
Treatment Redirection: Moving From Curative to Palliative Care

Robert Lyman Potter

Treatment redirection occurs when the patient or surrogate, together with the health care providers, recognize that aggressive curative treatment must give way to supportive palliative care. The author offers us clues by which we can recognize, deliberate, and implement the process of redirection.

Introduction

Treatment redirection is the process of moving from *curative* to *palliative* care. Seriously and terminally ill patients often are subjected to curative treatments that they do not want, or from which they will receive little, or no, benefit. The goal of treatment redirection is to improve care of seriously ill and dying patients by withdrawing unwanted and unwarranted curative treatments and moving the patient into palliative care. This is accomplished by a treatment-redirection process that alerts stakeholders that death is probably approaching and allows them to agree on a new treatment plan, one that includes palliative care.

This article supports the need for treatment redirection, suggests three barriers to meeting that need, and outlines a treatment-redirection process (*Pathways* 1997).

Accepting treatment redirection is blocked by three interrelated barriers:

- Clinicians and patients often are narrowly focused on curative or ameliorative intervention;
- Clinicians and patients are unable to discuss palliation as a treatment option;
- Clinicians and patients are not confident that a comfortable death will be an outcome of palliative care.

The treatment-redirection process is made up of three sequential elements.

- An alerting system for recognizing patients' signals and key physiological signs
- A deliberation for informed consent about the appropriate new direction
- An implementation plan that activates excellent palliative care.

The Need for Treatment Redirection

Findings of the SUPPORT study offer a convincing argument that unwanted and unwarranted treatment is a real problem in today's health care environment (SUPPORT 1995). As many as fifty percent of patients were subjected to burdensome, curative treatment because the patient, family, and physician had not thoroughly recognized or discussed the realities of the terminal situation. Frequently health care providers do not understand their patients' beliefs about their condition and their preferences (American Health Decisions 1997). This often results in unwanted treatment. Physicians sometimes provide interventions that are unwarranted because of low probability of successful outcome (Asch 1995). All these facts support the need for a process of treatment redirection.

Barriers to Treatment Redirection

Clinicians and Patients Are Focused on Cure

Physicians often assume that patients and families want "everything done," even if it will provide little or no benefit. Although sometimes this is true, it should not be assumed without clarification of the patient's and family's expectations.

The intense focus on *curative* treatment implies that physicians have reliable knowledge about what works and what does not work. This is only partially true. Evidence-based medical decisions can be claimed for no more than fifteen to twenty percent of clinical situations (Feinstein 1997). Even though guidelines for recognizing terminal prognoses are of proven value, there is a persistent resistance among clinicians to use them (National Hospice 1996).

Problems Discussing Palliative Care

Physicians are often reluctant to discuss bad news with patients and to recommend that curative treatment be changed to palliative care (Weeks 1998). There is evidence of a change in physician practice, resulting in greater willingness to withhold or withdraw treatment from seriously ill patients (Prendergast 1997). Even so, patients and families report that their greatest disappointment with physicians is lack of communication on the issue of shifting treatment to palliative care (Hanson 1997).

It is usually thought that when patients and families disagree with health care professionals on effective treatment, the conflict can be resolved through good communication, empathic persuasion, and sensitivity to emotional content. This, too, is only partially true. Resistance from both patients and professionals can obstruct such a resolution of conflict (Jacobson 1997).

Disparity of beliefs and preferences causes much of this communication problem. Patients' beliefs and interpretations of their medical diagnosis and prognosis are often imperfectly formed from a collage of emotion, experience, and values.

Health care providers work through the same grid of beliefs and preferences. The assumption that the beliefs of professionals about the medical situation will be more realistic than that of patients may or may not be accurate. Professional interpretation can be distorted by uncritical and unacknowledged personal values. Interpretation of a medical condition by a professional remains a

"belief" about the situation. Facts and values become so mixed in the decisional process that public confidence in "the doctor knows best" cannot be sustained.

Lack of Confidence in Palliative Care

Patients do not assume that physicians wisely will combine the roles of technological wizards who oversee curative treatment and compassionate guides who provide excellent palliative care. Physicians often do not know enough about palliative care and have a negative attitude toward embracing it (Bulger 1997).

Although there is a growing trend toward patients wanting to be in control of their own death, cultural diversity factors, belief in the power of medical technology, and a strong tendency to deny death prevent a working consensus about how to approach the experience of dying.

Moreover, there is limited cultural consensus about the nature of a good death that can guide palliative care (Lynn 1997). Although there is a growing trend toward patients wanting to be in control of their own death, cultural diversity factors, belief in the power of medical technology, and a strong tendency to deny death prevent a working consensus about how to approach the experience of dying.

