June 22, 2015

End-of-life care for those on skid row

To the Editor:

I have been a physician in homeless shelters for over 30 years, and back in the day I was the medical director at numerous alcohol and drug rehab units. In addition, I have served as a hospice medical director. I am the type of clinician who never gives up on a patient and have used the skills I’ve learned in the field of substance abuse to treat the homeless and, yes, also hospice care patients.

Unfortunately, we treat the end of life caused by addiction to tobacco differently than we treat the end of life caused by the addiction to alcohol or recreational drugs.

In the case of tobacco addiction, even if the patient has end-stage COPD or end-stage lung cancer, we often tolerate smoking and permit our patients to smoke until they die. We don’t like it as clinicians, but we tolerate it and permit the smoking to continue.

Over the years, I have seen the worst of the worst of the worst addicts who live in urban skid rows return over and over again to their “best friend” — unfortunately, they often see drugs and alcohol as their best friend. No matter what they try, these patients cannot preserve their sobriety.

I don’t ever turn my back on anyone, instead offering people multiple ways to help break their addictions. But some patients just can’t — or won’t — preserve their sobriety. This is similar to the COPD or lung cancer patient who continues to smoke until death. I propose to you that the field of palliative care should treat end-stage drug- or alcohol-addicted patients with the same mindset they treat end-stage cancer patients and end-stage COPD patients.

“Addiction is not our field,” you might say. But all human conditions intersect in the field of palliative care.

I honestly don’t know where these patients might best receive palliative care, be it government dorms or shelters run by a third party. But consider what it would be like if the field of palliative care explored the end-of-life suffering of those on skid row. With end-of-life care, some patients may thrive, some may stabilize, and some may even survive. But isn’t that the case with all diagnoses? Does the field of palliative care wish to cross the Rubicon to include the end stages of addiction and end-of-life care of these very ill and unstable individuals?

Imagine what it would be like to expand the definition of palliative care beyond, “Yes, sure — if they meet certain criteria,” to “Yes, these people are suffering and dying. Palliative care will step up and care for this patient population.”
Do we have the courage to define this need within the field of palliative care?

Sincerely,

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