Words Before Actions

Mr C, a 78-year-old man with a history of Zollinger-Ellison syndrome with metastatic gastrinoma requiring subtotal gastrectomy with gastrojejunostomy, multiple past gastrointestinal tract bleeding events, and severe aortic stenosis was seen at an emergency department in Central California after an episode of melena. On upper endoscopy, he was found to have a bleeding ulcer with a visible vessel, which was clipped. Once hemodynamically stable, he was transferred to a tertiary care center for a surgical intervention aimed at preventing future gastrointestinal tract bleeding by addressing his tumor burden.

On his arrival, given his severe aortic stenosis and history of a positive stress test result, the surgical team consulted the cardiology service for a preoperative risk assessment. During my initial conversation with Mr C, when I mentioned that I was from the cardiology service, he responded quickly, “I don’t want surgery.” While he initially thought I was trying to offer him aortic valve replacement, which he had refused in the past, he also adamantly refused the surgical interventions for which he had been transferred to a tertiary care center. We spoke instead of the health issues he found most concerning to him. He immediately endorsed a progressive functional decline over the past year, stating that he “used to be able to do groceries with my wife, but now I sit in the car while she does the shopping because I get too tired.” He also described worsening shortness of breath when undertaking hobbies such as gardening and explained that he knew valve replacement—the treatment of choice given his degree of aortic stenosis—could relieve his symptoms but also posed significant risks, given his age and comorbidities. “I’ve been through surgeries before,” he said wearily, “and every time the recovery was complicated. I’m 78. I’ve lived a good life. Just let me go home.”

Mr C’s wife, son, and daughter-in-law, gathered at his bedside, confirmed that his mobility had decreased and his fatigability had increased over the past year. “The pain in his hips bothers him the most,” his son told me. On the basis of his desire to maximize his time at home and continue the activities he enjoyed, Mr C wished to optimize medical management of his multiple conditions and to forego surgical procedures addressing his tumor burden.

Mr C and his family were unaware that he was transferred to a tertiary care center specifically for a surgery that he did not want. What they all appeared to want, however, was an opportunity to discuss his declining functional status and his prognosis. How could this particular surgery help? His son wondered. Was there a chance his recovery from this surgery might be different from his prior experiences? Hospitalizations for older adults often provide a crucial opportunity for patients and families to discuss goals of care and how proposed treatments may affect their functional status and daily lives. An increasing number of medical and surgical options to address disease come with a number of questions and uncertainties on the part of patients and families; suddenly, making a treatment choice may seem overwhelming in the face of the sheer number of choices available. Understanding a patient’s goals of care is a crucial starting point in helping patients decide how appropriate proposed interventions might be.

These conversations have well-studied effects, both on the end-of-life care of patients and on the mental health of their loved ones. A 2008 study published in JAMA that examined the relationship between end-of-life discussions and patient quality of life found that patients who discuss their goals of care with their physicians enjoy better quality of life, fewer aggressive interventions at the end of life, and earlier hospice referrals. Furthermore, patients’ caregivers experienced less depression and anxiety after their loved ones’ death.1 Similarly, a 2009 prospective randomized control trial in Australia found that coordinated, interdisciplinary advanced care planning discussions resulted in end-of-life care concordant with patient wishes, increased patient satisfaction, and significantly reduced depression, anxiety, and posttraumatic stress disorder experienced by patients’ loved ones.2 Finally, a 2007 intensive care unit—specific study in France found that adopting a proactive communication strategy—consisting of providing families with a brochure on bereavement and longer family meetings—significantly reduced family members’ anxiety, depression, and posttraumatic stress disorder experienced by patients’ loved ones.3 Together, these studies emphasize the importance of ascertaining and privileging patients’ goals for their health and their lives and using this understanding to guide patients and families through an increasingly complex web of treatment choices.

Such conversations are particularly pressing, as our health care system identifies ways to provide cost-effective yet high-quality, patient-centered care. Had a member of the health care team spoken with this patient about his pending transfer for surgery, Mr C or any of his family members likely would have explained his opposition to surgery. The costs of ambulance transfer and a second hospital stay would have been spared, as would the stress his family experienced in commu-
ing to be with him in a hospital 3 hours away from their home.

Yet as our medical system becomes increasingly strapped for time, whose job will it be to have these time-intensive, emotional conversations? Between his 2 hospital stays, Mr C interacted with emergency physicians, hospitalists, gastroenterologists, cardiologists, and surgeons—a very typical roster for hospitalized older adults. As such medically complex patients shuttle between multiple physicians, it is increasingly important that all physicians refine their ability to assess whether interventions they can offer resonate with a patient’s goals. It is commonly assumed that such conversations should be left to primary care providers, but as Mr C’s experience suggests, these providers are not always involved in hospital-based decision making, and documentation of any such prior conversations may be inaccessible to hospital-based providers. Improved training curricula in communication about goals of care across medicine’s many specialties will result in outcomes all physicians ultimately desire: patient comfort at the end of life, patient satisfaction with medical care, and improved mental health of a patient’s loved ones.

Our cardiology consultation team’s recommendations ultimately included optimizing medical therapy and engaging him in physical therapy. Two days later, he was discharged home. Focusing our consultation on Mr C and his goals of care empowered him to defer surgery and return home with the care and support of his family, who better understood his prognosis. His experience reminds us that sometimes a conversation can truly be the most appropriate intervention—that, sometimes, words matter more than actions.

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REFERENCES

