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Physicians at the crossroad of prognosis and faith: practical help communicating with patients and families during the COVID-19 pandemic

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ABSTRACT

Physicians will ultimately face the necessary but unpleasant task of caring for a dying patient at some point in their careers. Communicating with patients or their families during such dire times is very important especially when the patient or family members have unrealistic expectations. Herein, we have highlighted practical suggestions which if applied can prevent unnecessary draining encounters with patients and families; for example, incorporating ancillary staff such as palliative and pastoral care into the care team. We have also proposed a new concept of 'physician optimism'. Based on this concept, the physician can be classified as a pessimist or an optimist with realistic or unrealistic expectations and communicate to patients with or without requisite empathy. To ensure the best outcomes, we conclude that physicians must be realistic optimists who always communicate with empathy. Unrealistic optimism, no matter how well-intentioned, is deceiving to patients and their families will never allow a culture of trust.

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The Coronavirus disease-19 (COVID-19) pandemic has already caused more than 2 million deaths worldwide since first reported in Wuhan, China[1]. More than 420,000 deaths have been reported in the USA alone; a grim statistic expected to worsen in the near future despite significant strides made in treatment involving, but not limited to, the use of ramdesevir, convalescent plasma, and corticosteroids [2–5]. Although significant progress in understanding its pathogenesis has been made [6–8], the case-fatality rate for COVID-19 is currently about 17 deaths per 1000 cases, and it can be as high as 30% in patients aged ≥85 years in the US or 40% in ICU hospitalized patients [9,10]. As we embarked into our career as 'full-fledged' physicians, we did so with a largely optimistic outlook, ready to take on the world on behalf of our patients. The current COVID pandemic, however, has taught us that we can be ill-equipped to deal with complicated interpersonal family dynamics which can be further upended by the impending death of a loved one.

Physicians are expected, even assumed to be empathetic individuals trained to communicate effectively with their patients and ably direct decision making in their patient's best interests. In many cases, there can be conflicts between different family members and the designated health care surrogate or next of kin despite there being a clear written advanced directive per patient wishes on file. Often, subtle competing viewpoints between direct- and step-family members with different levels of familiarity with the intricacies of the patient's health condition and treatment challenges may lead to the physician having to assume the role of a mediator or facilitator between these factions. These conflicts often come to the forefront when the patient is nearing death, as increasingly encountered with COVID-19 patients, is in significant pain and discomfort, or is in a 'vegetative state" using multiple resources with no obvious end in sight. In these instances, efficient and timely informed decision making is paramount.

The impact of faith and spiritual/religious leanings of the patient and family members often come to the foreground during such times and is a difficult path to traverse for the physician, especially if the physician seemingly (or as perceived by the family) is not as invested in a similar belief system. Physicians strive to be comforters, helpers, and 'do no harmers' as they dutifully strive to uphold the Hippocratic Oath, even as they are guided by their own spiritual or religious beliefs, and are rarely conflicted over their medical decisions. Taking all these variables into account, the interaction with the patient and family members in an end-of-life situation can take a toll on the treating providers as they work to make it as meaningful and painless an experience as possible for their patients and family/care providers. What then could be some practical ways for physicians to avoid confrontations with family members under these circumstances,

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which can be a waste of time at best and a self-defeating endeavor at worst.

An adage states that 'shrewd is the one that has seen the calamity and proceeds to conceal himself'. In this instance, the 'calamity' is dealing with a confrontational situation involving the patient and family members whose demands are at odds with the standard of medical care prescribed by the physician, although both sides profess to have the same goal, i.e, the patient's best interests at heart. From a physician's standpoint, the draining effects of such confrontational situations are indeed unwittingly carried over to their dealings with subsequent patients [11]. One way to 'conceal' oneself, as stated in the adage, can be achieved by adjusting rounding times, if the setting permits, to avoid or at least minimize encounters with specific and especially difficult family members.

Secondly, carefully listening can be of tremendous help. Yes, there is limitless power in listening. Most of the time, patients and families just want to be heard and have their concerns and fears openly validated and not dismissed. They understand and accept that physicians cannot fix everything. In such a situation, there is no need to respond to everything said, which can also save energy and time that can be better spent on other patients.

Thirdly, communicate without any declarative or dismissive statements. In situations where a patient's family is desperate for a 'miracle' and repetitively states their belief in the same and the pragmatic physician in you knows this is not going to happen, it is acceptable to 'leave the door open', letting the family know that you are open to reassessing the situation and adapt management decisions depending on the patient's clinical course, even as we embrace palliative measures and comfort care in the meantime [12]. It is a useful tool to emphasize that the decision is 'what the patient would have wanted' rather than what we/family desires for the patient, which puts the weight of the decision on the patient rather than the caregiver.

Next, effectively utilize the strengths of the multidisciplinary health care team who have the time and inclination to form a connection with patients and may also develop an innate 'chemistry' with the patient and his/her family members that can help crack communication barriers.

