



Department of Health

Choosing wisely and avoiding futile surgery

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Care at the End of Life



Qld Statewide Strategy for E-o-L Care

1. Improve death awareness and encourage open discussion of death in the community generally
2. Identify patients for whom ACP should be considered early
3. Improve skills of **all** clinicians in communication about death and care at the end of life
4. Ensure appropriate palliative care is available across the state

Wisdom

- The quality of being wise
- esp. in relation to the choice of means and ends; the combination of experience and knowledge with the ability to apply them judiciously; sound judgement, prudence, practical sense. (Oxford dictionary)

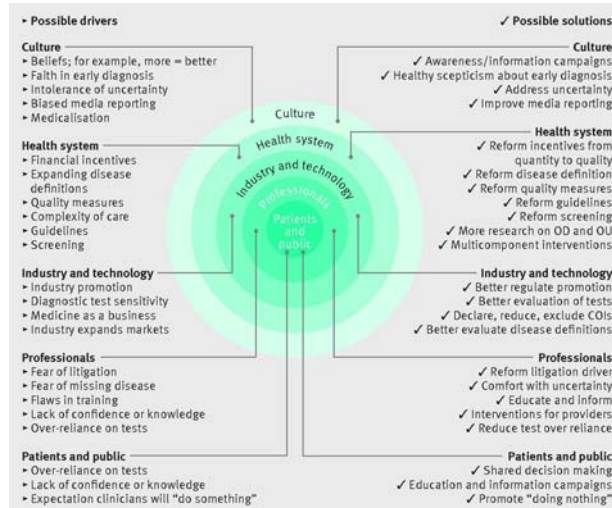
Futility

- Doing something that will not achieve the desired outcome
- So who decides which outcome defines success?
 - The patient?
 - The doctor?

Worldwide activity

- <http://www.bmj.com/content/358/bmj.j3879>
- **Mapping the drivers of overdiagnosis to potential solutions**
BMJ 2017; 358 doi: <https://doi.org/10.1136/bmj.j3879> (Published 16 August 2017) Cite this as: *BMJ* 2017;358:j3879
- www.preventingoverdiagnosis.net

Fig 2 Overdiagnosis and related overuse.



Thanya Pathirana et al. BMJ 2017;358:bmj.j3879



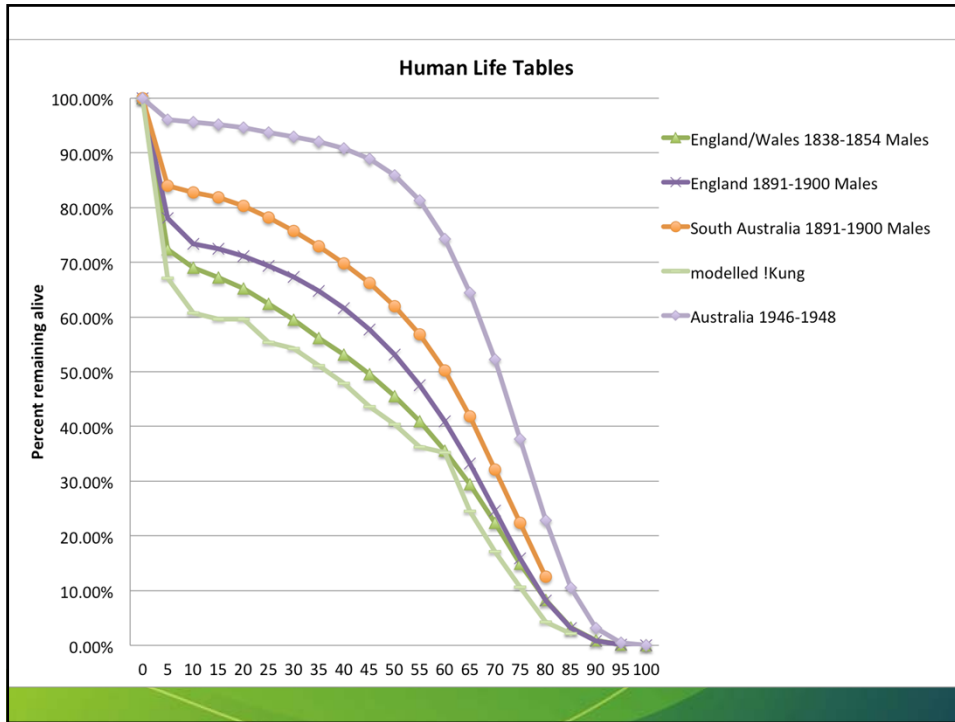
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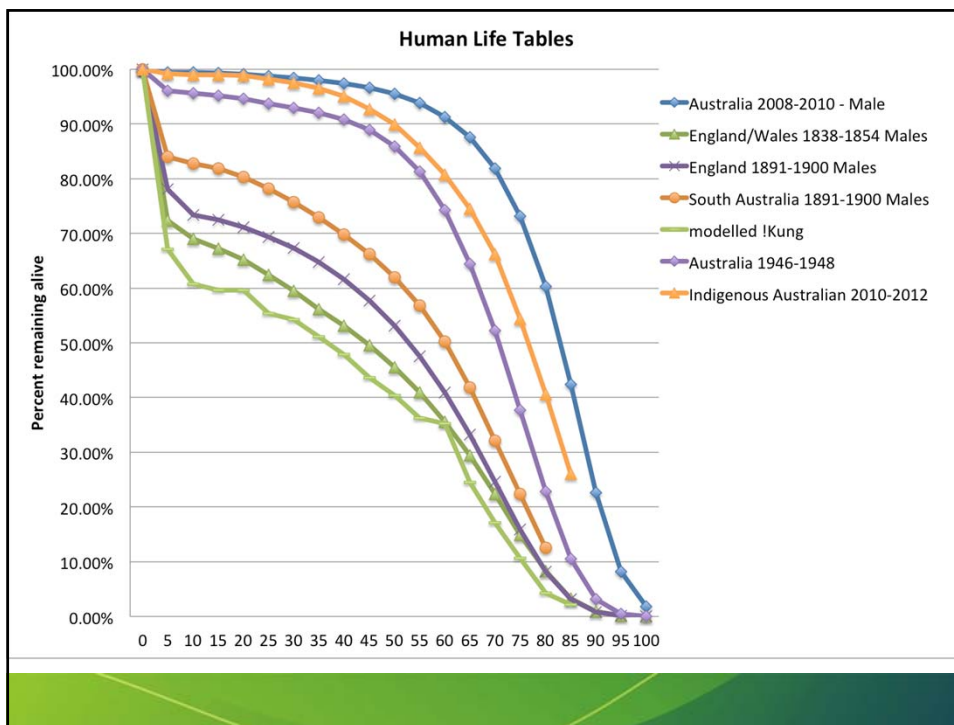
The world and medicine are changing dramatically

