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EDITORIAL

John Hickner, MD, MSc
Editor-in-Chief

Getting it right at the end of life

Although the concept of the living will was first proposed in 1969,[1] the idea caught on slowly. In fact, the first scholarly article discussing the topic didn't appear until 16 years later.[2]

In contrast, an informal search of PubMed reveals that at least 38 articles on advance directives and end-of-life care have been published during the first 7 months of 2017. And a feature article in this month's issue of *JFP* (see opposite page) makes one more. Why is there such strong interest now in an issue that seldom arose when I began practice in 1978?

More complex, less personalized medicine. As medical care has become more sophisticated, there is a great deal more we can do to keep people alive as they approach the end of life, and a great many more decisions to be made.

Additionally, people are much less likely today to be cared for in their dying days by a family physician who knows them, their wishes, and their family well. In my early years in small-town practice, I was present when my patients were dying, and I usually knew their family members. Family meetings were easy to arrange, and we quickly came to a consensus about what to do and what not to do. If I was not available, one of my practice partners was. We cared for our patients in the office, nursing home, and hospital. Now, most dying hospitalized patients are cared for by hospitalists who may be meeting the patient for the first time.

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Getting more people to participate. Consequently, it is important to understand patients' wishes for end-of-life care and to document those wishes in writing, using things like a POLST (Physician Orders for Life-Sustaining Treatment) form. Although randomized trials support the value of advance care planning, especially in primary care settings,[3,4] two-thirds of Americans have not completed an advance directive.[5] Rolnick suggests we "delegalize" the process to remove barriers and make it easier for people to execute such documents and integrate them into health care systems.[6]

Make it part of your office routine. A 70-year-old patient of mine with advanced COPD arrived at his office visit last month with advance directive and POLST forms in hand. We had an excellent, frank conversation, spiced with humor that he supplied, about his wishes for end-of-life care. Just like so many other tasks that we must squeeze into our busy schedules, this is one that we should hard-wire into our office systems and routines.

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