Lastly and most importantly, in our viewpoint, be a realistic optimist. We coined the concept of 'physician optimism', defined as maintaining an upbeat attitude with patients and family even in the setting of a grim prognostic situation. Although physicians,

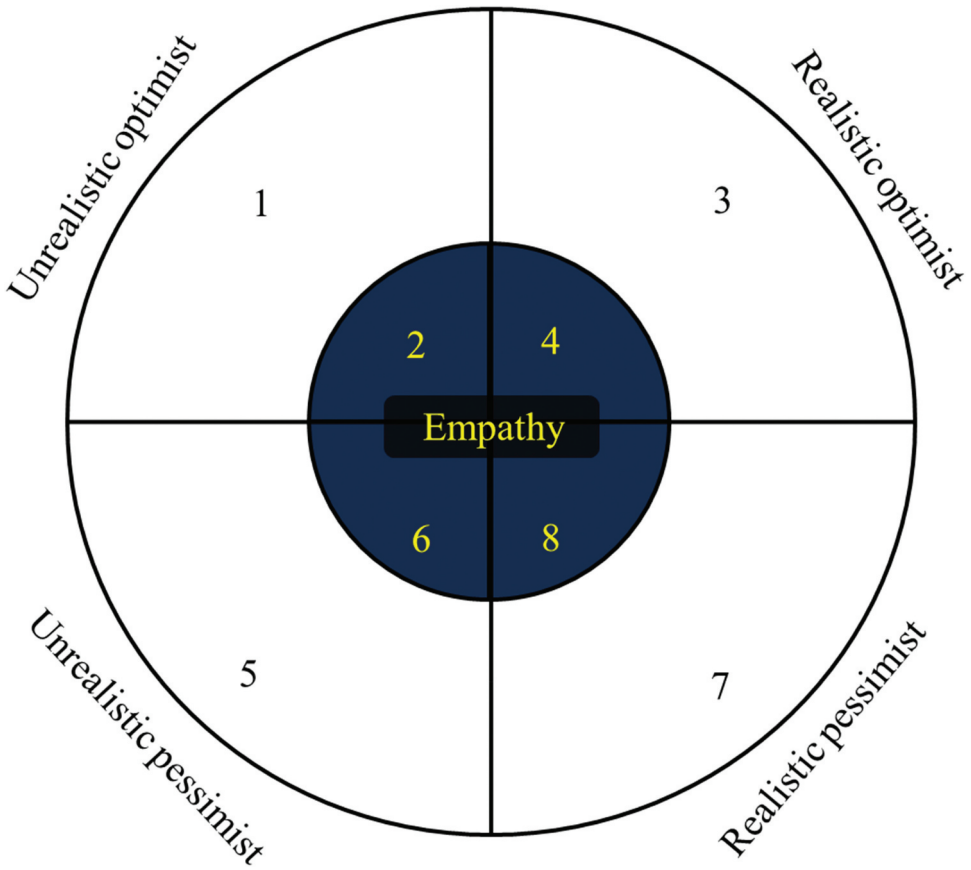

Figure 1. Pictorial representation of physician optimism. A physician should ideally be a realistic optimist with empathy (4). A realistic optimist will draw the least amount of confrontations. An unrealistic pessimist – with (6) or without (5) empathy will find themselves in unnecessary draining confrontations. A realistic pessimist (7) is brutally honest and is better than an unrealistic optimist with empathy (2) who promises 'heaven and earth' but fails to deliver.

as well as patients and family, understand that we are all mortal, communication of a grim prognostic diagnosis to a patient and family in any setting remains a tricky objective. The physicians' personality and actions under such circumstances put them into one of the following four categories shown in Figure 1. In brief, the physician can be a pessimist or an optimist with realistic or unrealistic expectations and convey the news to patients with or without requisite empathy. We would like to emphasize the importance of being realistic when delivering bad news but to be mindful to do so with empathy.

If we are unrealistic, however optimistic and empathetic we might be, patients are eventually going to feel deceived and may be compelled to accuse the physician of wrongdoing. A realistic pessimist is only slightly better since he or she is not going to be of any comfort to the patient. An unrealistic pessimist with or without empathy is the worst combination, in our viewpoint, and is likely prone to mentally draining confrontations.

As we traverse through this pandemic, we should remember that while making end-of-life decisions, it is not our personal biases but the patient's wishes (expressed by them or via a health care proxy), that need to be primarily considered [13,14]. Lastly, we must keep in mind that it is impossible to satisfy everyone despite one's best and sincere and well-meaning efforts. It is however well within our control to always remain a realistic optimist, with empathy, of course!

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Highlights

- Caring for a dying patient during this COVID-19 pandemic is inevitable
- A multidisciplinary approach to care during such times is critical
- Physicians must be realistic optimists, communicating with empathy
- A realistic/optimistic approach prevents confrontations with families

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