Patients' suspicions that managers of health care systems promote palliative care as a way to save money contributes to this lack of confidence. Empirical evidence shows a minimum of cost reduction in palliative care (Emanuel 1996). There is also evidence that leaders of managed care

organizations have not dealt well with end-of-life issues as simply a way to avoid the appearance of rationing.

Is the Goal of Treatment Redirection Realistic?

The barriers to improving care of seriously ill and dying patients are formidable. Is it possible, through better shared decision making, to improve the care of seriously ill and dying patients? Suffering a serious disease or being terminally ill are difficult experiences. It is *not* the goal of treatment redirection to make dying pleasant. Rather, the goal is to minimize suffering by agreeing through shared decision making to eliminate unwanted and unwarranted treatments and move the patient into effective palliative care that can provide comfort in dying.

To what extent can the culture of medicine and the wider community culture be changed to allow for shared decision making? Advocates of shared decision making have some empirical evidence that physicians are more open to dialogue with patients than they were three decades ago when the bioethics movement began in earnest (Keenan 1998). It may be unreasonable to expect patients and physicians to communicate meaningfully during times of stress mixed with factual uncertainty and high levels of complexity (Dowdy 1998). Nevertheless, shared decision making remains an important goal of the bioethics movement and a central strategy for improving care of seriously ill and dying patients (*Pathways* 1997). Shared decision making is at the core of the treatment-redirection process.

The Strategy of Treatment Redirection

An effective treatment-redirection process can guide the movement from active curative treatment to active palliative care, overcoming the barriers discussed above. Treatment redirection involves three steps: recognition, deliberation, and implementation.

Recognition

The first part of the treatment-redirection process involves recognizing clues that indicate the current form of treatment may not be wanted or may

not be warranted. The patient or family may question whether or not the treatment is their preferred option; the medical team may question whether or not the treatment can lead to a good outcome. This is a critical transition in the clinical process and is often unrecognized. Recognition requires an alertness to shifting and differing beliefs and preferences of any stakeholder. Courage is often required to admit that the goals and means of a medical intervention are not coherent.

Once such clues are recognized, all stakeholders—the care team, the patient, family, and others invested in the situation—come together for deliberation.

The recognition step requires certain knowledge, skills, and attitudes:

- Knowledge of specific disease and traumatic conditions
- Evidence-based concepts of appropriate treatment
- The use of prognostic systems such as APACHE, the Mortality Prediction Model, and criteria for hospice admission (Randolph 1998)
- Ability to interpret and apply statistical probabilities
- Familiarity with statements of authoritative deliberative bodies, such as the Critical Care Ethics Committee (Ethics Committee 1997).

Development of skills such as critical self-reflection, openness to team interaction and accountability, capacity for observation, the ability to search the literature for information relevant to a specific case, and sensitivity to patient and family input facilitate the recognition process.

The humble admission that unwanted or unwarranted medical technology can intrude upon a patient's dying is the guiding principle in recognizing clues to treatment redirection.

There are physiological clues that should alert the health care team to recognize that the current therapeutic direction may not be warranted. These

are primarily clues to physiological states that can be observed by attending to the monitored vital signs, laboratory tests, and the overall condition of the patient. A partial list of such physiological states include:

- Coma
- Persistent vegetative state
- Multiorgan failure
- Advanced cancer
- Major trauma
- Prolonged mechanical ventilation
- High-dose pressors
- Advanced dementia
- Unresolvable pain and associated symptoms

Psychological, social, and spiritual clues also alert the health care team that the current therapeutic direction is unwanted, and, therefore, may not be justified. Attention to the patient's perspective often reveals such preferences. These clues include:

- Patient requests
- Advance directive instructions
- Family requests
- Raising of quality-of-life issues
- Expression of cultural and religious issues
- Indirect or tentative objections and suggestions

When a person recognizes that a treatment is unwarranted or unwanted, that recognition needs to be shared with other members of the health care team. This alerts others to possible clues, or the team may have a better alternative explanation of the meaning of the clue. The key idea is multidisciplinary team work, both to be alert to, and make evaluative judgments about, the meaning of the clues. The team approach gives validity to the recognition

stage of the treatment-redirection process.

Deliberation

The deliberation step of treatment redirection is an exercise in informed consent and focuses on the appropriateness of the current treatment option. In the informed consent process, the health care provider communicates to the patient relevant information about the diagnosis, prognosis, and the risks and benefits of various treatment options. With this information, the patient chooses, or consents to, a treatment option. The same obligations and expectations associated with informed consent pertain to deliberation about treatment redirection. The deliberation stage of treatment redirection is a continuation, or reconsideration, of the informed consent that initially permitted the current intervention.

Prognosis, a powerful factor in making treatment decisions, has a quality of uncertainty because it involves a set of possibilities qualified by probabilities.

