness can be difficult to judge. While it is the physician's judgment that ultimately determines whether a patient meets this definition, it is usually nurses and other allied health professionals who recognize when a patient may be nearing a timeframe when action may be taken to initiate the assisted suicide process. Still, according to a survey of Oregon physicians, half of all respondents said that they were "not confident that they could predict that a patient requesting physician-assisted suicide had less than six months to live" (Ibid.,153).

Explaining prognoses and probabilities is another area where great care must be taken in order to guarantee that a patient is not confused or misled by conflicting information. Methods used to estimate survival of critically ill patients include the Acute Physiology and Chronic Health Evaluation (APACHE III) and the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT). APACHE III was designed to assess a non-randomized, observational, cohort study, in two hundred eighty-five ICUs across 161 U.S. hospitals. Looking at a sample of 37,668 ICU admissions, researchers used demographic, clinical, and physiologic information to predict the probability of hospital mortality for each of these patients. APACHE III accurately predicted aggregate hospital mortality, based on sixty-five specific ICU admission diagnoses. The most frequent diagnoses with significant differences between observed and predicted hospital mortality rates were acute heart attack, drug overdose, non-operative head trauma, and non-operative multiple trauma (Zimmerman, 1297-1298). These results highlight the value of data collection at the time of admission, not only in terms of being useful for predicting a patient's probable mortality, but more importantly, in helping the patient and family to develop an advanced care directive.

Similarly, SUPPORT was designed to study the efficacy of advance directives in the treatment of terminally ill patients, being cared for in a hospital setting. The PSDA requires that patient education about advanced directives be delivered at the time of admission to a hospital and must be documented in the patient medical record. SUPPORT used nursing staff to facilitate communication between patients, surrogates, and physicians about preferences and outcomes of treatment. Additionally, the nursing staff presented medical alternatives and encouraged completion and use of an advanced directive. Interviews with patients, surrogates, and attending physicians regarding their familiarity with, use of, and results from advance directives suggested that they did not "substantially enhance physician-patient communication or decision-making about resuscitation" (Teno, 519-520). This suggests that increasing the frequency of advanced directives is not likely to bring about an improvement in the care of terminally ill patients. The authors suggest that improvements to the decision-making process should focus on looking for ways to improve the exchange of information between nursing staff, physicians and patients.

Pain Management

What Is Known About Pain

Pain is a complicated process that involves an intricate interplay between a number of important chemicals found naturally in the brain and spinal cord. In general, these chemicals, called *neurotransmitters*, transmit nerve impulses from one cell to another.

There are many different neurotransmitters in the human body; some play a role in human disease and, in the case of pain, act in various combinations to produce painful sensations in the body. Some chemicals govern mild pain sensations; others control intense or severe pain.

The body's chemicals act in the transmission of pain messages by stimulating *neurotransmitter receptors* found on the surface of cells; each receptor has a corresponding neurotransmitter. Receptors function much like gates or ports and enable pain messages to pass through and on to neighboring cells. One brain chemical of special interest to neuroscientists is *glutamate*. During experiments, mice with blocked glutamate receptors show a reduction in their responses to pain. Other important receptors in pain transmission are opiate-like receptors. Morphine and other opioid drugs work by locking on to these opioid receptors, switching on pain-inhibiting pathways or circuits, and thereby blocking pain.

Another type of receptor that responds to painful stimuli is called a *nociceptor*. Nociceptors are thin nerve fibers in the skin, muscle, and other body tissues, that, when stimulated, carry pain signals to the spinal cord and brain. Normally, nociceptors only respond to strong stimuli such as a pinch. However, when tissues become injured or inflamed, as with a sunburn or infection, they release chemicals that make nociceptors much more sensitive and cause them to transmit pain signals in response to even gentle stimuli such as breeze or a caress. This condition is called *allodynia* -a state in which pain is produced by innocuous stimuli.

The body's natural painkillers may yet prove to be the most promising pain relievers, pointing to one of the most important new avenues in drug development. The brain may signal the release of painkillers found in the spinal cord, including serotonin, norepinephrine, and opioid-like chemicals. Many pharmaceutical companies are working to synthesize these substances in laboratories as future medications.

Endorphins and *enkephalins* are other natural painkillers. Endorphins may be responsible for the "feel good" effects experienced by many people after rigorous exercise; they are also implicated in the pleasurable effects of smoking.

