

## ***Virtual Mentor***

American Medical Association Journal of Ethics  
January 2003, Volume 5, Number 1: 13-15.

### **IN THE LITERATURE**

#### **Influence of Physician Bias on End-of-Life Care**

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The debate over end-of-life care issues has long centered on the correct balance between patient autonomy and physician judgment. Despite the common notions of shared decision making and societal emphasis on patient choice, studies have shown apparent discrepancies between the patients' preferences and physicians' decisions regarding the management and care of patients with terminal prognoses. More often than not, these studies support the argument that physician biases are more influential in end-of-life care decisions than patient values.<sup>1-4</sup> Other studies argue further that patient "choice" is more of an illusion than a reality.<sup>5-6</sup> A 1997 study in *Clinical Nephrology* by physician George W. Rutecki, et al. entitled "Nephrologists' Subjective Attitudes Towards End-of-Life Issues and the Conduct of Terminal Care",<sup>7</sup> adds a new perspective to the debate of physician bias by examining how physicians' attitudes towards death and dying affect the type of end-of-life care they give. The authors found that nephrologists' discomfort with dying patients greatly influences their decisions regarding life-sustaining treatments and their willingness to hasten the death of terminal patients.<sup>7</sup>

Rutecki, et al. anonymously surveyed 125 nephrologists to assess their attitudes towards death and their care of terminal patients. Part of the survey measured the physicians' anxiety towards death and their discomfort with dying patients. Another part of the survey asked physicians how often they: (1) omit life-saving treatments (with or without patient knowledge); (2) have been asked by the patient or the patient's family to hasten death; and (3) would, in the event that it became legal, hasten death of certain patients. Physicians were also asked what factors, such as dementia, depression, or the presence of cancer, they considered prior to recommending the discontinuation of dialysis treatment. Other factors, such as the physician's age, their formal ethics training, the number of years spent caring for dialysis patients, and the percentage of time spent teaching versus private practice were also included in the survey.<sup>7</sup>

The authors focused their analysis on the nephrologists' self-reported discomfort with dying patients and their fear of death as these correlated to their attitudes towards the hastening of death and the omission of life-sustaining treatments. They found that the more uncomfortable physicians were with dying patients the more likely they were to initiate or continue life-prolonging treatments. These physicians were also less likely to say they might assist in death-hastening measures, even if this option were legalized. In fact, 43 percent of the respondents stated they would

"never" assist in hastening death if such measures were legalized. And 25 percent reported "difficulty honoring advance directives" if these went against what the physician believed was best for the patient. No significant association was found between the fear of death scale and omission of treatments or death-hastening responses.<sup>8</sup>

Based on these results, Rutecki, et al. suggest that decisions regarding terminal patient care may be altered by a nephrologist's point of view and subjective attitudes toward dying patients. The authors believe that this study adds another dimension to the possible physician influences that affect decision making in end-of-life care. After reviewing studies that asked physicians in other specialties about their attitudes towards end-of-life care, the authors found results consistent with their own findings.<sup>7</sup>

Rutecki, et al. present suggestions to remedy the disturbing trend, based on recommendations made by Dr. David Orentlicher and the American Medical Association's Ethics and Health Policy Counsel.<sup>5</sup> The authors suggest that physicians carefully examine their practices to ensure they are not imposing their subjective attitudes onto patient decision making and that they are involving patients in the decision-making process by encouraging them to express their values and preferences. They further propose intensifying ethics education, especially for physicians routinely involved in end-of-life care. Rutecki, et al. refer to a study which suggests that educational interventions result in greater expression of patient preferences and patient-physician discussion of treatment choices during the decision-making process.<sup>9</sup> Based on this study, they advise that such educational initiatives focus physician attention on how their subjective attitudes influence end-of-life care. Then, presumably, physicians will become more sensitive to their patients' desired treatment.

### **Questions for Discussion**

1. As a clinician, how would you balance your professional medical judgment with your patient's treatment preferences for end-of-life care if they differ?
2. Rutecki, et al suggest educational interventions directed at physicians' subjective influences on end-of-life care decision making. What do you think that educational intervention (curriculum) should include?
3. The authors believe that nephrologists' personal attitudes influence treatment decisions for their patients with terminal illnesses. How might attitudes of other physicians influence their treatment decisions for patients with acute or chronic illnesses?

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