

“If we can not heal in one way, we must learn to heal in another”

Sherwin B. Nuland

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Communicating About Resuscitation



Having discussions about resuscitation with patients can require skills which do not always come naturally. Physicians, nurses and other staff can fear the possibility of an emotional response to questions about resuscitation and becoming engaged in a lengthy conversa-

tion in response to a patient's questions. It is essential, however, that we understand the importance of these conversations for our patients. It is often a reality that patients may be thinking about medical decisions such as resuscitation and other questions about end of life care but will wait for their physicians to raise these questions with them. This is not to say that any team member may discuss issues in relation to resuscitation, provide information about resuscitation to patients and substitute decision-makers or point them towards resources.

In the 1990s, an American physician, Sherwin Nuland, came to some interesting realizations. His brother had been given a diagnosis of cancer with a terminal prognosis. Nuland colluded with his brother's doctor to keep the reality of the prognosis a secret. At the time he did this, Nuland believed that if his brother knew of his prognosis, it would be extremely upsetting and would lead to giving up hope. As he continued to observe his brother's life Nuland realized, far too late in his estimation, that his brother would have approached his final months very differently had he known of his prognosis and not been given false hope. He had a right

to know about his disease and how it would play out and what his dying would involve. One of Nuland's books, *How we die: Reflections of life's final chapter*, published in 1995, became a best seller and Pulitzer Prize finalist in the United States. The book raised many questions and became the basis of discussions about end of life decisions in America. Nuland had desired to bring death and dying into the open, to promote informed decisions regarding end of life care, and to assist people to have reasonable expectations. Nuland critiqued the prevailing attitude of the doctors of his era, many of whom saw death as an enemy to be defeated even in the face of a terminal prognosis. This, he noted, often led to the pursuit of aggressive medical interventions with little or no benefits to patients which in many cases had detrimental impacts upon quality of life. He had previously recognised this attitude in himself and the false hope it had engendered in both his patients and his own brother. He came to realize, through his own experiences, that giving realistic presentations of information about prognosis, diagnosis, course of a disease and the realities involved with the medical interventions which may be possible for them, was the right thing to do.

It is important to remember that when a patient or substitute decision maker reacts emotionally to medical information he or she is reacting to the information and not to the messenger. When an emotional reaction occurs after disclosing bad news, for example, a health care provider may have the uncomfortable feeling that he or she has upset the person and done the wrong thing. Being honest and candid about diagnosis, prognosis, the interventions that are available and promoting reasonable expectations in the face of these realities is the right

thing to do. Such conversations cannot be avoided if one is to act ethically and doctors and other health care providers should be encouraged to develop the ability to have these conversations without being fearful of the emotions which may ensue from them. In my own work, I have seen such emotional reactions occur in an initial presentation of information. These emotions may, on rare occasions, lead the hearer of bad news to want to attack the bearer of the information. The reaction is often one of anger or distress upon hearing unwanted information, or the necessity of dealing with the information. The emotions, at least generally speaking, will abate. Only by having the information will patients or substitute health care decision-makers be able to face the realities of the situation they are confronting and make decisions based on reasonable expectations. Sometimes I hear that people are making unreasonable decisions, only to find that they are uninformed as those around them fear having a conversation which may result in an emotional reaction.

Dr. Nuland's message was also that one could be candid with patients and be humane. To tell the truth while maintaining empathy, to have an understanding of what patients will go through as they die from their disease and an ability to walk with a patient through his or her experience and to speak of it are invaluable skills. Building the skills to have difficult conversations requires not only a knowledge base but a willingness to engage the patient. The more opportunities taken to build skills, the more likely it will be that conversations are approached with

candour and empathy. The role of mentoring should not be underestimated in building the skills of health care providers. Having conversations with patients and substitute decision-makers about difficult issues such as end of life decision-making demonstrates a skill set to junior colleagues and staff and stresses the importance of these conversations to the patient. The importance of these conversations for high quality decision-making should also be promoted. Are our patients informed when we ask them to make decisions about issues such as resuscitation? Have we elicited patients' goals of care based on their beliefs, values, wishes and expectations? Have we discussed the risks and benefits of resuscitation given diagnosis and prognosis? There are aids, such as videos and booklets, available to providers to support these conversations. If you are interested in accessing them, please let me know and I will provide links: joy.mendel@saskatoonhealthregion.ca Each patient's circumstances are different, and therefore, each conversation will be unique. Thus, decision-making supports cannot replace the conversation or be used as a means of avoiding the conversation.

Dr. Joy Mendel
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References:

Nuland S (1995) *How we die – reflections of life's final chapter*, Vintage, ISBN 9780679742449

NOTE: CHANGE OF DATE

'Dealing with tough situations in health care'

William F. Mitchell Bioethics Seminar

Professor Carol Taylor

Senior Research Scholar, Kennedy Institute of Ethics, Georgetown University

Carol Taylor is a well-respected nurse-ethicist who has previously visited Saskatchewan to present lectures and seminars. Carol will address dealing with situations of ongoing conflict, difficult personalities and other tough situations in health care provision. The seminars will be offered this year in both Regina and Saskatoon.

Wednesday 7th October, Santa Maria Home Regina (Time TBA) – All are welcome to attend

Thursday 8th October, Morning - St. Paul's Hospital (Time TBA), Afternoon –

Long Term Care Session (Location and Time TBA).

(Thursday morning session will be made available via Telehealth - details to follow)