



## Voices of Medicine

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By Del Meyer, MD

**Talking to terminal patients, dangers of the nurse/patient ratio, dealing with the Legislature.**

### **Talking with the Dying**

*San Francisco Medicine* has two articles on talking to terminal patients. Fran Moreland Johns, author of the forthcoming book, *But I Don't Know What to Say*, explains "Conversations 101: How to Talk with Patients Who are Facing Death." She outlines the questions and fears surrounding terminal disease in three areas.

*Assessment:* "What do you want to know about your illness?" gives the patient a chance to ask, or not ask, specific questions about how much longer he might live, what treatment options to consider and what would be involved.

*Dialogue:* "Let's look at all this" addresses the personality - a fearless stoic, a fragile worrier, a cynic? Conduct the conversation thoughtfully and unhurriedly. Most patients will give their physicians clues.

*Assurance:* Dying patients want to know their physicians will be around to do what they can. Few want false hopes or empty promises. The more certain patients are that they won't be abandoned and will be kept comfortable, the better their final days and months will be.

She gives several examples.

Jack Kenny declined when told that removing his tongue, voice box and a portion of his jaw would extend his life the longest. Instead, he went to Seattle for external beam radiation and then to Southern California for brachytherapy. Although he recalls his surgeons told him exactly how bad it would be, "I guess I didn't quite believe them." He praised his physician for his straightforwardness. The lesson of Kenny's experience is simple but profound: Getting to know the patient is key to successful doctor-patient communication.

A woman was more devastated by the way her physician delivered the news of her terminal disease than by the knowledge of her condition. Word games are seldom necessary, but physicians are wise to consider them. References to pain, distress, comfort and control are easier to handle than, "You're dying." One 48-year-old woman said, "Nobody wants to hear, 'There's nothing more we can do.' What I want to hear is 'I'll do everything I can.'" That covers the primary issue and requires no lies.

Oncologist Brian Lewis, MD, tells of a personal friend and exceptionally strong woman who was his terminally ill patient but had never spoken of her impending death. He sat at her bedside feeling these were the longest few minutes of his life. Then she began to talk about her apprehensions and to raise questions that clearly had been on her mind for some time.

Jack Kenny wanted straight talk. Dr. Lewis's friend needed the encouragement of his time.

Every death is unique. Physicians whose words bring peace give a very special gift. The entire article is at [www.sfms.org/sfm/sfm304e.htm](http://www.sfms.org/sfm/sfm304e.htm).

Christine Okon, a hospice volunteer, expresses the importance of helping a dying patient create a personal legacy. She writes that leaving a legacy is bestowing a gift of continuity to those who survive us. The legacy of one's self is deeply personal and precious.

A personal legacy could be as simple as a letter, an audio or video recording or a photo album. A chronological approach is probably the most familiar way to tell one's story. When asked about themselves, people generally start with where and when they were born and move on from there. Another approach might be to discuss an area of personal significance, or "domain" in an individual's life. Important areas might be family, career, travels, religion, hobbies, pets, humor, friends and philosophy. Domains traverse decades, but are not defined by chronology. A third approach is perhaps the most profound: making a statement to loved ones. The dying person can share lifelong dreams, loving wishes, sound advice and mend emotional rifts.

Helping patients create a legacy involves listening actively and encouraging them to leave behind their essence, that which is most meaningful to them. To read the entire article, go to [www.sfms.org/sfm/sfm304g.htm](http://www.sfms.org/sfm/sfm304g.htm). More on end-of-life issues such as hospice, palliative care, pain, grief, death with dignity, is at [www.growthhouse.org](http://www.growthhouse.org).

### **Safety and the Nurse/Patient Ratio**

The president of the Alameda-Contra Costa Medical Association, Vin Sawhney, MD, comments in the *ACCMA Bulletin* that the law passed to prevent overworking nurses may worsen safety. Compliance is required at all times under minimum nurse to patient ratios established for each hospital department by the Department of Health Services (DHS). Although the law seeks to improve quality of care, the ACCMA has learned that strict adherence is actually jeopardizing patient care.

Under the Nurse Practice Act, a nurse can refuse responsibility for a patient if unable to ensure quality of care for the patient. Some staff are thus refusing to admit patients if the ratio is not met. Significant delays are occurring in assessing and treating patients in hospital emergency departments due to strict application of this new law. One emergency department reports that the number of patients leaving the emergency department without being seen has doubled. Patients are also sent to the lobby to await triage while emergency physicians and treatment beds remain idle.

It is understandable that nurses should not assume responsibility for more patients than is medically appropriate, but delaying assessment and treatment of patients in emergency departments where patient census is constantly changing may be dangerous. The ACCMA will continue to assess this matter to ensure that quality of health care delivery in emergency departments is maintained. To read the entire article, go to [www.accma.org](http://www.accma.org) and enter Sawhney.

As an alternative, we might consider repealing the law. When politicians who know little about health care tell physicians (or nurses) how to practice, health care will worsen and patients will get less care. It looks like the need for a part-time legislature, similar to 47 other states, is extremely important.

### **Politics as Unusual**

The late vice president of CMA's Government Relations Department, in an article in *Southern California Physician*, explained why physician involvement in the political process is critical. The California Medical Association is organized medicine's eyes and ears in Sacramento. Quite simply, its job is to pass legislation beneficial to physicians, kill legislation harmful to physicians, and maintain a practice environment that is economically healthful and free from intrusions on clinical decision making. A large amount of information is available on the [www.socalphys.com](http://www.socalphys.com) website and on the CMA site.

Since a large number of the physicians in my primary hospital are not members of CMA, I've been presenting the above four theses to them. The majority feel that CMA should be our eyes and ears, but that all four tenets are worse today than two decades ago. Many feel the very nature of physician advocacy is causing this, and also hurting the physician image in the public eye.

A full-time legislature leaves our Senate and Assembly with far too much time to become busybodies. Organized medicine should advocate for a legislature that meets for three months at the beginning of each year and returns for a one-month session every October. This would eliminate at least two-thirds of harmful laws that interfere with our practice, with nursing practice and with health care.

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