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Ethical Issues and Spiritual Challenges in End-Of-Life Care

Danijela Vučević,[1] Igor Pantić,[2] Janko Samardžić,[3] Bojan Jorgačević,[1] Jovana Paunović Pantić,[1] Tatjana Radosavljević[1]

[1] Institute of Pathophysiology "Ljubodrag Buba Mihailović," Faculty of Medicine, University of Belgrade, Serbia
[2] Laboratory for Cellular Physiology, Institute of Medical Physiology "Rihard Burian," Faculty of Medicine, University of Belgrade, Serbia. University of Haifa, Israel
[3] Institute of Pharmacology, Clinical Pharmacology and Toxicology, Faculty of Medicine, University of Belgrade, Serbia

Abstract

Clinicians' care of patients at the end of life is guided by the same ethical principles that inform other types of medical care. Providing good care for dying patients requires that physicians and other caregivers be knowledgeable of ethical issues pertinent to end-of-life care. Physicians need to incorporate spiritual issues into the management of patients at the end of life. The caregivers have a moral imperative to assure good care for dying patients. Much progress has been made to address the ethical issues and spiritual events surrounding end-of-life care. However, there is a necessity for further research into both topics.

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ETHICAL ISSUES AND SPIRITUAL CHALLENGES IN END-OF-LIFE CARE

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INTRODUCTION

All humans are mortals and death is an inevitable occurrence.[4] Dying is not primarily a biomedical event.[5] It is an intimate personal experience with profound psychological, interpersonal and spiritual meanings.[6] From the biomedical perspective, the end of life may be defined as that time when death, whether due to terminal illness, or acute or chronic illness, is expected within hours to months and can no longer be

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[1] Institute of Pathophysiology "Ljubodrag Buba Mihailović," Faculty of Medicine, University of Belgrade, Serbia.

[2] Laboratory for Cellular Physiology, Institute of Medical Physiology "Rihard Burian," Faculty of Medicine, University of Belgrade, Serbia. University of Haifa, Israel

[3] Institute of Pharmacology, Clinical Pharmacology and Toxicology, Faculty of Medicine, University of Belgrade, Serbia.

[4] Sameera Karnik and Amar Kanekar, "Ethical issues surrounding end-of-life care: a narrative review,“ *Healthcare (Basel)* 4 (2016): 24 doi:10.3390/healthcare4020024

[5] Michael Rabow, Steven Pantilat, Scott Steiger, and Ramana Naidu, "Palliative care and pain management,“ in *Current Medical Diagnosis and Treatment*, eds. Maxine Papadakis and Stephen McPhee (New York: Mc Graw Hill, 2018), 72-99.

[6] Stephen Scher and Kasia Kozlowska, *Rethinking health care ethics eBook*, doi: 10.1007/981-13-0830-7 (New York: Palgrave Pivot, 2018). Holly Nelson-Becker, Amy Ai, Faith Hopp, Thomas McCormick, Judith Schlueter, and Jessica Camp, "Spirituality and religion in end-of-life care ethics: the challenge of interfaith and cross-generational matters,“ *The British Journal of Social Work* 45 (2015): 104-119. Lindsay Carey and Timothy Hodgson, "Chaplaincy, spiritual care and moral injury: Considerations regarding screening and treatment," *Frontiers in Psychiatry* 9 (2018): doi: 10.3389/fpsut.2018.00619.

reasonably forestalled by medical intervention.[7] Advancements in medical technology are changing the norms of natural death.[8] These technologically advanced treatments have the capability to intervene at the time of death and prolong the lives of people. Biomedical technologies are facilitating to reshape the circumstances around natural death, by sustaining human lives.[9] Although medical treatments have advanced technologically, they hold no promises for recovery.[10] Moreover, they can sustain life with or without meaningful existence, or with secondary support (like feeding tubes, ventilators, etc.).[11] Hence, these medical advancements have empowered patients and their families with the important task of choosing their treatment preference during end-of-life care. In such cases, palliative care may become the sole focus of care, since its main goal is to improve patients' quality of life.[12]

On a global scale, more than 20 million persons are in need of palliative care at the end of life annually.[13] Additionally, 18 million die in unnecessary pain and distress, also impacting the health and well-being of their family members and caretakers.[14] Palliative care, as interdisciplinary care (medicine, nursing, social work, chaplaincy, and other specialties when appropriate) includes management of physical symptoms (pain, dyspnea, nausea, vomiting, constipation and agitation), emotional distress (depression, anxiety and interpersonal strain), and existential distress, such as spiritual crisis.[15] Simultaneously, palliative care supports patients' families and loved ones and helps align patients' care with their preferences and goals. Ideally, this care is initiated at the

