Religious Patients Seek More Aggressive End of Life Care

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As a person of faith and an advocate of hospice care, I read with interest and was somewhat surprised by the findings of a recent article published in JAMA (JAMA, 2009; 301(11):1140-11:47). The study found that those with positive religious coping sought out intensive life-prolonging medical care near death. "Positive religious coping" was characterized as "a constructive reliance on faith to promote health adaption". "Intensive life-prolonging care" was defined as "receipt of mechanical ventilation or resuscitation in the last week of life." This is painful just to think about.

There was speculation as to why these patients wanted such aggressive care at the very end of their lives. In a subsequent article about the study entitled "Finding Religion at the End of Life: Patients of Faith Seek Lifesaving Care", by Joseph Brownstein of ABC News, Paul Simmons, an adjunct professor of philosophy at the University of Louisville, noted that "there tends to be a divide among religious people when it comes to end of life. I know of many religious people who would say 'no, my faith says death is a transition, it's not an absolute evil', while he said those who choose aggressive care say "I have different beliefs: Death is an absolute evil; people cannot choose death over life at any cost." Other patients reportedly sense a religious purpose in the concept of suffering like Jesus. One of the researchers in the study, Dr. Holly Prigerson, was quoted in the ABC News article as saying that "It seems like those patients. . .they would hold on as long as possible to give God every opportunity to save them."

The study raised many questions for me. It does not state how mature in their faith these patients were or how long they had been religious. Were they newly religious? I also wondered about the median age of these patients—I could see a young parent seeking aggressive treatment more quickly than an elderly person who had lived a full life. Are the religious more afraid of death and a final judgment day than their non-religious counterparts?

Also, I question whether those who did seek the intensive life-prolonging care were really "allowing God every opportunity to save them." God works in His own time. We don't patronize Him by giving Him more time—it is just the reverse. He has our days numbered. Perhaps these were positive, hopeful, everyday people of faith who just wanted a little more time to enjoy the friends and families God had blessed them with here on earth.

The conclusion of the study is that more research is needed to determine the mechanisms for the association between positive religious coping and the associated receipt of intensive life-prolonging medical care near death. Dr. Prigerson also noted that "We find that those who get more aggressive care have decrements in their quality of life."

The decision to choose end of life care is completely unique to each person. For those who do choose hospice care, it can be difficult for their families to get on board. Often the patient may be at peace with his or her decision but the family may not, and therefore the family members may continue to call 911 or rush the patient to the ER for resuscitation. This just results in more anguish for everyone involved, including the hospice caregivers.

While hospices are required to inform a patient of his or her right to execute advance directives, it is also illegal to require a patient to do so. Moreover, families (and caregivers) do not always honor the directives a patient has given.

The ABC News article suggests that patients need to inform their physicians "in a nice way" of their faith-based beliefs, and that churches can also educate their members about end of life choices. (Why does faith need to be tip-toed around outside the church setting?)

Religious faith and hospice care can co-exist and complement each other. This study underscores the need for better education, including among those with strong religious beliefs, regarding hospice and palliative care. Those with positive religious coping were found to be younger, less educated, and less likely to be insured than those with a low level of positive religious coping.

Moreover, attending physicians need to be better educated about hospice and palliative care choices available to their patients, so that they may likewise educate the patient and his or her family about their options. Houses of worship can also aid in this education. Once hospice care is chosen, the patient has the right to choose a spiritual counselor to help guide the patient/family through the dying and bereavement process.

I find it tragic that so many people of faith apparently request--and receive--painful, futile, aggressive care at the end of their lives. They could instead be enjoying a better quality of life in their final days with their loved ones in a relatively comfortable symptom-controlled condition at home or in a peaceful hospice residence rather than in an ER or ICU. They could choose to receive better quality of care in their final days of life here on earth and ultimately in their death. And making the choice to do so will not affect their final eternal destination.