Resolution: 601
(A-22)

Introduced by: New York

Subject: Development of Resources on End of Life Care

Referred to: Reference Committee F

Whereas, The questions regarding life and death have been debated by scholars, philosophers, religious leaders and doctors for centuries and technology has blurred the distinction between a quality human life and biological life on a cellular or organ basis; and

Whereas, Economic, social and religious views influence modern definitions of human and biological life, making technology in modern medicine a double-edged sword, favoring the betterment of patients and their quality of life and care; and

Whereas, Physicians have been sworn to do no harm, yet this is increasingly challenging with today’s competing forces of technology, shifting social mores and the economics and legislation of health care; and

Whereas, Confronted/ burdened with the more complicated questions of when life begins and ends, physicians have not always been able to transition patients effectively from life to death, which has contributed to decreased use of tools such as palliative care and hospice care; and

Whereas, End-of-life care as defined by the World Health Organization (WHO) “is the term used to describe the support and medical care given during the time surrounding death”; and

Whereas, Palliative Care is the treatment of patients with serious illnesses and disease with the goal to help the patient feel better, prevent or alleviate symptoms and side effects of disease and treatment, treating the whole patient including the emotional, social, practical, and spiritual costs of that illnesses, striving to improve a patient’s quality of life as they deal with serious illness; and

Whereas, Hospice is the treatment of patients at the end of life or with a terminal illness, generally for patients who have less than six months to live and which uses many elements of palliative care to keep patients comfortable during their transition from life to death; and

Whereas, Physicians need to educate themselves on what the treatment goals offer and the reasonableness of the outcome, while all physicians should understand what palliative and hospice care offer a patient in terms of treatment, palliative care is an appropriate bridge to care; and

Whereas, There needs to be more certificate programs for physicians on palliative care until such time as there are enough fellowship trained end of life physicians, education is critical with respect to hospice care which does not mean “no care” but should redefine the scope of care; and
Whereas, Currently, the delivery of end of life care is fragmented with services provided in the hospital, skilled nursing facility or community with each setting having different resources, definitions and protocols and no seamless way to transfer patients from one setting to the next and back again; and

Whereas, The current “one size fits all” approach does little to address the spectrum of end of life issues but reinforces the need for a centralized depository of end of life orders that is easily accessible; therefore be it

RESOLVED, That our American Medical Association develop educational resources for physicians, allied health professionals and patients on end of life care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with all stakeholders to develop proper quality metrics to evaluate and improve palliative and hospice care. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

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