

# Editorial

## Chief Medical Officer Perspective on End-of-Life Issues in a Health System

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baby  
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wouldn't like  
Death if Death  
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when(instead of stopping to think)you  
begin to feel of it,dying  
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cause dying is  
perfectly natural;perfectly  
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it mildly lively(but  
Death  
is strictly  
scientific  
& artificial &  
evil & legal)  
we thank thee  
god  
almighty for dying  
(forgive us,o lifel!the sin of Death

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All of us die. Some of us will die suddenly and without warning. Most of us will go through a process of dying as we approach the end of life. Just as we healthcare professionals struggle to extend and improve life, we also have an obligation to improve the process of dying. How do we help our patients and their loved ones experience a process that is "miraculous... perfectly natural...lively" rather than the "scientific & artificial & evil & legal" experience that often characterizes the modern, healthcare-supervised "Death."

Patients expect the best quality care. At Ochsner, we share their expectations for quality. We also believe

it is important to share quality information with our patients and our community, so they can make informed decisions regarding their care. This approach empowers patients to take a more active role in their care and the care of their loved ones. Access to data on health outcomes and processes permits patients to make choices about where to seek care.

However, information on how a health system performs on critical end-of-life care is not yet well developed. It is certainly not at the same publicly available level as door to balloon times. Yet how we deal with end-of-life care is just as important as how well we prevent hospital-acquired infections.

How to measure quality in end-of-life healthcare is not clear. We all want to have a good death. A good death means that death does not occur before its time. The patient or surrogate is in control of the major decisions along the path. Adequate information is provided in a manner that facilitates decisionmaking. There is strong emotional and spiritual support. Finally, relief from anxiety and pain is available as needed. In 1997, the Institute of Medicine's Committee on Care at the End of Life stated that "people should be able to expect and achieve a decent or good death—one that is free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards."<sup>1</sup>

The committee identified the following factors as important: 1) control of symptoms, 2) preparation for death, 3) opportunity for closure or sense of completion of the life, and 4) good relationships with healthcare professionals.

So how do we measure the quality of end-of-life healthcare? I do not have all the answers, but I do want to share some of the steps Ochsner has taken in this direction in the hope that it will spark a discussion on how we might define high-quality end-of-life care.

- Ochsner has strong palliative care, chaplaincy, and bioethics programs. We have an annual Bioethics Grand Rounds on a key topic for the medical staff and an annual Saturday morning bioethics training program for Bioethics Committee members and

others on the medical, nursing, and social work staff.

- A few years ago we formed a systemwide Bioethics Executive Committee with key members of our central campus Bioethics Committee and the chairs of the Bioethics Committees in all our other hospitals. The committee meets quarterly to review bioethics consults that occur throughout the system. This process permits systemwide feedback about how bioethics consults can improve and functions as a sort of morbidity and mortality conference for our bioethics groups.
- A revised, comprehensive end-of-life policy came out of the Bioethics Executive Committee and was approved by our System Quality Committee. Although much of the document integrates past disparate policies and updates some sections, the policy will provide a systemwide opportunity for discussion as it is submitted to our various hospitals' medical staffs for their consideration and adoption.
- This *Ochsner Journal* devoted to end-of-life issues will begin important conversations about these topics among medical staff, nurses, and committees throughout our system. We hope it will be useful to others outside our system also.
- One of our goals is that the System Quality Committee and our Board's Medical Advisory Committee will consider and adopt specific end-of-life quality measures into our quality dashboard so we can track our progress in this area.

To meet our obligation to our patients, it is time we begin to apply the same relentless drive for improvement that characterizes modern healthcare quality to the process of dying. Then we can assure that dying is "miraculous...perfectly natural...lively."

## REFERENCES

1. Field MJ, Cassel CK, eds. *Approaching Death: Improving Care at the End of Life*. Committee on Care at the End of Life, Division of Health Care Services, Institute of Medicine. Washington, DC: National Academy Press; 1997. [http://www.nap.edu/openbook.php?record\\_id=5801](http://www.nap.edu/openbook.php?record_id=5801). Accessed August 25, 2011.