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[7] Michael Rabow, et al., "Palliative care and pain management," 72-99.
[8] Ibidem.
[9] Randall Curtis and Jean-Louis Vincent, "Ethics and end-of-life care for adults in the intensive care unit," *Lancet* 376 (2010): 1347-1353.
[10] Sameera Karnik and Amar Kanekar, "Ethical issues surrounding end-of-life care," 24.
[11] Ibidem. Randall Curtis and Jean-Louis Vincent, "Ethics and end-of-life care for adults in the intensive care unit," 1347-1353.
[12] Bidhu Mohanti, "Ethics in palliative care," *Indian Journal Palliative Care* 15 (2009): 89-92.
[13] Amy Kelley and Sean Morrison, "Palliative care for seriously ill," *The New England Journal of Medicine* 373 (2015): 747-755.
[14] Ellen Fink-Samnick, "The evolution of end-of-life care. Ethical implications for case management," *Professional Case Management* 21 (2016): 180-192.
[15] Michael Rabow, et al., "Palliative care and pain management," 72-99. Bidhu Mohanti, "Ethics in palliative care," 89-92. Amy Kelley and Sean Morrison, "Palliative care for seriously ill," 747-755.

time of diagnosis and is provided concordantly with all other disease-directed or curative treatments.[16]

AGING "TSUNAMI" AS A GLOBAL PROBLEM

> My older patients are like rich paintings, and do they have stories to tell. On my best days I can look at them and see all the way back to their childhood. I think of their parents (long gone now), the places they've been, the things they've seen. To me, it's like looking through the other end of telescope, back to the beginning.
>
> David Dosa, geriatrician[17]

Caring for the aging population is one of the most important challenges of the twenty-first century.[18] Media outlets, political figures, books, and television programming frequently elaborate on the difficulties the world will face as the age of the population increases.[19] Studies also indicate that not only are people living to an older age, but they may also have an increased number of quality years, as defined by better cognitive function and self-perceived health at the end of life.[20]

According to the World Health Organization (WHO), 71 years was the average life expectancy of the global population in 2013.[21] However, the average life expectancy in developing countries is as low as 50 years.[22] Most developed countries use the age of 65 years as the cutoff to define

[16] Amy Kelley and Sean Morrison, "Palliative care for seriously ill," 747-755. Michael Rabow, et al., "Palliative care and pain management," 72-99.
[17] David Dosa, *Making Rounds with Oscar: The Extraordinary Gift of an Ordinary Cat* (New York: Hyperion, 2010).
[18] Kristin Oliveira and Linda Maerz, "Epidemiology of critical illness in the elderly," in *Principles of Geriatric Critical Care,* eds. Shamsuddin Akhtar and Stanley Rosenbaum (Cambridge, United Kingdom: Cambridge University Press, 2018), 1-10.
[19] Michael Gusmano and Sara Allin, "Framing the issue of ageing and health care spending in Canada, the United Kingdom and the United States," *Health Economics, Policy and Law* 9 (2014): 313-328.
[20] Kristin Oliveira and Linda Maerz, "Epidemiology of critical illness in the elderly," 1-10. Michael Gusmano and Sara Allin, "Framing the issue of ageing and health care spending in Canada, the United Kingdom and the United States," 313-328.
[21] Kristin Oliveira and Linda Maerz, "Epidemiology of critical illness in the elderly," 1-10.
[22] World Health Organization, *Global health observatory data: life expectancy*, 2013, available at www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en/ (accessed February 13, 2021).

an older person, but in developing countries this definition does not necessarily correlate.[23]

Aging is a chronologic biologic certainty, but it is also subject to the social constructs of cultures.[24] In developed countries, such as the United States, chronologic age plays a paramount role.[25] However, in developing countries, the change in social roles plays a far more important part in defining the elderly.[26] In most developed countries, 60 or 65 years is the age of retirement and is therefore often the cutoff for the definition of old age.[27] In contrast, in developing countries, where retirement is less common, social roles and loss of social station due to physical decline play a far more critical part in dictating the definition of old age.[28] Therefore, in developing countries, old age commences at the stage of life where one is no longer able to contribute to one`s assigned role in society.[29]