Similarly, *peptides*, compounds that make up proteins in the body, play a role in pain responses. Mice bred experimentally to lack a gene for two peptides called *tachykinins-neurokinin A* and substance P-have a reduced response to severe pain. When exposed to mild pain, these mice react in the same way as mice that carry the missing gene. But when exposed to more severe pain, the mice exhibit a reduced pain response. This

suggests that the two peptides are involved in the production of pain sensations, especially moderate-to-severe pain. Continued research on tachykinins, conducted with support from the NINDS, may pave the way for drugs tailored to treat different severities of pain.

Treatment of Pain

The goal of pain management is to improve function, enabling individuals to work, attend school, or participate in other day-to-day activities. Patients and their physicians have a number of options for the treatment of pain; some are more effective than others. Sometimes, relaxation and the use of imagery as a distraction provide relief. These methods can be powerful and effective, according to those who advocate their use. Whatever the treatment regime, it is important to remember that pain is treatable.

Background

- The majority of hospitalized elderly patients suffer from both acute and chronic pain.
- Elderly adults with cognitive impairment experience pain but are often unable to verbalize it.
- Both patients and health care providers have personal beliefs, prior experiences, insufficient knowledge, and mistaken beliefs about pain and pain management that:
 - influence the pain management process and
 - must be acknowledged and addressed before optimal pain relief can be achieved.
- Pain assessment must be regular, systematic, and documented in order to accurately evaluate treatment effectiveness.
- Self-report is the gold standard for pain assessment.

Strategies for Pain Assessment

- Review medical history, physical examinations, and laboratory and diagnostic tests in order to understand the sequence of events contributing to pain.
- Assess present pain, including intensity, character, frequency, pattern, location, duration, and precipitating and relieving factors.
- Review medications, including current and previously used prescription drugs, over-the-counter drugs, and home remedies. Determine what pain control methods have previously been effective for the patient.
- Assess patient's attitudes and beliefs about use of analgesics, anxiolytics, and nonpharmacological treatments.
- Gather information from family members about patient's pain experiences. Ask about patient's verbal and nonverbal/behavioral expressions of pain, particularly in demented patients.

- Use a standardized tool to assess self-reported pain. Choose from published measurement tools, and recall that elders may have difficulty using 10-point visual analog scales. Vertical verbal descriptor scales or faces scales may be more useful with elders, especially those with some cognitive losses.
- Assess pain regularly and frequently, but at least every 4 hours. Monitor pain intensity after giving medications to evaluate effectiveness.
- Observe for nonverbal and behavioral signs of pain, such as facial grimacing, withdrawal, guarding, rubbing, limping, shifting of position, aggression, depression, moaning, and crying. Also watch for changes in behavior from patient's usual patterns.

Nursing Care Strategies

- Prevention of pain
 - Assess pain regularly and frequently to facilitate appropriate treatment.
 - Anticipate and aggressively treat for pain before, during, and after painful diagnostic and/or therapeutic treatments.
 - Educate patients, families, and other clinicians to use analgesic medications prophylactically prior to and after painful procedures.
 - Educate patients and families about pain medications, their side effects and adverse effects, and issues of addiction, dependence, and tolerance.
 - Educate patients to take medications for pain on a regular basis and to avoid allowing pain to escalate.
 - Educate patients, families, and other clinicians to use nonpharmacological strategies to manage pain, such as relaxation, massage, and heat/cold.
- Treatment guidelines
 - Pharmacologic
 - Elderly adults are at increased risk for adverse drug reactions and drug--drug interactions.
 - Monitor medications closely to avoid over- or undermedication.
 - Administer pain drugs on a regular basis to maintain therapeutic levels; avoid prn drugs.
 - Document treatment plan to maintain consistency across shifts and with other care providers.
 - Nonpharmacologic
 - Investigate elderly patients' attitudes and beliefs about, preference for, and experience with nonpharmacological pain treatment strategies.
 - A variety of techniques exist, but they must be tailored to the individual.
 - Cognitive-behavioral strategies focus on changing the person's perception of pain (e.g., relaxation therapy, education, and distraction), and may not be appropriate for cognitively impaired persons.

- Physical pain relief strategies focus on promoting comfort and altering physiologic responses to pain (e.g., heat, cold, transcutaneous electrical nerve stimulation [TENS] units).
- A combination approach is often the best.

