

Virtual Mentor

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Clinical case

When doctors disagree

Commentary by David J. Casarett, MD, MA

Mr. Williams was admitted to the hospital with febrile neutropenia, a common complication for patients receiving aggressive chemotherapy. He had been diagnosed with lung cancer six months before, and more recently the doctors discovered that the cancer had spread to his brain and bones. This time, the care team planned to discharge him as soon as possible because of his poor prognosis and the possibility of his acquiring another infection. After broad spectrum antibiotic therapy, Mr. Williams' fever subsided. Even though he would continue to need a few weeks of antibiotics, it was thought that he would be more comfortable receiving this treatment in his own home. His discharge plan included daily visits from a home health nurse for further therapy and care.

Two days after being discharged Mr. Williams returned to the emergency room, again with a high fever. Having now spent more time with Mr. Williams and his family, the team began to suspect that he lacked a full understanding of his prognosis, and they decided to consult the oncologists. The oncology fellow visited Mr. Williams, but was clearly uncomfortable with the situation and failed to have a substantive discussion with him about his cancer therapy and quality of life. He later informed the inpatient team that Mr. Williams most likely had less than six months to live. The fellow emphasized that, after their discussion, Mr. Williams still wished to continue his treatment and have full code status.

The inpatient team became frustrated. Despite Mr. Williams' prognosis of less than six months to live, the oncologists seemed unwilling to be frank in their discussions with his family, "not wanting to remove hope" and pushing for an aggressive alternative treatment strategy. This is what the family would want, they reasoned. But the inpatient team knew that the family failed to understand Mr. Williams' prognosis and thus could not make a truly informed decision. Looking back through his records, they discovered that Mr. Williams had spent more than half of the past six months in the hospital and that each hospitalization stemmed from a known complication of chemotherapy. It seemed as if the therapy was killing him faster than his cancer and had significantly lowered the quality of whatever remaining time he had.

The inpatient team confronted the oncology fellow, who became upset and defensive. "We're not ready to give up on Mr. Williams, and neither is his family,"

he interjected. The inpatient team countered, explaining that the Williams family did not understand that this therapy was making Mr. Williams so sick and that it really had no medical benefit. It was time for hospice, the team reasoned, so that Mr. Williams could live out his remaining months more comfortably, in his own home. This suggestion only made the oncologist angrier. An impasse had been reached, and the fellow stormed off, threatening to discontinue his participation in Mr. Williams' care.

Commentary

The chief problem in this case is not the conflict between physicians per se, but rather that Mr. Williams and his family are caught in the middle of that conflict. It's unrealistic to expect that health care professionals will always agree about which plan of care is best. It is essential, though, that they discuss their differences openly. A physician's primary obligation is to the patient, and it is never appropriate for a physician to abandon a patient, as this oncologist appears about to do, over a clinical disagreement with other members of the health care team.

While there is reason for legitimate uncertainty in this case, surely there are some points that the inpatient team and the oncologists can agree on. For instance, it is important that Mr. Williams and his family have the best possible estimate of his prognosis. Even an estimate that lacks precision (e.g., "a few months" or "less than 6 months,") can help Mr. Williams and his family to plan for the future. Trying to come together on a prognosis—even an inexact one—would be a good place for the disagreeing physicians to start resolving their conflict.

They should also agree that Mr. Williams and his family need information about his treatment options and alternatives in order to make an informed decision. Continued chemotherapy may or may not be the best choice for him, but Mr. Williams should be the one to make that decision. Assuming that aggressive treatment is what the family would want is a poor substitute for an open and honest discussion.

One of the treatment alternatives that Mr. Williams and his family should have the opportunity to consider is hospice. Hospice programs provide a unique set of benefits for dying patients and their families. For instance, patients enrolled in hospice receive medications related to the hospice-admitting diagnosis, durable medical equipment, home health aide visits and the services of an interdisciplinary team of health care workers experienced in end-of-life care. Families also receive emotional and spiritual support while the patient is enrolled in hospice and bereavement counseling after the patient's death. A growing body of evidence indicates that hospice delivers quality care that meets with high levels of patient and caregiver satisfaction [1-4].

Only a minority of dying patients in this country take advantage of hospice care, however. Furthermore, those who do enroll in hospice generally do so very late in the course of illness. The median length of stay is only three weeks; one-third of

patients are referred in the last week of life and 10 percent are referred in the last 24 hours [5].