The deliberation step requires the health care team to possess certain knowledge, skills and attitudes. There must be knowledge of the prognosis, of the patient's values and goals, and self-knowledge on the part of providers.

Prognosis, a powerful factor in making treatment decisions, has a quality of uncertainty because it involves a set of possibilities qualified by probabilities. A physician's clinical decision is made up of prognostic information, uncertain and probabilistic though it may be; and preference, or value judgment, about what is good and right. Belief about prognosis plus preference about treatment goals must be mixed together in the crucible of decision.

It is important to know the patient as a person. This is facilitated by taking a values history and listening to the patient's stories, which give meaning to the person's life. The listener must under-

The goal of deliberation is to bring together what is warranted with what is wanted: what is warranted by a medical interpretation of the facts and what is wanted by the informed patient.

stand the psychological, social, and spiritual dimensions of seriously ill persons so that this subtle material can be appreciated. One must be clear about the patient's short and long-term goals. This process includes becoming acquainted with the patient's beliefs and preferences by listening to the voice of the patient.

Because the patient is embedded in a social context of family and friends, there must be an inclusive attitude that searches out the wider origin of beliefs and preferences in the patient's moral community. Knowledge of the expectations of the patient's cultural group is important. Deliberation is the stage in which open dialogue is necessary.

Self-knowledge on the part of health care providers is necessary because personal beliefs and preferences can create biases and distort clinical judgment. Critical self-reflection assists the professional in avoiding mixing personal agenda with the patient's life-situation.

Primarily, the skill set for deliberation is good communication:

- Listening skills
- Empathic presence
- Facilitation of group process
- Mediation among conflicted positions

- Techniques of ethical discourse
- Ability to tolerate anger and other strong emotions
- A positive attitude toward open dialogue and shared decision making

The deliberation stage of treatment redirection is a shared decision-making process through which differing beliefs and preferences are worked into a coherent action plan that unifies what is good for the patient and which good the patient prefers. The goal of deliberation is to bring together what is *warranted* with what is *wanted*: what is warranted by a medical interpretation of the facts and what is wanted by the informed patient.

The Central Exchange in Shared Decision Making

Each person in a particular situation has beliefs about the "facts" of that situation, about what is warranted by the evidence. Each person also has a preference about "what ought to be done" about the situation, about what is wanted in this situation.

Shared decision making is the process of bringing together the beliefs and preferences of patients and physicians.

THE SHARED-DECISION FORMULA	
Physician's beliefs preferences	Patient's beliefs preferences

Treatment redirection requires a unification of differing beliefs and preferences. It is sometimes difficult to bring these two sets close together and often requires skilled negotiating. Compromise is the subtle interplay of integrity and empathy. While the physician's belief about the situation may be more medically informed than that of the patient, a respect for autonomy lends power to the patient's preference. Generally, the physician's knowledge ought to prevail over the patient's, but

the patient's preferences ought to prevail over the physician's (Weeks 1998).

There are cases in which the patient or family and the health care team cannot reach agreement. There are instances in which doctors have good reasons to refuse to withhold or withdraw life-sustaining treatment or other significant intervention. There are instances in which the patient and family cannot be reconciled to the idea of futility. There are instances in which legal or policy pressures dominate the decision (Peters 1997). There are instances in which so much uncertainty and ambiguity prevail that none of the parties has a clear vision of a goal or the means to a goal.

In addition to pain and symptom relief, the care team must sensitively deal with the psychological, social, and spiritual issues of the terminal patient and the grieving family.

If conflicting interpretations cannot be reconciled, the choices include the following:

- Let the patient/family have their way and support them
- Let the patient/family have their way but continue to negotiate
- Tell the patient to choose another doctor or facility
- Suggest a limited trial period of some action
- Ask for mediation by an ethics committee
- Go to binding arbitration
- Go to court for legal resolution

It is useful to remember that the goal of deliberation is not to force a decision, but rather to dialogue about whether or not treatment redirection to palliation is warranted and wanted.

Implementation

Implementation involves procedural steps for redirecting treatment toward effective palliative care. There are issues of timing, transition, and completeness of comfort care.

Implementation requires certain knowledge, skills, and attitudes. The key knowledge base includes the entire range of good palliative care. Being informed about excellent palliative care in the broadest sense requires concentrated effort by providers. It is uncommon that physicians, or health care institutions, have invested enough educational and organizational effort to deliver excellent palliative care.

The same critique applies to the skill level to accomplish good palliative care. Very few physicians are fully able to perform at an excellent level when managing pain and other symptoms, or dealing with the patient's personal issues about dying. Even minimal training in these areas would improve provider performance.

The most constructive attitude in implementing treatment redirection is the belief that excellent palliative care is an important part of medical care and that a well-conducted death is to be cherished.