According to the UN *World Population Prospects,* in 2015, the world population reached 7.3 billion, an increase of nearly 1 billion over the last 12 years.[30] It is estimated that the world population is growing at an average rate of 1.18 percent per year.[31] Population growth has been particularly high in the least developed countries.[32] Continents with high fertility rates, such as Africa, have had the highest rate of population growth in the last decade (2.5 percent annually).[33]

[23] Kristin Oliveira and Linda Maerz, "Epidemiology of critical illness in the elderly," 1-10.
[24] Ibidem.
[25] Anthony Glascock and Susan Feinman, "A holocultural analysis of old age," *Comparative Social Research* 3 (1980): 311-332.
[26] Anthony Glascock and Susan Feinman, "A holocultural analysis of old age," 311-332.
[27] Kristin Oliveira and Linda Maerz, "Epidemiology of critical illness in the elderly," 1-10.
[28] Ebrahim Shah, "The ageing and development report 1999: poverty, independence and the world`s older people," *British Medical Journal* 321 (2000): 517.
[29] Ibidem.
[30] United Nations Department of Economic and Social Affairs, *World population prospects: the 2015 revision*, 2015, available at http://esa.un.org/unpd/wpp/ (accessed February 13, 2021).
[31] American Statistical Association, *World population likely to surpass 11 billion in 2100: US population projected to grow by 40 percent over next 85 years, 2015*, available at www.sciencedaily.com/releases/2015/08/150810110634.htm (accessed February 13, 2021).
[32] Kristin Oliveira and Linda Maerz, "Epidemiology of critical illness in the elderly," 1-10.
[33] United Nations Department of Economic and Social Affairs, *World population prospects: the 2015 revision*, 2015, available at http://esa.un.org/unpd/wpp/ (accessed February 13, 2021).

Given the increased number of industrialized countries in the world, the population has aged at unprecedented rates. Predictably, over the last ten years, life expectancy has increased globally by 3 years (from 67 to 70 years).[34] The most significant increase in life expectancy occurred in Africa. However, this increase is still significantly lower than the North American life expectancy (60 versus 79 years).[35] As a result of increased life expectancy, the population group older than 60 years of age has had the largest annual growth rate at a global level (3.2 percent per year), nearly three times that of the population as a whole.[36] In 2015, the United Nations reported that globally, there were 901 million people older than 60 years of age, which comprised nearly 12 percent of the world population.[37]

Elderly patients, especially those who are more than 80 years old, are one of the fastest-growing segments of the population.[38] Population demographics are changing, and the proportion of elderly patients who are being treated for critical illness continues to increase rapidly.[39] The United Nations estimates that by 2050, the number of elderly in the world will, for the first time in history, be greater than the number of young individuals.[40] Increasing numbers of elderly patients are undergoing surgical procedures that decades ago would have been considered prohibitively high risk and would not be offered to elderly patients.[41] Thus, many elderly patients require intensive monitoring and postoperative care in critical care units.

[34] United Nations Department of Economic and Social Affairs, *World population prospects: the 2015 revision*, 2015, available at http://esa.un.org/unpd/wpp/ (accessed February 13, 2021). Kristin Oliveira, Linda Maerz, "Epidemiology of critical illness in the elderly," 1-10.
[35] Ibidem.
[36] United Nations Department of Economic and Social Affairs, *World population prospects: the 2015 revision*, 2015, available at http://esa.un.org/unpd/wpp/ (accessed February 13, 2021).
[37] United Nations Department of Economic and Social Affairs, *World population prospects: the 2015 revision*, 2015, available at http://esa.un.org/unpd/wpp/ (accessed February 13, 2021). Kristin Oliveira and Linda Maerz, "Epidemiology of critical illness in the elderly," 1-10.
[38] Shamsuddin Akhtar and Stanley Rosenbaum, "Preface," in *Principles of Geriatric Critical Care*, eds. Shamsuddin Akhtar and Stanley Rosenbaum (Cambridge, United Kingdom: Cambridge University Press, 2018).
[39] Shamsuddin Akhtar and Stanley Rosenbaum, "Preface."
[40] Kristin Oliveira and Linda Maerz, "Epidemiology of critical illness in the elderly," 1-10.
[41] Shamsuddin Akhtar and Stanley Rosenbaum, "Preface."