As these numbers indicate, Mr. Williams' situation is all too common. Even when hospice is a logical, clinically appropriate choice, physicians are reluctant to discuss it with their patients. In large part, this reluctance stems from the eligibility criteria that the Medicare hospice benefit requires. To enroll in hospice, patients must have a prognosis of less than six months and must forfeit many aggressive therapies. Physicians tend to be reluctant to discuss hospice, fearing that it will be perceived as taking away hope.

But these discussions do not need to be difficult, nor do they require patients and families to give up hope. Several techniques can be useful in structuring hospice discussions to make them as easy and as productive as possible. First, as with any important health care conversation, Mr. Williams' inpatient team should identify a time and place where an uninterrupted conversation can take place. Because hospice decisions are often shared with family members [6, 7], it is also important to make sure that family and friends who will help a patient make a decision regarding hospice enrollment can be present.

Second, the team should determine what Mr. Williams and his family know about his prognosis. Patients often have overly optimistic views of their prognoses given the severity of their illness [8-10]. Furthermore, physicians may contribute to this discrepancy by inflating the prognostic estimates that they provide to patients [11]. Therefore, it is useful to ask patients to describe, in general terms, their perceptions of their current medical situations.

Third, the team should help Mr. Williams define his goals for care. In some situations, it is enough for the physician to summarize the goals in the form of a question, e.g., "From what you've told me and the things we've talked about in the past, it seems like what's most important to you is.... Is that right?" In other circumstances, a patient's goals may not be clear or may be unrealistic. In such cases a formal discussion of the topic is essential. At a minimum, it is important to inquire about patients' hopes and their fears, which offer insights into their values and desires (e.g., remaining at home, avoiding discomfort) [12].

Fourth, the team should define Mr. Williams' needs for care and services. In addition to planning for management of symptoms like pain, fatigue and constipation that are common in patients with cancer [13-16], it is important to identify those that are less common e.g., dyspnea, depression, anxiety, but that still respond particularly well to the multidimensional treatment that hospice can provide, even in a home setting.

At this point in the discussion, the team can introduce hospice as a way to achieve Mr. Williams' goals and meet his needs for care. Ideally, this part of the discussion should connect Mr. Williams' understanding of his illness, goals for care and needs for specific types of care in a way that makes some sense to him. This can help his

team to present a coherent plan, with clear links between what he wants, what he needs and what hospice can offer him and his family.

There are at least three advantages to this approach to discussing hospice, which emphasizes the positive aspects of hospice and hospice services. First, it helps physicians to avoid temporarily patients' and families' misconceptions about hospice and hospice eligibility. Many believe that hospice is only for patients who are imminently dying or only for patients with cancer. Others believe that hospice only provides inpatient care [5, 17-18]. By focusing first on the patient's goals and needs for care and introducing hospice late in the discussion, physicians can ensure that patients and families hear the benefits of hospice before negative preconceptions color their responses.

Second, by beginning with a discussion of the patient's goals and needs for care, physicians can more clearly explain why hospice is a good option. They can demonstrate their understanding of the patient's wishes and how the hospice recommendation is based on this common understanding. They can also emphasize the services that hospice provides and describe it in a positive light. This element of transparency is a key feature of consent discussions and of good communication more generally [20].

Third, this strategy can avoid concerns that a hospice discussion will take away a patient's hope. If done well, a hospice discussion offers an opportunity to define a patient's hopes and to present hospice as a way to help him or her achieve those goals. Viewed in these terms, a hospice discussion offers an opportunity to recalibrate the patient's expectations and to set goals that are achievable. For instance, it may no longer be reasonable for Mr. Williams to hope for a cure. But he might still hope to see a daughter graduate from college, go on a fishing trip or simply return home for whatever time he has left.

Finally, it is essential to recognize and respond to the patient's and family's feelings. The team can do this by acknowledging their responses, by legitimating their emotions and by reassuring Mr. Williams and his family that a hospice referral does not mean he only has a few days to live. The physician and his or her colleagues should conclude the conversation by reinforcing their commitment to care for the patient and family regardless of the decision they make.

Conclusion

Physicians' own fears and uncertainties should not prevent them from discussing hospice when it appears to be an appropriate option. Of course, as with many end-of-life discussions, discussion of hospice can be emotional, particularly when patients and families have strong preconceived ideas about hospice care. However, the communication techniques summarized here can make hospice discussions easier for physicians, as well as for patients and families.

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