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Physician Communication: Make it Clear and Convincing

PERSPECTIVE ON MEDICAL ETHICS AT THE END OF LIFE.

Our guest today writes in his book Embracing Our Mortality that lawyers as officers of the court are not permitted to tell their clients to lie, but physicians are under no such obligations. Under what situations, would it be best for us to advise people to may be polish their recollections?

Welcome to the Clinician's Roundtable. I am Dr. Leslie Lundt, your host and with me today is Dr. Lawrence Schneiderman, Professor Emeritus in the Department of Family and Preventive Medicine and Adjunct Professor in the Department of Medicine at the University of California in San Diego. He has had a distinguished career in medicine and ethics. Dr. Schneiderman was founding co-chair of the UPSC Medical Center Ethics Committee and he has been an invited visiting scholar and visiting professor at institutions across the United States and abroad. He is also a recipient of the Pellegrino Medal in medical ethics.

DR. LESLIE LUNDT:

Welcome to ReachMD, Dr. Schneiderman.

DR. LAWRENCE SCHNEIDERMAN:

Thank you very much for inviting me. Happy to be here.

DR. LESLIE LUNDT:

Thank you. As a preeminent medical ethicist, you have been part of so many contentious medicolegal deliberations. Our audience today is physicians that could benefit from your perspective on the law in these life and death matters. Can you please enlighten us?

DR. LAWRENCE SCHNEIDERMAN:

Okay. First of all you know the usual disclaimer, some of my best friends are lawyers and judges and, in fact, many of them deplore how medicine has kind of ended up too often in the courts. Judges say that they hate to make these medical decisions, but if they are forced

to there is nowhere else to go. One of the cases that really illustrated the problem for me was a case in California of a 46-year-old man, who while drunk, crashed his car, and had severe brain damage was unconscious for over a year, that would qualify him under the Multi-Society Task Force Neurology definition of permanent vegetative state. He was being maintained on a feeding tube. A devoted wife was allowing this to happen. Now what happened after a couple of months, he began to show some signs of emerging to what we call now a minimal conscious state. The prognosis was very dire. She decided at that point that he started to pull out his feeding tube that was the only really purposeful gesture he seemed to make and imagine something that is stitched into his abdominal wall. After he did this 3 times, she said she did not want to insert it again saying that her husband would not want it. That is what her children also thought and they had some quotes of his that seemed to confirm that he would want to be independent. Well, the mother of the man was estranged from the wife, and she demanded that the feeding tube be kept intact. This case went all the way up to the California State Supreme Court. They ruled that the wife of some 20 years did not have clear and convincing evidence that this patient would want his feeding tube removed under these circumstances. Now the physicians and the audience and anyone else they talk to have to ask, how many of them have given specific instructions what to do if they were in this circumstance and here is the actual reading is only when the patient's prior statements clearly illustrate a serious, well thought out, consistent decision to refuse treatment under these exact circumstances or circumstances highly similar to the current situation, should treatment be refused or withdrawn. That was the decision of the California State Supreme Court and I am afraid it has been echoed in several state legislatures. This is in my opinion inhuman, people particularly if they are young, particularly if they have some cognitive inability, never have a chance to be this exact, and I would suspect that most of the audience has never told anyone or written anything that would say under these exact circumstances, you may remove the feeding tube. This is why I say when it comes to only people by the way if the decision is contested as it was in this case, it has to be by someone who has legal standing and a mother of the patient would be considered. So you don't have to be afraid of this as a general rule, but if it comes to a battle between relatives over what to do with doctors patients and you see the patient being abused by someone who has a personal agenda, which is unrealistic medically, this is where I say you know what you should tell the family that if they are forced to testify in court, this is a high standard that has to be met. They should really think about what they are going to say. Now, I admit right off the bat that this is a controversial stance. In other words, are you telling doctors that they should tell patients to lie, very close to it. In other words, I think I am on the side of the patient in this case rather than on the stipulations of an unrealistic court. I have had too many cases where judges have appointed guardians, particularly of infants, newborns, have appointed guardians, who don't want to have it own their watch that the feeding tube or other life-sustaining treatment is withdrawn. It is the doctors and nurses who have to suffer treating for a long period of time of very disabled, uncomfortable patients. The judges who made the appointment never saw the patient and never will see the patient. Once again, I think there are so many instances where the law has harmed patients, but I do take this rather strong stand and as part of being a medical professional, we as physicians have to take a stand on behalf of patients. I might add, if I may that everyone has heard of Dr. Kevorkian. If you worry about being sued, if you are worried about that Dr. Kevorkian is the only doctor who has ever been found guilty of killing a patient deliberately. If you follow a good course of action and can justify it and especially if you had colleagues involved and especially if you take it to the Ethics Committee, you will be safe because the courts over and over and over again have shown that they don't want to remove the practice of medicine to the courtroom.