Geriatric patients develop significant physiologic changes with aging, including an increased incidence of frailty and diminished physiologic reserve.[42] Complicating the care of geriatric patients are concurrent multiple comorbidities and a high rate of polypharmacy.[43] Elderly patients are more likely to develop chronic critical illness and cognitive dysfunction and to consume significant healthcare resources. Recovery from critical illness implies not only physical recovery and survival, but also a successful return to baseline function and quality of life. Unfortunately, many elderly patients are unable to achieve these goals after acute illness.[44]

ETHICAL ISSUES AT THE END OF LIFE

The clinicians' care of patients at the end of life is guided by the same ethical principles that inform other types of medical care.[45] Foremost among these is truthtelling, nonmaleficence (to not harm), beneficence (to do good), autonomy (to respect individuals' rights to make their own decisions), confidentiality (to follow through and to keep promises), and procedural and distributive justice (to treat other fairly). In order to promote patient autonomy, clinicians are obligated to inform patients about risks, benefits, alternatives and expected outcomes of medical interventions, such as cardiopulmonary resuscitation (CPR), mechanical ventilation, hospitalization and treatment in an intensive care unit (ICU), as well as artificial nutrition and hydration.[46]

Physicians are all too often under the public spotlight for the ethical dilemmas they face in end-of-life care.[47] For example, many treatments that promote beneficence and autonomy, such as surgery or bone marrow transplantation, may violate the clinician's obligation for nonmaleficence.[48] Similarly, while patients may express their autonomy

[42] Ibidem.
[43] Sameera Karnik and Amar Kanekar, "Ethical issues surrounding end-of-life care: a narrative review," 24. Michael Rabow, et al., "Palliative care and pain management," 72-99.
[44] Shamsuddin Akhtar and Stanley Rosenbaum, "Preface."
[45] Michael Rabow, et al., "Palliative care and pain management," 72-99.
[46] Michael Rabow, et al., "Palliative care and pain management," 72-99. Randall Curtis and Jean-Louis Vincent, "Ethics and end-of-life care for adults in the intensive care unit," 1347-1353.
[47] Michael Rabow, et al., "Palliative care and pain management," 72-99.
[48] Ibidem.

as a desire for a particular medical intervention, such as CPR in the setting of multisystem organ failure, the clinicians may decline to provide the intervention since it is of no therapeutic benefit and thus violates beneficence and nonmaleficence.[49] On the other hand, because such unilateral actions violate the autonomy of patients, clinicians should rarely resort to do such a thing. However, clinicians must use caution in invoking futility since strict futility is rare and what constitutes futility is often a matter of controversy.[50]

Futility is often raised as a justification for withdrawing and withholding decisions.[51] Treatment that is perceived to be futile is common in the ICU setting.[52] In one study, approximately 20 percent of patients in the ICU were adjudged to have received futile (11 percent), or probably futile (8.6 percent) care.[53]

There is little if any disagreement among ethicists or clinicians that truly futile therapy need not be offered, should not be knowingly undertaken, and is probably actually unethical.[54] Care that fails to meet a patient's goals, or that maintains them in a suspended state of intensive therapy, but the minimal function is not only costly, but also runs counter to professional values in medicine and creates serious moral conflicts for all concerned. Finding consensus regarding exactly what futility is, however has proven problematic.[55]

When a therapy presents a patient with more burdens than benefits, it should trigger a discussion about the goals of therapy.[56] Defining a treatment as futile implies that there are few or no benefits to consider (or that at least the primary goal of the therapy will not be met) and therefore the treatment will result primarily in harms. Offering such

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[49] Michael Rabow, et al., "Palliative care and pain management," 72-99. Randall Curtis and Jean-Louis Vincent, "Ethics and end-of-life care for adults in the intensive care unit," 1347-1353.

[50] Gail Van Norman, "Ethical issues: withdrawing, withholding, and futility," in *Principles of Geriatric Critical Care*, eds. Shamsuddin Akhtar and Stanley Rosenbaum (Cambridge, United Kingdom: Cambridge University Press, 2018), 200-209.

[51] Gail Van Norman, "Ethical issues: withdrawing, withholding, and futility," 200-209.

[52] Ibidem.

[53] Thanh Huynh, Eric Kleerup, Joshua Wiley, Terrance Savitsky, Diana Guse, Bryan Garber, and Neil Wenger, "The frequency and cost of treatment perceived to be futile in critical care," *JAMA Internal Medicine* 173 (2013): 1887-1894.