- Recognition of the inevitability of death
- Recognition that modern medical technology can prolong life without quality
- Modern medicine demands that decisions be managed as a dialogue between the the clinician and their patient.
- Only by exploring patients' and our own values, hopes, wishes and expectations can we help them decide which, of the things that we are offering them, are the right things to do.



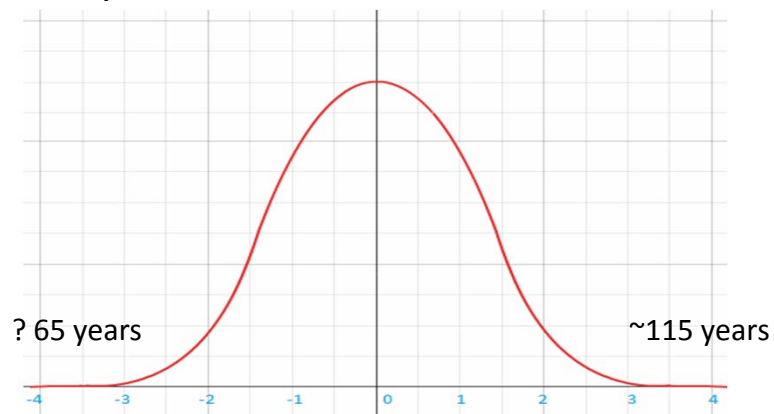






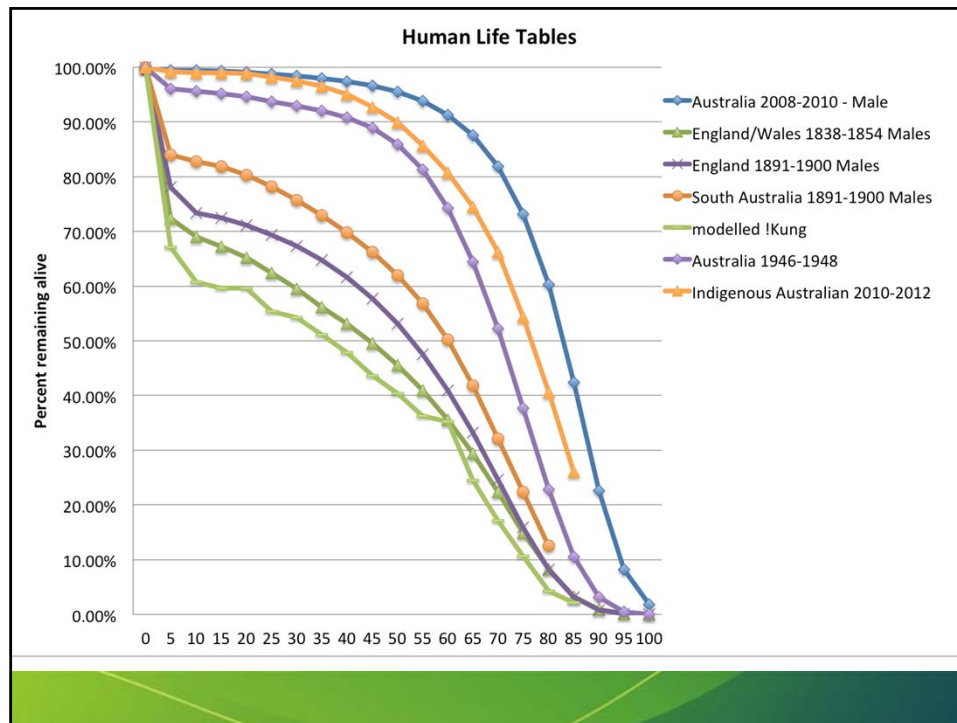
Maximum, maximum life-expectancy about 115 years

Distribution of maximum life-expectancies



Pathophysiology of those who are patients has greatly changed

- Multiple comorbidities
- General frailty
- Greater risk of poor outcomes from treatment
- Nearer to their maximum life expectancy
- Shifting of goals from quantity to quality of life
- “Oldhood” – “Don’t treat 90 year olds like 70 year olds”



Foundations of practice in cultural and biological drivers that echo from the past

- Healthcare practice is driven by values that evolved for a time when we could wish that those we love did not die, and yet could do nothing about it -- when people died, we grieved and (usually) moved on
- Survival benefit of bonds, with little or no survival cost
- New paradigm - we can delay death, but find we have not escaped distress.
- Increasing complexity, and with extended burden of care
- Personal and community interest are not always the same – the balance between individual and community
- Cultural adaptation is underway

Patient knowledge and attitudes, and the doctor\patient relationship have changed and are changing

More open communication

- At some level the patient generally already knows what is going on – much more aware and informed
- Patients and families may be relieved that at last someone is talking openly to them
- Uncertainty is decreased and the burden is shared
- Imagination may generate more fear than reality
- Knowledge is power and the patient can regain some control
- It is not our information, it is theirs

However

- Patients may be overwhelmed by diverse information and opinions
- Many patients have not considered what is important to them
- Many are challenged in trying to understand the balance of risk, burden and benefit, and to comprehend the implications for the way that they will be able to live their lives
