
To the Editor:

As a former family physician with a keen interest in respiratory disease, and as a present full-time palliative care physician with an interest in end-of-life care, I was very interested in your editorial comment on Dr Rocker et al’s paper on end-of-life care for chronic obstructive pulmonary disease (COPD) patients published in the July/August 2008 edition of the Canadian Respiratory Journal. Toward the end of your editorial, you queried the relevance of a palliative care approach to patients with advanced COPD, quite rightly contrasting it with the more predictable course of cancer. Cancer follows a fairly well-defined trajectory, whereas COPD patients, similar to end-stage heart failure patients, have cycles of exacerbation and comparative remission that may continue for an unpredictable length of time until the patient’s death (1).

However, palliative care is not only about care at the end of life, but also about preparing someone for a possible end-of-life scenario. With a disease that has such an unpredictable course, one problem is when to introduce such discussions. It is the experience of many physicians that when someone dies as a result of an exacerbation of COPD, their family and friends are often very surprised and view the death as unexpected; but, in fact, it was not surprising to the patient’s health care attendants, but no discussions had been held with the patient or the family (2).

The challenge thus becomes when to introduce discussion with the patient about where the disease is going and what is likely to happen. Different studies have shown that patients with COPD vary in their willingness to discuss such matters, but this may be due to the timing of the discussion (3).

A useful guide that is recommended in this situation is for the attending physician to ask him- or herself whether he or she would be surprised if the patient under consideration died within the next year due to their COPD (4). If the answer is that one would not be surprised, then this would be an indication to offer discussion about the disease prognosis and preparation for the likely course of the disease. The patient may decline the offer, but now is aware that the physician is ready to discuss the topic when he or she is ready.

This approach may mean that palliative care is taking place in parallel with active medical treatment. The patient can still be as aggressively treated as he or she wishes, and medical management can still be maximized. However, symptom management, for example with opioids, can take place at the same time, along with psychosocial, emotional and spiritual support as necessary. For a more complete description of the approach that I would recommend for end-of-life care for COPD patients, I refer you to my article published earlier this year (5).

Yours sincerely,

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REFERENCES