[54] Gail Van Norman, "Ethical issues: withdrawing, withholding, and futility," 200-209.

[55] Ibidem.

[56] Ibidem.

treatment would be unethical because it would violate principles of beneficence and nonmaleficence, both of which are pillar concepts in Western medical ethics. Intentionally providing futile therapy furthermore threatens the value of veracity in medical practice.[57] Moreover, offering or pursuing futile treatment encourages false hopes.[58] Besides, the concept of futility may have limited usefulness at the bedside, but is a critical concept in understanding the perspectives of multiples parties in withdraw or withhold decisions.[59]

The ICU presents daily opportunities for ethical dilemmas and discussions. Issues run the gamut from competency and informed consent to surrogate decision making, futility, withdrawing and withholding of life-sustaining treatments (LSTs) and vital organ donation.[60]

Withholding an LST refers to a decision to not start or escalate an intervention, and withdrawing an LST refers to discontinuing therapy that has already begun.[61] In the ICU, the withdrawal and withholding of decisions concern a wide spectrum of interventions, e.g., artificial hydration and nutrition, ventilator therapy, CPR, and pacemaker or implantable cardioverter-defibrillator therapies.[62] Regardless of the therapy involved, ethical considerations underlying a withdrawing or withholding of a decision stand on similar moral reasoning. Despite long-standing consensus, there is still considerable disquiet among clinicians about whether ethically relevant differences exist between withholding and withdrawing decisions.[63]

In the late twentieth century, about half of ICU deaths occurred after withholding or withdrawing LSTs.[64] Such decisions have increased over

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[57] Stephen Scher and Kasia Kozlowska, *Rethinking health care ethics*.

[58] Sameera Karnik and Amar Kanekar, "Ethical issues surrounding end-of-life care: a narrative review."

[59] Gail Van Norman, "Ethical issues: withdrawing, withholding, and futility," 200-209.

[60] Ibidem.

[61] Ibidem.

[62] Randall Curtis and Jean-Louis Vincent, "Ethics and end-of-life care for adults in the intensive care unit," 1347-1353.

[63] Randall Curtis and Jean-Louis Vincent, "Ethics and end-of-life care for adults in the intensive care unit," 1347-1353. Gail Van Norman, "Ethical issues: withdrawing, withholding, and futility," 200-209.

[64] Thomas Prendergast, Michael Claessens, and John Luce, "A national survey of end-of-life care for critically ill patients," *American Journal of Respiratory and Critical Care Medicine* 158 (1998): 1163-1167.

time, and now precede death for 70 to 93 percent of patients dying in ICUs worldwide.[65] Studies indicate that a growing number of elderly patients across multiple cultures prefer not to have prolonged LSTs.[66] Older age is a significant factor for withdraw and withhold decisions by physicians and patients.[67]

In most Western countries, ethicists favour the view that doing and allowing are not sufficient, and may even be immaterial, in identifying morally relevant differences of withholding and withdrawing treatments.[68] The morally relevant features of withdrawing or withholding are the motives and intentions of reducing patient suffering and/or other burdens at the end of life and of respect for patient autonomy. Since these motives are the same with both decisions, there is widespread agreement that, in most cases, withdrawing and withholding are morally equivalent.[69] This position has been supported by numerous professional and international organizations (Table 1).[70]

Table 1. Some medical societies confirming ethical equivalency of withdrawing/withholding treatment decisions

American Medical Association
American College of Physicians
American College of Chest Physicians
American College of Critical Care Medicine
American Thoracic Society
The Australian and New Zeland Intensive Care Society
College of Intensive Care Medicine of Australia and New Zeland
Austrian Association of Intensive Care Medicine
Belgian Society of Intensive Care Medicine
Canadian Critical Care Society
The Duch Intensive Care Society
French Society of Intensive Care
The UK General Medical Council

[65] Gail Van Norman, "Ethical issues: withdrawing, withholding, and futility," 200-209.

[66] Elie Azoulay, Barbara Metnitz, Charles Sprung, Jean-François Timsit, François Lemaire, Peter Bauer, Benoît Schlemmer, Rui Moreno, Philipp Metnitz, and SAPS 3 investigators, "End-of-life practices in 282 intensive care units: data from the SAPS 3 database," *Intensive Care Medicine* 35 (2009): 623-630.

[67] Gail Van Norman, "Ethical issues: withdrawing, withholding, and futility," 200-9.

[68] Ibidem.

