Happy new year! I hope all of you have a great start to 2018. I recently attended the Nursing Organizations Alliance (NOA) meeting, where nurse leaders from professional nursing organizations meet to share information and promote professional nursing activities. Key areas of discussion presented at the meeting by the Hospice and Palliative Nurses Association (HPNA) were advanced care planning, palliative care, and end-of-life (EOL) care. Clearly, these are serious and necessary topics for all nurses. Therefore, I wanted to share some information with you regarding these issues.

Having the Conversation

In general, we are living much longer. By 2040, the number of people age 85 or older in the United States is expected to triple – from 6.2 million in 2014 to 14.6 million in 2040 (DiJulio, Hamel, Wu, & Brodie, 2017). As HPNA representatives noted, many healthcare personnel do not have a living will, a medical power of attorney, or an updated document indicating who our proxy for medical care will be in situations where we may be unable to speak for ourselves. The first step is for us to make sure we have these documents for ourselves. Also, we must initiate conversations about dying and expectations with our family members. Although this is not a fun topic, it is an important one! According to a survey of 2,000 Americans, 94% of Americans think it’s important to have such conversations. Yet, only 27% have discussed what they want when it comes to their EOL care (The Conversation Project, 2013). Moreover, 70% of Americans say they prefer to die at home, but 70% die in a hospital, nursing home, or long-term care facility (Public Broadcasting Service, 2010). In a large national survey only 34% of adults had a written document outlining their wishes for EOL and only 4 in 10 (41%) had a written document designating someone to make medical decisions on their behalf (DiJulio et al., 2017). Twenty-three percent of Americans indicated they hadn’t discussed their EOL care wishes because they aren’t sick yet and EOL care was not worrying them. Also, nearly 30 million Americans who hadn’t had a conversation about their EOL care wishes with their loved ones said the discussion hadn’t occurred because they just don’t know how to start talking about it. The reality is people may not know how to express these wishes and medical providers may have failed to ask about them in a comforting and effective way. In addition, we must dispel the notion that EOL decisions are permanent. Preferences about the kind of care desired can change, and often do as people age and their health changes.

There are two simple goals regarding EOL conversations:

- First, people need to have the conversation about EOL care wishes with their families to let their loved ones know what matters most to them well in advance of a medical crisis. They need to have this conversation before a medical crisis occurs: at the kitchen table, not in the intensive care unit or the medical-surgical unit.
- Second, clinicians need to strive to understand what matters most to patients, and then provide care that aligns with their wishes as much as possible.

Free starter kits are available in a variety of languages on The Conversation Project website (theconversationproject.org). The Conversation Project is a national campaign dedicated to helping people talk about their wishes for EOL care, and to transforming our culture by bringing discussions about dying into the open. A perfect example of a problematic end-of-life situation was published recently by a group of physicians (Holt, Sarmento, Kett, & Goodman, 2017). Paramedics brought an unconscious 70-year-old man with a history of several chronic illnesses to the emergency department, where he was found to have an elevated blood alcohol level. His chest had a tattoo that read Do Not Resuscitate, accompanied by his presumed signature. An ethics consultation was requested and it was later decided to honor his tattooed request. In the meantime, the patient was given extensive care to include antibiotics, fluid resuscita-
tion, and vasopressors. The tattoo clearly produced confusion for the staff. I encourage you to read the case. The reality is that medical-surgical nurses are integral to EOL care, and we must become familiar with the literature about this topic and our own feelings about dying.

New HPNA Position Statements

Our colleagues in HPNA also have provided a variety of new position statements to assist us with understanding difficult EOL situations. The statements introduced at the NOA meeting included the following:

- Advance Care Planning
- Physician-Assisted Death/Physician-Assisted Suicide
- Guidelines for the Role of the RN and APRN when Hastened Death Is Requested

HPNA also updated its position statement regarding the Ethics of the Use of Opioids in Palliative Nursing. All of these position statements can be found online (advancingexpertcare.org/position-statements).

As medical-surgical nurses, we care increasingly for older patients with multiple chronic illnesses. We should know their wishes regarding palliative care and EOL care. I encourage you to think about how we can have these conversations with our patients and their families so their wishes can be honored. One of my new year resolutions is to update my advanced directive documents!

REFERENCES


