Questions+Answers

# Making end of life decisions is far from simple

By PATRICIA ANSTETT
FREE PRESS MEDICAL WRITER

Dr. John Popovich Jr. is chairman of the Department of Internal Medicine at Detroit's Henry Ford Hospital.

Dr. John Popovich Jr., has spent more than 30 years talking with patients and their families about the care of critically ill patients.

To understand the discussion, we spoke with Popovich, a pulmonary and critical care physician who also is the chairman of the Department of Internal Medicine at Detroit's Henry Ford Hospital. Here's some of what he said. To read more of the interview, go to **freep.com**.

**QUESTION:** Is it harder now to predict how long people will live and what's best?

**ANSWER:** Unquestionably, yes. Let's take two scenarios. A patient with ALS (Lou Gehrig's disease), a uniformly fatal illness, gets pneumonia that results in lung failure. They, their family, and their physician have a decision about using a ventilator. ... Do they stay on a ventilator for the rest of life or pass, naturally without a ventilator or intensive care support, comfortably at home, without a whole lot of pain and difficulty? Many patients faced with that disease, which my father had, choose not to go on a machine.

When my father went through this, it was extraordinarily difficult to me as an ICU physician seeing your father dying in front of you and knowing you can keep him alive, even for a short period of time. But the choice he had made was to not to be placed on a ventilator, which he viewed as merely prolonging his death. It was what he so clearly decided was best for him, with help of a very good physician, his own physician, to die at home, not in a hospital. I've had many other patients who wanted otherwise, and chose the option of a ventilator. These are the most personal decisions, and there is clearly no right or wrong.

Another example would be a person with congestive heart failure, diabetes, cognitive failure (dementia) and then pneumonia. What medical intervention is in the patient's best interest? If highly expensive care merely forestalls the patient's death by a few days or weeks, have we provided benefit? If you apply those techniques and interventions at the end of life in all patients, costs rise and we have provided limited benefit to the patient. I think society is better served to support health and provide quality of life in the patient's best interest over applying marginally beneficial and intrusive interventions at the end stages of an expected death.

We need to have these very difficult conversations. They are fraught with a lot of difficulties in trying to determine what a patient wants to do as they face inexorable decline. If we could predict better the trajectory of decline in patients it might give us and the patient and/or family a better idea of who is likely to survive an illness or not. This is one area where approaches such as palliative care, with the goal of providing patients with symptom relief and maintaining function and quality of life, as much as possible, rather than other medical care that is not directly achieving those goals.

■ CONTACT PATRICIA ANSTETT: 313-222-5021 OR PANSTETT@FREEPRESS.COM