Physicians have limited time to complete training on End of Life (EOL) care. While many resources exist to help patients understand end of life care and to initiate conversations about end of life, very few organized and succinct resources on this topic exist for physicians. Using a variety of resources, we developed a toolkit for physicians.

The toolkit includes modules on:
- Hospice vs Palliative care
- Initiating the end of life conversation
- The role of a health care proxy
- Patient misconceptions about hospice
- Discussing end of life care.

In 2010, the total number of deceased individuals in Massachusetts was 52,420, representing a daily all cause mortality of 144.

Seventy-eight percent (40,950) of deaths in Massachusetts occurred among individuals sixty-five years and older. Cancer was the most common cause of mortality (12,973, 25%), followed by heart disease (11,996, 23%) and then stroke (2,505, 5%) across all ages.

Important forms exist that patients need to complete to give legally or medically binding advance care directives; in Massachusetts, health care proxies are legally assigned, Medical Orders for Life Sustaining Treatment (MOLST) are medical orders, and living wills are not legal documents.

End of life (EOL) care is medical care for those with a terminal illness or condition that has become advanced, progressive and incurable.

Table 1. Top Ten Leading Underlying Causes of Death by Age, Massachusetts 2010

<table>
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<th>Age Group</th>
<th>Most Common Causes of Death</th>
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| 0-1 year  | Cancer (25%)
| 2-14 years| Congenital malformation (25%)
| 15-64 years| Congenital malformation (25%), Heart disease (23%)
| 65-74 years| Cancer (28%), Congenital malformation (23%)
| 75-84 years| Cancer (31%), Congenital malformation (24%)
| 85-94 years| Cancer (35%), Congenital malformation (25%)
| 95 years+  | Cancer (38%), Congenital malformation (26%)

In 2010, 29% of deaths occurred at home, 13% at a nursing home, 39% at a hospital, and 13% were home deaths. By contrast, 73-75% of patients surveyed want to die at home. This highlights a disconnect between patients' known preferences and the state of end of life care.

- Initial reception of the educational module was positive.
- Copies of the module are being produced for use at future events within the school.
- Discussions are ongoing regarding wider distribution of the module.
- This module and other programs like it are critical to training competent and humanistic health care providers.
- Providing accurate information about patients’ perspectives on death and dying, including preferences for communication and concerns about the dying process, will empower practitioners to have these discussions.
- Opening this dialogue will impact the well being of individuals with life-limiting illnesses and can affect the physical, emotional and spiritual health of caregivers.

- Important forms exist that patients need to complete to give legally or medically binding advance care directives; in Massachusetts, health care proxies are legally assigned, Medical Orders for Life Sustaining Treatment (MOLST) are medical orders, and living wills are not legal documents.
- Differences between standard of care, palliative care and hospice care will likely need to be explained to patients.
- Cultural competence/humility is important in addressing end of life in a culturally diverse population; community health workers can facilitate the interaction.
- Currently, there are racial disparities in end of life care.

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- Many thanks also to the Central Massachusetts Area Health Education Center.
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- Other Lessons
  - Important forms exist that patients need to complete to give legally or medically binding advance care directives; in Massachusetts, health care proxies are legally assigned, Medical Orders for Life Sustaining Treatment (MOLST) are medical orders, and living wills are not legal documents.
  - Differences between standard of care, palliative care and hospice care will likely need to be explained to patients.
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