[69] Ibidem.

[70] Ibidem.

The ethical principle of "double effect" argues that the potential to hasten imminent death is acceptable if it comes as the known but unintended consequence of a primary intention to provide comfort and relieve suffering.[71] For example, it is acceptable to provide high doses of opioids if needed to control pain, even if there is the known and unintended effect of depressing respiration.[72]

Studies confirm that most disagreements between patients, families and clinicians can be resolved with good communication.[73] Additionally, open communication and respectful discourse between the physician and patient or their surrogates are prerequisites for resolving differences in values and finding an appropriate therapeutic pathway.[74]

Working with the dying requires tolerance of uncertainty, ambiguity, and existential challenges.[75] Clinicians must recognize and respect their own limitations and attend to their own needs in order to avoid being overburdened, overly distressed, or emotionally depleted.[76] Generally

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[71] Michael Rabow, et at., "Palliative care and pain management," 72-99.

[72] Amy Kelley and Sean Morrison, "Palliative care for seriously ill," 747-755.

[73] Michael Rabow, et at., "Palliative care and pain management," 72-99.

[74] Gail Van Norman, "Ethical issues: withdrawing, withholding, and futility," 200-209.

[75] Sameera Karnik and Amar Kanekar, "Ethical issues surrounding end-of-life care: a narrative review," 24. Michael Rabow, et al., "Palliative care and pain management," 72-99.

[76] Michael Kearney, Radhule Weininger, Mary Vachon, Richard Harrison, and Balfour Mount, "Self-care of physicians caring for patients at the end of life," *The Journal of the American Medical Association* 301 (2009): 1155-1164. Madhav Goyal, Sonal Singh, Erica Sibinga, Neda Gould, Anastasia Rowland-Seymour, Ritu Sharma, Zackary Berger, Dana Sleicher, David Maron, Hasan Shihab, Padmini Ranasinghe, Shauna Linn, Shonali Saha, Eric Bass, and Jennifer Haythornthwaite, "Meditation programs for psychological stress and well-being," *JAMA Internal Medicine* 174 (2014): 357-368. Jennifer Wolff, Brenda Spillman, Vicki Freedman, and Judith Kasper, "A national profile of family and unpaid caregivers who assist older adults with health care activities," *JAMA Internal Medicine* 176 (2016): 372-379. Shannon Carson, Christopher Cox, Sylvan Wallenstein, Laura Hanson, Marion Danis, James Tulsky, Emily Chai, and Judith Nelson, "Effect of palliative care–led meetings for families of patients with chronic critical illness: a randomized clinical trial," *The Journal of the American Medical Association* 316 (2016): 51-62. Arif Kamal, Janet Bull, Steven Wolf, Keith Sweitz, Tait Shanafelt, Katherine Ast, Dio Kavalieratos, Christian Sinclair, and Amy Abernethy, "Prevalence and predictors of burnout among hospice and palliative care clinicians in the U.S," *Journal of Pain and Symptom Management* 51 (2016): 690-696. Dio Kavalieratos, Jennifer Corbelli, Di Zhang, Nicholas Dionne-Odom, Natalie Ernecoff, Janel Hanmer, Zachariah Hoydich, Dara Ikejiani, Michele Klein-Fedyshin, Camilla Zimmermann, Sally Morton, Robert Arnold, Lucas Heller, and Yael Schenker, "Association between palliative care and patient and caregiver outcomes.

speaking, clinicians must become proficient at delivering serious news and then dealing with its consequences (Table 2).[77]

Table 2. Suggestions for the delivery of serious news

Prepare an appropriate place and time.
Address basic information needs.
Be direct; avoid jargon and euphemisms.
Allow for silence and emotional ventilation.
Assess and validate patient reactions.
Respond to immediate discomforts and risks.
Listen actively and express empathy.
Achieve a common perception of the problem.
Reassure about pain relief.
Ensure follow-up and make specific plans for the future.

In this context, geriatrician David Dosa said: "In medical school, they used to teach you to be detached but empathetic when giving bad news. Listen and support but don't get involved. Easier said than done … But her eyes said something else. She knew there was a problem. People usually do… A doctor's office should feel like a safe place, an arena in which you can bring out your demons or your angels, your deepest fears and most intimate secrets…"[78]

The promise of non-abandonment is the central principle of end-of-life care and is a clinician's pledge to serve a caring partner, a resource for creative problem solving and relief of suffering, a guide during uncertain times, and a witness to the patient's experiences, no matter what happens.[79]

SPIRITUAL CONSIDERATIONS

Spirituality is the attempt to understand or accept the underlying meaning of life, one's relationships to oneself and other people, one's place in the universe, one's legacy, and the possibility of a "higher power" in the

A systematic review and meta-analysis," *The Journal of the American Medical Association* 316 (2016): 2104-2114.