Potential Benefits and Harms of Implementing These Guidelines

Potential Benefits

Patient Will:

- Either be pain free or pain will be at a level that the patient judges as acceptable
- Maintain the highest level of self-care, functional ability, and activity level possible
- Reduce the risk of iatrogenic complications, such as falls, gastrointestinal upset/bleed, or altered cognitive status

Nurse Will:

- Demonstrate evidence of ongoing and comprehensive pain assessment
- Document evidence of prompt and effective pain management interventions
- Document systematic evaluation of intervention effectiveness
- Demonstrate knowledge of pain management in elderly patients, including assessment strategies, pain medications, nonpharmacological interventions, and patient/family education.

Institution Will:

- Provide evidence of documentation of pain assessment, intervention, and evaluation of treatment effectiveness
- Provide evidence of referral to specialists for specific therapies (e.g., psychiatry, psychology, biofeedback, physical therapy or pain treatment centers).
- Provide evidence of pain management resources for staff (e.g., care planning and pain management references, pain management consultants).

Potential Harms

Medication Side-Effects

- *Acetaminophen* (Tylenol): Has few side effects and is probably the safest non-opioid for most people. Use with caution in people with underlying hepatic or renal disease; renal dysfunction may be associated with prolonged use.
- *Nonsteroidal Anti-inflammatory Drugs (NSAIDs)* (e.g., ibuprofen [Advil, Motrin]): Common side effect is gastric damage resulting in increased

gastrointestinal tract susceptibility to injury. The elderly are more likely to develop ulcer disease and have a greater incidence of death from gastrointestinal effects of NSAIDs. Renal insufficiency is more likely to occur in the elderly with NSAID use. Use with caution with hepatic and renal disease.

Other side effects include increased bleeding time, central nervous system effects, hepatic disease, and worsening asthma. When NSAIDs are used as single-doses, in low doses, and for short periods of time, side effects are usually less common than with long-term use. Co-administration of misoprostol (Cytotec) has been shown to reduce the gastrointestinal complications associated with NSAID use.

- *COX-2 Inhibitors* (e.g., Rofecoxib*, Celecoxib): Are as effective as NSAIDs for pain relief and are associated with less gastrointestinal bleeding, but have a similar risk for other side effects
- *Tramadol* (e.g., Ultram): Nausea and vomiting are common side effects associated with the use of tramadol, along with dizziness, sedation, restlessness, diarrhea or constipation, dyspepsia, weakness, diaphoresis, seizures, and respiratory depression. It should be used cautiously in hepatic or renal impairment.
- *Opioid Drugs* (e.g., codeine and morphine): Potential side effects include nausea, constipation, drowsiness, cognitive effects, and respiratory depression. Tolerance to the side effects develops with use over time; therefore coadministration of stool softeners for relief of constipation is recommended.
- *Hydrocodone, Oxycodone, Morphine sulfate, MS Contin, Fentanyl, Hydromorphone*: Same as codeine (see above).

Conclusion

The goal of healthcare providers is to offer quality and competent care to the individual patient. However, the best way to provide such care when a patient's prognosis does not include the goal of recovery to daily life functions, involves a complex set of considerations. The experiences of death and dying is one that each person must manage in coordination with their healthcare providers. As a healthcare professional, your role is largely determined by the wishes of the patient and, to the extent that they choose, their families. Patients and their families often look at death and dying through a uniquely personal set of "lenses." These "lenses" are made up from the patient's cultural background, religious belief system, family structure, socioeconomic perspective geographic location and individual medical prognosis. Taking the time to discover ways of learning about a patient's "lenses," helps healthcare professionals to understand how patients see themselves in this final, life experience. In knowing more about the patient's perspective on their own death, healthcare professionals are more able to aid patients and their families in achieving the most satisfactory experience. Aiding patients in the self-determination process is an integral part of today's healthcare professionals. Nurses and other allied healthcare staff play an especially important role in helping physicians to better know their patients, and their perception of their death and dying experience.

While the law plays a paramount role in how all healthcare professionals manage terminally-ill patients' wishes, the value of improving communication between all parties cannot be overstated. Improved knowledge of a patient's perspective will only aid healthcare providers in adhering to the law and, at the same, providing the patient with dignity and respect in this final act.

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