Carrying out a decision to redirect treatment requires continuing negotiation and careful planning. The timing of withdrawing current treatments will be crucial if a patient is on life support. Considerations about organ donation, funeral arrangements, spiritual care, and initiation of aggressive palliation to minimize suffering are all issues that must be attended in the implementation step.

Timing issues have to do with allowing patients, family, and caregivers an adequate period to process grief. It may be necessary to delay for hours or days for the family to gather or for an important life event to occur such as a birthday or anniversary. It may take time to process various psychological, social, and spiritual issues.

Transitioning from an aggressive curative mind set to acceptance of aggressive palliation can

create stress. A mixture of guilt, anger, and doubt tend to dominate this transition stage. It may be necessary to provide reassurance to the patient and family to counter feelings of abandonment or guilt over being disloyal to the patient or the values of their moral community.

The completeness of comfort care requires a very broad understanding of palliation. In addition to pain and symptom relief, the care team must sensitively deal with the psychological, social, and spiritual issues of the terminal patient and the grieving family.

While some health care teams may have the knowledge, skills, and attitudes necessary for good palliative care, consultation with a palliative specialist or hospice referral should be open options.

Conclusion

In the course of each patient's illness there comes a time at which medical science will no longer bring benefit. Treatment redirection begins with a recognition of that transitional time. This recognition causes the health care team to initiate the second step of deliberation. The honest sharing of beliefs and preferences about what is happening and what ought to be done can lead to a clear choice to shift from curative to palliative care. When that shared decision is reached, the third step of implementation can move the patient into palliative care. Treatment redirection can be an important factor in improving care of seriously ill and dying patients.

References

American Health Decisions. 1997. *The Quest to Die with Dignity*.

Asch, D., et al. 1995. "Decision to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States: Conflicts Between Physicians' Practices and Patients' Wishes." *American Journal of Respiratory and Critical Care Medicine* 151:288-292.

Bulger, R. J. 1997. "The Quest for Mercy: The Forgotten Ingredient in Health Care Reform." *Western Journal of Medicine* 167:362-373; 443-457; 168:54-72.

Dowdy, M.D. 1998. "A study of proactive ethics consultation for critically and terminally ill patients with extended lengths of stay." *Critical Care Medicine* 26: 252-259.

Emanuel, E. 1996. "Cost Savings at the End of Life." *Journal of the American Medical Association* 275:1907-1914.

The Ethics Committee of the Society of Critical Care Medicine. 1997. "Consensus Statement of the Society of Critical Care Medicine's Ethics Committee Regarding Futile and Other Possibly Inadvisable Treatments." *Critical Care Medicine* 25:887-891.

Feinstein, A. R., and R. I. Horwitz. 1997. "Problems in the 'Evidence' of 'Evidence-based Medicine'." *American Journal of Medicine* 103: 529-535.

Hanson, L. C., et al. 1997. "What is Wrong With End-of-Life Care? Opinions of Bereaved Family Members." *Journal of the American Geriatric Society* 45: 1339-1344.

Jacobson, J.A., et al. 1997. "Dialogue to Action: Lessons Learned from Some Family Members of Deceased Patients at an Interactive Program in Seven Utah Hospitals." *Journal of Clinical Ethics* 8: 359-371.

Keenan, S.P. 1998. "Withdrawal and Withholding of Life Support in the Intensive Care Unit: A Comparison of Teaching and Community Hospitals." *Critical Care Medicine* 26: 245-251.

Lynn, J., et al. 1997. "Perceptions by Family Members of the Dying Experience of Older and Seriously Ill Patients." *Annals of Internal Medicine* 126:97-106.

The National Hospice Organization. 1996. *Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases*, 2nd. ed.

Peters, P.G. 1997. "When Physicians Balk at Futile Care: Implications of the Disability Rights Laws." *Northwestern University Law Review* 91:798-864.

Prendergast, T. J., and J. M. Luce. 1997. "Increasing Incidence of Withholding and Withdrawal of Life Support from the Critically Ill." *American Journal of Respiratory and Critical Care Medicine* 155:15-20.

Randolph, A. G., et al. 1998. "Prognosis in the Intensive Care Unit: Finding Accurate and Useful Estimates for Counseling Patients." *Critical Care Medicine* 26:767-772.

The SUPPORT Principal Investigators. 1995. "A Controlled Study to Improve Care of Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Treatments (SUPPORT)." *Journal of the American Medical Association* 274:1591-1598.

Tomlinson, T., and D. Czlonka. 1995. "Futility and Hospital Policy." *Hastings Center Report* 25:28-35.

Weeks, J. D., et al. 1998. "Relationship Between Cancer Patients' Predictions of Prognosis and Their Treatment Preferences." *Journal of the American Medical Association* 279:1709-1714.