



**MINISTERIAL STATEMENT
TO THE HOUSE OF ASSEMBLY
BY THE HONOURABLE KIM N. WILSON, JP, MP
MINISTER OF HEALTH
CONVERSATIONS ABOUT END OF LIFE CARE
10th November 2017**

Mr Speaker and Honourable Members,

Today I rise today to address this Honourable House about an issue that will affect every single one of us: mortality and end of life care.

Although this is a sensitive and difficult topic for many of us, I have brought the matter here precisely because this is a conversation we all need to have. Talking about what we want for our end of life care is more important to Bermuda today than ever, and I want to applaud those working in our community to help us have these conversations so we can change things to

make sure everyone has the opportunity for humane and compassionate care.

Mr Speaker This topic took centre stage with Atul Gwande's highly acclaimed book, "Being Mortal: Medicine and what happens in the end". It is an amazing read that has triggered many to ask how "we can better live with age-related frailty, serious illness and approaching death". This is a question we have to resolve as individuals, families and as a health system. I mention this book now as I will quote from it throughout my statement. Indeed, "Being Mortal" is redefining this conversation globally.

Mr Speaker, why is end of life care such an important conversation? This conversation is vital to ensure our last days are comfortable, meaningful and affordable. This means ensuring our individual care wishes are known and respected; decreasing the stress, anxiety and infighting that can occur when loved ones have to make decisions on our behalf and they don't know what you want; and preventing the use of often quite invasive and costly medical interventions that do not improve the quality of our last days although they may increase the quantity.

It is this discrepancy between quality and quantity in our healthcare system, especially around end of life care that we must question and address.

Now, **Mr Speaker**, we can and must acknowledge the successes of our healthcare system and medical knowledge that it is founded on. For example, in Bermuda we have a life expectancy of 81 years which has increased by 15 years since the 1970s. This is a great achievement, but there are consequences to it.

Greater longevity means, for example, that we now require care for longer periods of time, and that we are more likely to have decreased quality of life during our final years. As Atul Gwande states, medical professionals are taught “how to save lives, not to tend to their demise”. Accordingly, the default response in healthcare is for aggressive intervention unless the patient, or their responsible person, states otherwise. The question we must ask ourselves is this: are such interventions wanted by the individual in question?

CPR is a great example of an intervention where we must better understand the benefits and costs. Unfortunately most of our understanding is based on TV which inaccurately portrays both the process and outcomes. In reality, CPR can result in broken ribs at best or a punctured lung at worst; and the average success rate in hospital is 15%, that's right 15%. The success rate drops lower as you hit age 70; and for the chronically ill elderly it is between 0-5%. Also of importance to know is that at least 44% of survivors have a significant decline in functional status. Therefore if we want to ensure quality of life rather than just quantity for our end of life care, it means we must question our assumptions that all forms of medical interventions at certain stages are desirable and beneficial.

To challenge these assumptions requires open and honest dialogue with ourselves and our doctors. We must understand what our options are, the impact of our choices, and ensure those responsible for our care know what we want.

Now **Mr Speaker**, this is easier said than done. In the US, "The Conversation Project", a non-profit agency, found that 90% of people surveyed said this is one of the most important

conversations to have; but only 27% have actually had it. We have a lot of fear and discomfort with talking about death. However not talking about it doesn't prevent it. A wonderful example on the overall beneficial outcomes of these conversations is seen by the following example from Being Mortal, which reads:

“Two-thirds of the terminal cancer patients in the Coping with Cancer study reported having had no discussion with their doctors about their goals for end-of-life care, despite being, on average, just four months from death. But the third who did have discussions were far less likely to undergo cardiopulmonary resuscitation or be put on a ventilator or end up in an intensive care unit. Most of them enrolled in hospice. They suffered less, were physically more capable, and were better able, for a longer period, to interact with others. In addition, six months after these patients died, their family members were markedly less likely to experience persistent major depression. In other words, people who had substantive discussions with their doctor about their end-of-life preferences were far

more likely to die at peace and in control of their situation and to spare their family anguish.”

We in the Ministry of Health, **Mr Speaker**, want to support these conversations and also the opportunities available for people for their end of life care. The recent inclusion of the palliative home care benefit under the standard health benefit is one step in this direction, as well as the personal home care benefit offered through HIP and FutureCare. These benefits ultimately help people remain in their homes as long as possible for their end of life care; and to be cared for in a less medicalized and more humane manner. However accessing these benefits requires you to consider what you want for end of life care, and community organizations are taking a lead in encouraging these conversations.

Mr Speaker I was extremely pleased to see that Friends of Hospice hosted multiple events during October to raise awareness on the option of palliative care. In addition they have had two events this year focusing specifically on the importance of end of life conversations and tips on how to have them. This work from the community is vital to begin to shift the understanding,

expectations and culture around death and end of life care. As are the education programs for healthcare professionals initially funded jointly by BHB, Friends of Hospice and PALS which trained three BHB physicians to provide training to doctors and other healthcare professionals in having Difficult Conversations with patients.

Mr Speaker, we encourage everyone to take a look at Ageing and Disability Services' Resource page on gov.bm with links to the starter kits from the Conversation Project used by Friends of Hospice to help people have these conversations. We also encourage people to get involved in these discussions with their loved ones and their doctors. It is never too soon to start.

For the most part, every one of us can easily articulate and express what we want in order to have a good life. **Mr Speaker**, It is as now vital that we learn to articulate and express what we want in order to have a good 'end'.

Thank you **Mr Speaker**