[77] Michael Rabow, et al., "Palliative care and pain management," 72-99.

[78] David Dosa, *Making Rounds with Oscar: The Extraordinary Gift of an Ordinary Cat.*

[79] Michael Rabow, et al., "Palliative care and pain management," 72-99.

universe.[80] It may be distinguished from particular religious practices or beliefs.[81]

The end of life offers an opportunity for psychological, interpersonal and spiritual development.[82] Clinicians can inquire about a patient's spiritual concerns, and ask whether the patient wishes to discuss them.[83] Questions that might constitute an existential "review of systems" are presented in Table 3.[84]

Table 3. An existential review of systems

Intrapersonal
1. What does your illness/dying mean to you? 2. What do you think caused your illness? 3. How have you been healed in the past? 4. What do you think is needed for you to be healed now? 5. What is right with you now? 6. What do you hope for? 7. Are you at peace?
Interpersonal
1. Who is important to you? 2. To whom does your illness/dying matter? 3. Do you have any unfinished business with significant others?
Transpersonal
1. What is your source of strength, help, or hope? 2. Do you have spiritual concerns or a spiritual practice? 3. How does your spirituality relate to your illness/dying, and

[80] Tracy Balboni, George Fitchett, George Handzo, Kimberly Johnson, Harold Koenig, Kenneth Pargament, Christina Puchalski, Shane Sinclair, Elizabeth Taylor, and Karen Steinhauser, "State of the science of spirituality and palliative care. Research part II: screening, assessment and interventions," *Journal of Pain and Symptom Management* 54 (2017): 441-453. David Drummond and Lindsay Carey, "Assessing spiritual well-being in residential aged care: An exploratory review," *Journal of Religion and Health* 58 (2019): 372-390. Lindsay Carey and Timothy Hodgson, "Chaplaincy, spiritual care and moral injury: Considerations regarding screening and treatment," *Frontiers in Psychiatry* 9 (2018): doi:10.3389/fpsut.2018.00619. Kalli Stilos, Bill Ford, Tammy Lilien, and Jennifer Moore, "The role of spiritual care with the introduction of an end of life order set," *The Journal of Pastoral Care & Counseling* 73 (2019): 41-48.

[81] David Drummond and Lindsay Carey, "Assessing spiritual well-being in residential aged care: An exploratory review," 372-390.

[82] Ibidem.

[83] Ibidem.

[84] Michael Rabow, et al., "Palliative care and pain management," 72-99.

how can I help integrate your spirituality into your health care?
4. What do you think happens after we die?
5. What purpose might your illness/dying serve?
6. What do you think is trying to happen here?

Individuals may grow, even achieve a heightened sense of well-being or transcendence, in the process of dying.[85] Through listening, support and presence, clinicians may help foster this learning and be a catalyst for this transformation.[86]

Predictions concerning the end of life are particularly difficult and may lead to excessive or insufficient medical interventions.[87] Thus, geriatrician David Dosa described one case of death prediction from his practice: "There was the elderly woman who announced to me on 31 December 1999, that she had accomplished her objective of living to turn of the century. – *I am going to die today, Doctor*, – she told me quite casually. Every test showed she had nothing wrong… She simply came to the hospital because she was ready to die. As she foretold, she did die several hours later of unknown cases. Maybe some people just know when their time has come. Some cats, too."[88]

Oscar is a therapy cat living in the Steere House Nursing and Rehabilitation Center in Providence, Rhode Island, in the United States since 2005 (Fig. 1).[89]

He earned his fame through a publication in the New England Journal of Medicine in 2007.[90] Oscar was noted to make his own ward rounds in the nursing home, sniffing and observing patients.[91] Indifferent to most, he would then decide to curl up on the bed of only certain patients. The patients he identified would invariably die within a few hours. The cat was so precise in his assessment of impending death

