The Importance of End-Of-Life Discussions in the Outpatient Setting: A Teachable Moment

Story from the Front Lines

When I called the name of my next clinic patient, a 90 year old female scheduled for a post hospitalization visit, I was greeted by a diminutive woman with a pink walker and a portable oxygen tank with flowers on its case. She had been hospitalized two weeks prior for chest pain, at which time she declined further interventions given her age and comorbidities, but was found to have an acute kidney injury and told to follow up for labs. She practically started a goals of care discussion herself, talking about her long, enjoyable life, her husband's passing four years ago, and her desire to leave this earth peacefully. Time got away from me as we chatted about a variety of topics, from the upcoming holidays to our mutual love of crab cakes. She was incredibly functional for her age, and although she lived in an assisted living facility, she only used their services for travelling to and from appointments. While we talked, her labs came back and showed a persistently elevated creatinine. I adjusted her medications and instructed her to return in one week to check the lab once more.

The following week, the lab called me with multiple critical values. She was now in acute renal failure. I gave her a call and she sounded tired; she confirmed feeling more fatigued. I implored the patient to go to the emergency room, and after some convincing, she agreed.

The next morning, I visited the patient in the hospital. Unsurprisingly, she felt fine. The nephrology team determined she would need dialysis. After a discussion with the patient, her children, and her close friends, she decided to decline dialysis and enter hospice care. This decision was very difficult for her family, but the patient seemed at peace. She passed away comfortably with family a few weeks later.

A Teachable Moment

Talking about end of life plans is rarely easy, but the benefits to the patient make this discussion worthwhile. Early integration of palliative care in patients with advanced cancer improves quality of life.[1] However, front line residents frequently endorse feeling uncomfortable with these discussions, even with additional training.[2, 3] While residents understand the importance of such training,[2] there are several obstacles to becoming proficient in leading these discussions.[3] This is worrisome, as poorly managed discussions can lead to unfavorable outcomes like depression in family members.[2]

Clinician discomfort can prevent adequate end of life care to patients in need. Physicians often have difficulty responding to emotional aspects of these discussions, and managing uncertainty surrounding end of life.[3, 4] Trainees often feel that education in this subject is left to observation rather than formal instruction.[5] Even then, residents are not always included in said discussions. To address this deficit, palliative care and end of life conversations deserve a place in didactic teaching. The experience is invaluable in improving trainee comfort, and both trainees and patients stand to benefit substantially from additional education in palliative medicine.[2, 4]

In addition to a lack of formal training, conversation timing remains an important barrier. It is difficult to bring up this sensitive topic in the outpatient setting, when the patient is stable, compared to when they are acutely ill in the hospital. Indeed, the

majority of end-of-life discussions occur for the first time while a patient is admitted.[3] Having this discussion outside of a medical crisis with a trusted primary care physician yields the opportunity to address and re-address patient goals in a setting removed from emotional duress.[4]

Misperceptions of life expectancy can also hinder discussions. Physicians are notoriously inaccurate when estimating prognoses, often erring on the side of caution and overestimation.[3] Disease states can fluctuate before reaching terminal stages, and the possibility of unexpected death is omnipresent. However, if a clinician asks themselves "would you be surprised if this patient died in the next year?" an answer of "no" should trigger an end of life discussion.[4]

Upon reflecting on my own discussion with my patient, I did her a disservice by not extending our outpatient discussion of her goals of care. I believe she would have been quite willing to delve into the particulars of her end of life desires, given her inpatient preference to defer aggressive measures. I fell victim to the previously noted barriers to having an end of life discussion. She seemed so functional and independent; I wanted to believe she had years left, despite her advancing age and multiple medical comorbidities. I felt uncomfortable bringing up this delicate subject in a patient with so much personality that appeared to be doing so well. Perhaps if I had discussed her wishes with her as an outpatient, she could have avoided a hospital stay and would have been made comfortable in her own home sooner.

Sources:

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