

CORRESPONDENCE

Response to “What Should Physicians Do When They Disagree, Clinically and Ethically, with a Surrogate’s Wishes?”

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This correspondence responds to Terri Traudt and Joan Liaschenko’s “[What Should Physicians Do When They Disagree, Clinically and Ethically, with a Surrogate’s Wishes?](#),” which appeared in the June 2017 issue, 19(6), of the AMA Journal of Ethics.

In their recent article, “What Should Physicians Do When They Disagree, Clinically and Ethically, with a Surrogate’s Wishes?” Terri Traudt and Joan Liaschenko present a didactic case of a patient admitted to the ICU with a worsening medical condition whose surrogate’s wish for continued intensive medical care is in obvious disagreement with the ICU resident’s impulse to stop care based on the patient’s prognosis and the course of his hospitalization [1]. The authors offer detailed commentary on several aspects of the case; this correspondence seeks to augment their analysis.

The first comment has to do with the differences between the reasoning of the ICU resident and the patient’s surrogate (his wife) in terms of faith and religion. It is obvious that the surrogate mostly relies on religious faith that allows space for the impossible to happen, and because of that the patient required aggressive medical interventions. On the other hand, the ICU resident’s reasoning relies on empirically based predictions of an unfavorable outcome concerning the patient’s prognosis, and because of that he felt that further aggressive medical interventions would be more harmful than beneficial. There is literature showing that religious faith can affect the way a patient and his surrogates perceive the end of life and how they make decisions when faced with important questions concerning [resuscitation](#) and use of medical care [2-5]. Although one could argue in this case that the surrogate’s wishes might sound irrational to some and that the results of the surrogate’s wishes, if acted on, might even be harmful for the patient, still, this is not the way the surrogate feels since, according to her beliefs, these choices sound quite reasonable [5]. Thus, understanding the religious background of the patient and his surrogate are of critical importance in order to establish trust and allow for common understanding and the planning of the patient’s medical care. Arguably, medical practitioners, especially young ones, cannot be expected to be competent in [communicating with patients](#) of every religion, but attempts could be made during postgraduate medical training to expose residents to these kinds of discussions, allowing for a deeper understanding of the different religious faiths that patients represent. Indeed, one could also think about the need to better educate health personnel more

generally in understanding surrogates' reasoning according to their religious views. Finally, one could suggest involvement of the clergy in these kinds of discussions, especially if the patients and their surrogates refuse involvement of the palliative care team, as in this case. However, involvement of the clergy can have an ambiguous result, since it could either enhance or decrease conversations about futile medical interventions [6-8].

The second comment has to do with [medical paternalism](#). The ICU resident's impulse to withdraw or withhold medical care from the patient might derive from an inner belief doctors have that they know best. Although this belief derives from years of exhaustive studies and medical training, it could still be a sign of misunderstanding about who should have the last word on how patients should be treated from a medical perspective [9, 10]. An attempt should be made, therefore, to reduce medical paternalism in current medical practice in order to ensure that patients receive the medical care they wish and deserve.

In conclusion, this case highlights several aspects that do not have to do with the actual practice of medicine per se (like examining a patient, making a diagnosis, or prescribing a potentially life-saving medication) that still pose some of the greatest challenges that physicians frequently encounter. In these cases, physicians should control their impulse to be paternalistic and give some space to dialogue. Understanding of religious differences, for example—which must be taught or learned through experience—makes a health practitioner competent to better serve his patients, no matter what their beliefs and faiths are.

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