[85] David Drummond and Lindsay Carey, "Assessing spiritual well-being in residential aged care: An exploratory review," 372-390.
[86] Michael Rabow, et al., "Palliative care and pain management," 72-99.
[87] Piotr Szawarski, "Classic cases revisited: Oscar the cat and predicting death," *Journal of the Intensive Care Society* 17 (2016): 341-345.
[88] David Dosa, *Making Rounds with Oscar: The Extraordinary Gift of an Ordinary Cat*.
[89] Wikipedia, *Oscar (therapy cat)*, available at http://en.wikipedia.org/wiki/Oscar_(therapy_cat) (accessed February 13, 2021).
[90] David Dosa, "A day in the life of Oscar the cat," *The New England Journal of Medicine* 357 (2007): 328-329.
[91] Piotr Szawarski, "Classic cases revisited: Oscar the cat and predicting death," 341-345. David Dosa, "A day in the life of Oscar the cat," 328-329.

that the staff developed a protocol that required that patient's family to be called in, in anticipation of death.[92] We read: "His mere presence at the bedside is viewed by physicians and nursing home staff as an absolute indicator of impending death."[93]

Fig. 1. Oscar (therapy cat)[94]

David Dosa later published a touching book about dementia – "Making Rounds with Oscar: The Extraordinary Gift of an Ordinary Cat."[95] Dr. Dosa reported about his first encounter with this famous therapy cat: "Making his way back up the hallway, Oscar arrives at Room 313. The door is open, and he proceeds inside. Mrs. K. is resting peacefully in her bed, her breathing steady but shallow. She is surrounded by photographs of her grandchildren and one from her wedding day. Despite these keepsakes, she is alone. Oscar jumps onto her bed and again sniffs the air. He pauses to consider the situation and then turns around twice before curling up beside Mrs. K. One hour passes. Oscar waits. A nurse walks into the room to check on her patient. She pauses to note Oscar's presence. Concerned, she hurriedly leaves the room and returns to her desk. She grabs Mrs. K.'s chart off the medical-records rack and begins to make phone calls. Within a half hour the family starts to arrive. Chairs are brought into the room, where the relatives begin their vigil. The priest is called to deliver last rites. And still, Oscar has not

[92] Ibidem.
[93] David Dosa, "A day in the life of Oscar the cat," 328-329.
[94] Wikipedia, *Oscar (therapy cat)*, available at http://en.wikipedia.org/wiki/Oscar_(thera py_cat) (accessed February 13, 2021).
[95] Piotr Szawarski, "Classic cases revisited," 341-345.

budged, instead it is purring and gently nuzzling Mrs. K. A young grandson asks his mother, ~What is the cat doing here?~ The mother, fighting back tears, tells him, ~He is here to help Grandma get to heaven.~ Thirty minutes later, Mrs. K. takes her last earthly breath. With this, Oscar sits up, looks around, then departs the room so quietly that the grieving family barely notices."[96]

While the reliability on the cat may seem strange in modern health care settings, the family of a patient that died with Oscar at the bedside reported: "It is not that we trusted the cat more than the nurse. Not, exactly. It was... well, there was just something about Oscar. He seemed so convinced of what he was doing. He was so clear in his intention and his dedication. This underscored the importance of the prediction of death and the acknowledgement of the dying process."[97] As of 2015, it is believed that Oscar has accurately predicted 100 deaths.[98] There is no solid scientific explanation for Oscar's behaviour. Hypotheses for this ability include that Oscar is picking up on the lack of movement in such patients, or that he can smell biochemicals released by dying cells.[99]

The simple example of a cat lying lovingly at a dying person's side calls health care practitioners back to the sacred role of being a compassionate presence.[100]

CONCLUSION

Much progress has been made to address the ethical issues and spiritual events surrounding end-of-life care. However, there is a necessity for further research into both topics, keeping in mind that "the experience of decision making can be a tremendous emotional burden likened to an arduous, unwelcome journey over unfamiliar territory filled with unrecognisable landmarks."

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[96] David Dosa, "A day in the life of Oscar the cat," 328-329.

[97] David Dosa, *Making Rounds with Oscar: The Extraordinary Gift of an Ordinary Cat*.

[98] Wikipedia, *Oscar (therapy cat)*, available at http://en.wikipedia.org/wiki/Oscar_(therapy_cat) (accessed February 13, 2021).

[99] Ibidem.

[100] James Marroquin, "Book review-Making Rounds with Oscar: The Extraordinary Gift of an Ordinary Cat by David Dosa," *Proceedings (Baylor University Medical Center)* 26 (2013): 200-201.

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