How We Care For Our Patients

By Chuck Dinerstein, MD, MBA — June 19, 2017

How we care for our patients at the end of their lives periodically bubbles up into the consciousness of the general public as well as health professionals. The media often cover the high cost like how much Medicare spends on beneficiaries in their last six months of life (28% of their budget in 2011). And among health professionals, there has been a push to initiate end of life care discussions. In 2016 Medicare began physician payments for specifically discussing these issues with patients or their care-givers and the Conversation Project, “dedicated to helping people talk about their wishes for end-of-life care” has been widely publicized. In this week’s JAMA Internal Medicine Nancy Schoenborn and her co-authors write about one aspect of this problem, Older Adults’ Views and Communication Preferences About Cancer Screening Cessation.

It is a narrative summary but provides us with some useful information. Using structured interviews, they asked patients over the age of 65 about continuing cancer screening using a discussion of the risk and benefits of screening in the context of their age, health status or life expectancy. Here is what they found:

- Participants were amenable to stopping cancer screening, especially in the context of a trusting relationship with their clinician.
- Although many participants supported using age and health status to individualize the screening decision, they did not often understand the role of life expectancy.
- Participants preferred that clinicians explain a recommendation to stop screening by incorporating individual health status but were divided on whether life expectancy should be
My takeaway - framing the discussion around how the patient feels about their health and long-term outlook is more persuasive than physician descriptions of their 'life-expectancy.' Life expectancy is a numerical prediction based on ill-understood probabilities. The authors seem to take the point of view that not utilizing this numerical ‘objective’ measure was due to a numeracy problem. (Numeracy is the equivalent to literacy, how well do you read and understand mathematical principles) The scale used to measure numeracy put the participants in the upper third of their test. [1] But the common reason that patients gave for objecting to framing around life-expectancy was not about numbers,

“… participants did not believe that clinicians can predict life expectancy: “A doctor cannot tell you how long you gonna live, he can’t tell you if you gonna die tomorrow, next week, or 10 years from now…”

To be honest, they are correct. We do not know. A patient’s perception of how close they are to their deaths is probably more a function of how they are physically and emotionally feeling. Those signals are far stronger than any number. The findings of the article are important, reinforcing the need for physicians to understand that frequently, framing the discussion dictates the subsequent decisions. Personalized medicine, in this instance, does not require high-tech genetic sequencing and need not rely on sophisticated numeracy, it requires trust and empathy.

[1] Subjective Numeracy Scale is a self-report of three questions, 1) How good are you at working with fractions? (1 = not good at all to 6 = extremely good); 2) How good are you at figuring out how much a shirt will cost if it is 25% off? (1 = not good at all to 6 = extremely good); and 3) How often do you find numerical information to be useful? (1 = never to 6 = very often). The first 2 questions focus on self-reported numeracy skills (“fractions” and “shirt”), while the third focuses on subject preference (“useful”).

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