 - Think brain tumors or extreme prematurity
- It is hard for any of us not to bring our values into discussions

Our changing role as clinicians

- Agents for change – community educators
- Introducing the normality of death and integrating it into clinical management
- Acquiring the skills to talk about death and dying
- Understanding the documents and the law about ACP
- Acquiring the skills of pall care appropriate to our clinical role

Preparing ourselves

- Contemplation of our own mortality
 - Self, family, community
 - Belief systems
- Recognition of personal perspective (e.g. my risk of nihilism, prostate cancer)
- Understanding our role to lead patients to wise decisions
- Dealing with uncertainty

Signs of change

Good Medical Practice: a code of conduct for doctors in Australia

In caring for patients towards the end of their life, good medical practice involves:

- Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient.*
- Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.*
- Accepting that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started.*

Signs of change

- We are agents of cultural change
 - Good Medical Practice
- The spoken words of a computer in the movie *Passengers*
 - “Various treatments are possible, none will meaningfully extend the patient’s life.”

Learning from colleagues

- Dr Denis Campbell
 - two cases as examples

Summary

- While at times we may see the things we do as an end in themselves, for our patients our therapies are a means to an end.
- However,
 - Patients may not have considered their goals
 - Patients (and/or their families) may have unachievable goals (Benefits of ACP)
- Our role is to help patients to make realistic choices from the options that are open to them.

So, can we be wise and avoid futility?

- Many things that we do may turn out to be futile when viewed in retrospect, but we should never say to ourselves that we knew it was futile before we started.
- Accept uncertainty and help our patients to integrate uncertainty into their lives
- Wisdom is an intangible quality and has a significant component of humility. Like good art, we know it when we see it.

“Life can only be understood backwards, but it must be lived forwards.”

- Soren Kierkegaard
1813 -1855

