

## **An Interview with Dr. John Goodill**

by Elizabeth Healy, MPH

John J. Goodill, MD, is the Director of Palliative Care Education and Outreach at Christiana Care Health System. Appointed in 2005, Dr. Goodill participates on an interdisciplinary team that provides consultations for hospital patients who are in the advanced stages of diseases such as cancer, renal failure, heart failure, and dementia. His team also works with patients who have chronic critical illnesses or failure of several organ systems. Additionally, Dr. Goodill is Co-Chair of Christiana Care's Ethics Committee. He concurrently works for the health system as a clinical instructor in medicine and is past director of the Adult Cystic Fibrosis Program.

Dr. Goodill (Figure 1) has worked in private practice as a pulmonary medicine specialist since 1987, the same year he joined CCHS as an active staff member. He was a partner in Pulmonary Associates of CCHS. He is board-certified in internal medicine, pulmonary disease, and hospice and palliative medicine. He is a fellow in the American College of Chest Physicians and American College of Physicians and is also a clinical instructor at Jefferson Medical College of Thomas Jefferson University in Philadelphia.

Figure 1. John Goodill, MD



***LH: With the baby boom generation aging, and the increase in the elderly cohort in the United States, what do you think is on the horizon for healthcare and public health as a result of this demographic shift?***

JG: I think much of the picture we are seeing is not a changing demographic, but an enlarging demographic of people who are living longer with a higher burden of illness; that's going to put stress on our healthcare system to take care of them in a different and better way.

People are living longer with serious advanced illness that is non-curable and often progressive. We don't cure a lot of them, but we do help improve their quality of life, and help them live and enjoy the time that they have.

***LH: How do you think individuals, as well as the healthcare system, and prepare for some of those challenges and inevitable stresses that lie ahead?***

JG: I think that we have to pay attention to people's experience living with serious illness and what their needs are, and try to do the best to understand what's important to them - that's what advance care planning is all about. What is important to one person is not necessarily what is important to another, so this is a very personal, person-centered approach.

We also need to pay attention to meeting the non-medical needs of people with serious illness. For example, social services are becoming increasingly important, and delivering the support that these people need in the place where they are, so they don't have to be in the hospital. People don't want to be in the hospital, they want to be at home. We have to support people where they are, and that means fashioning the system to ensure this kind of work is appropriately compensated.

I think there's a lot of evidence that shows the right medical care, at the right time and the right place, is in fact the most efficient and the least expensive treatment. The trick is to break down the old silos of health care delivery in a way that is more adaptable and more effective for patients and their caregivers. Caregivers are part of this too, and it's important to support them.

***LH: What are some of the changes you've seen within advance care planning and end-of-life care throughout your professional experience?***

JG: We've had advance directives for 40 years, but with most advance directives, the health care system wasn't usually involved in helping people craft those things. An individual would go to their lawyer, or they would complete it on their own. Often they would not share it with the appropriate people, nor would they have the appropriate informing conversations to make their advance directive really effective and useful. Now, because of the changes in demographics, the changes in healthcare options available, and because more people are living longer, and with serious illnesses, a lot of those people arrive at situations where they lose decisional capacity. Their families and friends are then put into a decision making role that they are often not ready for. So we're seeing that advance directives are increasingly important to help address a lot of these situations. Since they are becoming more important, the healthcare system is now beginning to pay attention to them, and beginning to get involved in helping people make more useful advance directives.

This leads into what the Delaware Medical Orders for Scope of Treatment (DMOST) is all about; it is not strictly an advance directive, it's a tool that helps us have the communication and conversations with patients and families that we need to have in order to direct their care appropriately. When that form can be appropriately filled out, and with the right conversations, it can direct the plan of care for that individual in a much more effective way. The best outcome for every patient, every time, that's what we're trying to achieve, and a well-informed patient and family is certainly one way to accomplish that.

DMOST is a tool that allows us to guide that conversation and then document the decisions that are made, so this conversation doesn't need to be had over and over again, and in every setting that person goes to, but remains nimble enough to be amended or adjusted as circumstances require.

***LH: You've been involved at the forefront of the DMOST process. Have you been involved in any other changes, similar to DMOST, with advance care planning?***

JG: I'm trying to get others to embrace advance care planning as a strategic initiative across the whole system, and I'm in the process of applying for a grant to do that. I haven't really done much community grassroots organizing related to advance care planning but maybe in the future.

***LH: What do you hope to see in the future with advance care planning, or what changes, other than those previously mentioned, do you hope to see implemented?***

JG: With the old type of advance care planning, only about 20-30% of the population had advance directive. There are little pockets around the country where with a concerted, organized effort, most of the population could have an advance directive. I'd like to see Delaware get to that point. I'd like to see us get DMOST up and running, and utilized appropriately across the state, as well as a statewide electronic registry for DMOST. There's a lot of work to be done in that area, and again, all providers should be aware of the importance of advance care planning and engaged in this at some level.

Palliative Care, specifically, is a piece of this aimed at the population that is living their lives with serious illnesses, focused on supporting this population in a better way, whether it be at home, in a long term care facility, or in the hospital.

***LH: Finally, what do you want readers to take away about end of life decisions and care from this issue of the DJPH?***

JG: I'd like them to realize that end of life care is increasingly important and it's changing. I would encourage them to read the book Being Mortal: Medicine and What Matters in the End, and I'd like them to realize that by being informed, they can have the best chance to advocate for themselves and their families. It's important to have these conversations and be prepared, and it's about living as well as you can, for as long as you can. End-of-life decisions and care are not something to be so fearful of, and this shouldn't be a taboo subject. This shouldn't be a taboo subject.

---

Copyright (c) 2016 Delaware Academy of Medicine / Delaware Public Health Association.

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<https://creativecommons.org/licenses/by-nc-nd/4.0/>) which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.