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VIEWPOINT

Addressing End-of-Life Treatment Conflicts through Improved Communication

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One of the more challenging situations in clinical medicine occurs when patients and their physicians have differing opinions on the utility of life-sustaining treatments. Such conflicts over the use or futility of treatment often present in the following manner:

A 75-year old man with stage IV colon cancer is admitted to the hospital for a sudden change in mental status. An evaluation which included a head CT and sepsis work up revealed that the cause for his mental status changes is uremia secondary to acute renal failure. After considering hemodialysis as an option, the attending physician recommends against it, given the patient's poor prognosis and the potential downsides of long-term hemodialysis. After the patient's wife hears the facts, she wants "everything done" and demands that the physician proceed with hemodialysis immediately.

In this case, the wife's demand for hemodialysis is driven, understandably, by her emotional response to the situation more than by her true grasp of the prognosis. The ensuing discussions will proceed more smoothly if the attending physician can bear in mind that the current hospitalization is one chapter in a long story for the patient and his family. Some chapters in this ordeal have been punctuated with hope and optimism that the patient's battle with cancer would conclude happily.

Confusion about the medical facts of the current incident can contribute to conflict between, in this case, the patient's wife and the physician. In helping the patient's wife understand her husband's present condition, the physician should avoid using jargon and technical language such as "vegetative state" or "hemodialysis" that confuse patients and their families. Because the use of medical terms and technical language is difficult to avoid completely, physicians and other members of the health care team should assess their patients' (or patients' surrogates') understanding of the information they provide. At the same time, information from sources such as television, magazines, and the Internet can foster unrealistic expectations concerning a given situation. In these situations, the ability to communicate a patient's prognosis clearly and accurately is critical. This is neither comfortable nor easy, especially given that physicians' prognostication skills are generally not on a par with their diagnostic and treatment skills [1-6].

Because none of his prior hospitalizations was terminal, the patient's wife may expect that, given proper treatment, her husband will go home again this time. Thus, she may not be psychologically prepared to hear and act on the facts of her husband's current prognosis and the physician's recommendations. Commands to "do everything" can be motivated by, in addition to denial, a wish to avoid guilt, a common emotional response to the death of a close relative. Statements such as "I cannot do this" or "I will not be able to live with myself" signal that a patient's decision maker is avoiding being party to decisions that could hasten the patient's death.

When talking with patients' relatives or decision makers who may be either confused about the true prognosis, in psychological denial, trying to avoid guilt, otherwise emotionally unprepared, or any combination of these, it is important that physicians be responsive listeners and clear communicators. Communication techniques that can help in these difficult conversations include active listening (repeating the speaker's thought or sentiment in your own words), simple silence, and open-ended questions. For example, physicians may initiate the discussion using opening statements such as, "It must be very hard for you to see your husband so ill," and, "You've been a wonderful caregiver for your husband during all this time that he has been sick." Avoiding language such as "withdrawing care" and "comfort measures only" may lessen the potential for future guilt. Instead actions that set positive objectives (e.g. maximizing comfort) should be the subject of these discussions.

Conflicts over the use or futility of treatment are unlikely to be resolved in a single conversation, and will likely require follow-up discussions. The first step is to identify, through responsive listening and communication, the multiple causes of the conflict; then to begin, with further careful and unambiguous language, the process of resolving the conflict. A mutually agreeable decision, while never guaranteed, is more likely attainable when physicians take adequate time for proper communication.

References

1. Christakis NA, amount EB. Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort stud. *BMJ*. 2000;320(7233):469-472.
2. Goold SD, Williams B, Arnold RM. Conflicts regarding decisions to limit treatment. *JAMA*. 2000;283(7):909-914.
3. AMA Council on Ethical and Judicial Affairs. Medical futility in end-of-life care. *JAMA*. 1999;281(10):937-941.
4. Quill TE. Initiating end-of-life discussions with seriously ill patients: Addressing the 'elephant in the room'. *JAMA*. 2000;284(19):2502-2507.
5. Larson DG, Tobin DR. End-of-life conversations: Evolving practice and theory. *JAMA*. 2000;284(12):1573-1578.

6. Christakis NA, Iwashyna TJ. Attitude and self-reported practice regarding prognostication in a national sample of internists. *Arch Intern Med*. 1998;158(21):2389-2395.

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