DR. LESLIE LUNDT:

Well it is a strong statement and I think one we all need to hear.

If you are new to our channel, you are listening to the Clinician's Roundtable on ReachMD, The Channel for Medical Professionals. I am Dr. Leslie Lundt, your host, and with me today is Dr. Lawrence Schneiderman, author of Embracing Our Mortality. We are discussing his perspective on medical ethics at the end of life.

Dr. Schneiderman, I am wondering if these issues are getting more complicated now with the proliferation of hospitalists who have no outpatient relationship with their patients or their families.

DR. LAWRENCE SCHNEIDERMAN:

In a way it is, I think that clearly there have been benefits from having hospitalists taking care of acutely ill patients in the hospital and not requiring doctors, who are primary care physicians, who are busy in their office, running in and out trying to attend to the moment by moment decisions, patients in the hospital particularly in the intensive care unit, but I do think the risk is and I have experienced as a consultant in the ICU that patients come in and they are strangers meeting strangers and we do not know what went on before, what if anything the patient said about his or her treatment preferences, what he or she has been told and some of this communication gap is very important to try to improve. I think that hospitals should make a special effort to coordinate communication between the physicians on their staff, who are primary care physicians with their hospitalist, that there should be meetings, that there should be ample opportunities for communication that should be expedited; so that when the patients are admitted and when the patients are discharged, the hospital takes responsibility that this be smoothly done and in that way, I think we will try to deal with the communication gap. I should also point out that primary care physicians have a big responsibility to get their patients as to make some sort of gesture in the form of an advanced directive. Only about 20% of patients have executed a written advanced directive. In our own studies, it took a great deal of attention to patient care to get that as high as 60%. There is a problem, in that many patients don't want to think about this, don't want to write down their wishes you know and that is a problem. On the other hand, we have done other studies that show that patients do want their doctors to initiate the discussion. This can be done as a routine just like what is your, you know, tell me about your past history, your social history, how much do you drink, have you executed or written any kind of advanced directive, have you talked to anybody about making decisions in case you cannot make them. I found that my patients were grateful when I introduced the topic, and I think this would be of big help. If patients came in and the hospitalist actually saw that the primary physician had information that could be useful, then that would of course make the communication much more likely.

DR. LESLIE LUNDT:

Give a good resource for our listeners on where to find information about advanced directives to give to our patients?

DR. LAWRENCE SCHNEIDERMAN:

You know, this may sound self-promoting, but I do have a good bit of information in my book on Embracing Our Mortality. There is a whole chapter that just deals with that and then all the complications that could arise from it. So I would first start them there and by the way, it has a fairly extensive bibliography.

DR. LESLIE LUNDT:

Any other tips about what we as physicians can do better to avoid some of these horrendous legal nightmares that we have all heard about?

DR. LAWRENCE SCHNEIDERMAN:

Well you know, there are only legal nightmare if doctors think of the law all the time and practice what we call defensive medicine. The fact is historically the law almost always comes down on the side of the physician unless the physician really committed an egregious medical error, which is then malpractice, but if you are dealing with a patient at the end of life where you in a very thoughtful way in conjunction with colleagues and perhaps with the help of an ethics committee you say you know this is the best I can do for this patient, I am talking to the patient, I am talking to the family, they are informed. This is the direction that I think we should go and we should not be attempting CPR on patients for example, who have metastatic cancer in bed or if sepsis or a multi-organ failure. The outcome for such patients is demonstrably so bad that you are more likely to harm them, breaking their ribs, shoving things down their throat, making them miserable with no realistic chance they will survive the hospital discharge. These are empirical data that I am citing. So under those circumstances, a doctor just like any other professional, should say here are the limits to what I can do and should do that is my professional integrity. I am doing what is best for the patient. Under those circumstances, if you have to testify to the jury, you will do well. If you say the reason I did it is because I didn't want to get sued, the jury will not like to hear that.

DR. LESLIE LUNDT:

Thank you so much for being on our show today.

DR. LAWRENCE SCHNEIDERMAN:

My pleasure.

DR. LESLIE LUNDT:

We have been discussing medical ethics, especially at the end of life with medical ethicist, Dr. Lawrence Schneiderman. I am Dr. Leslie Lundt. You have been listening to The Clinician's Roundtable on ReachMD, The Channel for Medical Professionals. Thank you for listening.

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