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At the Bedside

A Different Approach to Patients and Loved Ones Who Request "Futile" Treatments

Edmund G. Howe

ABSTRACT

The author describes an alternative approach that careproviders may want to consider when caring for patients who request interventions that careproviders see as futile. This approach is based, in part, on findings of recent neuroimaging research. The author also provides several examples of seemingly justifiable "paternalistic omissions," taken from articles in this issue of *The Journal of Clinical Ethics (JCE)*. The author suggests that while careproviders should always give patients and their loved ones all potentially relevant information regarding "futile" decisions, careproviders may wish to consider, paradoxically, not giving advice in these situations, when the advice is based mostly or wholly on their own moral views, based on this same, ethical rationale.

One of the most painful dilemmas that careproviders presently face is how to respond when a patient or a patient's loved one wants a treatment that the careprovider believes is "futile." Recent publications from the American Medi-

cal Association discuss *informed assent* and *selective paternalism* as possible approaches that careproviders could consider in these situations, which hints at the pain that all parties may feel in these situations. These publications suggest that many careproviders believe that, when necessary, they must be able to deny patients and loved ones such care.¹

In this issue of *The Journal of Clinical Ethics (JCE)*, I will present a different approach that careproviders may use, at least initially, that could be preferable for all parties. To support this approach, I will describe a just-published neuroimaging study—the first of its kind—and data regarding the use of this approach with real patients.

First, I will discuss three cases from articles that appear in this issue of *JCE*. All of the cases are characterized by careproviders and patients who feel particularly intense emotional turmoil. In the first case, a physician and nurse in Israel are performing a colonoscopy, and, during the procedure, the physician, nurse, and patient suddenly become subject to a rocket attack. In the second case, which occurred after the 2010 earthquake in Haiti, an emergency physician has to decide which of four patients she should try to save; all need oxygen, urgently, to save

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their lives, and all have air hunger. In the third case, a patient is dying and wants to go home, but there is no one there who can care for him. What should his careproviders do?

I will discuss important issues that each case raises, and a question that all of the cases pose, which has profound implications for how careproviders face questions involving futile treatment—and numerous other, similarly difficult ethical questions as well.

Finally, I will describe a different approach to futility. I will consider what is “state of the art” in this area, some early data on this different approach, and its underlying rationale. The core principle underlying this different approach is to start by considering what a patient or loved one is most likely to feel, and go from there. Intentionally or not, the careproviders in these three cases followed this approach.

THE “LESSON” INHERENT IN THESE THREE CASES

Should We Limit When We Ask Patients to Make Life-and-Death Decisions?

In “Endoscopy During a Missile Attack: A Military Dilemma for Physicians,” Stephen Malnick, Orit Faraj, and Alan Jotkowitz relate how, during a colonoscopy, rockets began to rain all around them.² This raised the ethical question of what to do: Leave the patient unattended and try, in 90 seconds, to reach safety? Remove the endoscope from patient and then try to seek safety for all? We might propose, for example, that the careproviders should simply stay with the patient, although this would cause all of parties to be at higher risk.

The authors note that many civilian urban centers of the world may become a “battlefield,” and that citizens in these areas may find themselves in “acute war situations” within “seconds.” It could be imagined that both patients and careproviders in these situations may feel that the loss of only one life is better than the loss of several.³ Malnick, Faraj, and Jotkowitz go beyond this. They ask, more generally, what greater measures careproviders can take to eliminate or diminish problems such as these that could be anticipated. They highlight two

concerns that pertain to careproviders everywhere: that they are vulnerable to outside factors, such as, in this case, the stress created by trying to perform a procedure during a rocket attack, as well as “inside factors” such as fatigue, that may greatly impair their capacity to give patients optimal care. For example, when a careprovider performs a colonoscopy, she or he may do this better in the morning than in the afternoon.

There is a question in this case that the careproviders did not ask; they did not ask the patient what he or she would want done. We might wonder why not. Usually, not asking a patient about something like this might be seen as insufficiently respecting a competent patient’s autonomy; after all, the patient’s life was also at risk. But was “asking” warranted under these circumstances? And, of course, was there adequate time to ask?

It may be that, consistent with the authors’ recommendation, once having had the experience of being subject to a rocket attack while performing a procedure, they could ask patients in advance what they would want to do in the future. On the other hand, this would hardly help to relieve any apprehension patients might feel. In this instance, we could imagine, the careproviders didn’t ask this patient because they believed that it would be “too much,” too overwhelming, if they did.

If these surmises are accurate, this case could be seen as illustrating *paternalism by omission*, that is, when a careprovider makes a choice, not maximize a patient’s autonomy, but instead to spare the patient from real (or imagined) unjustifiable harm. This is what occurs legally, overtly, when a careprovider exercises therapeutic privilege and knowingly withholds information from a patient for the patient’s own good. Whether a judgment was warranted can be contested in court. More covertly, this occurs when an institutional review board (IRB) precludes possible research participants from being able to subject themselves to certain kinds of research harms.⁴

My point is that the ethical considerations in this case of colonoscopy during missile attack begin, at least implicitly, from a conscious

(or unconscious) recognition of the patient's "human" (that is, emotional) limitations. Careproviders who confront ethical considerations in the delivery of futile treatment might also begin here, because patients may become overwhelmed by the same kinds of feelings when they fear that their careprovider will refuse to provide what the careprovider considers to be futile treatment.

Should We Limit What We Tell Patients about How Life-and-Death Decisions Are Made?

Michelle Daniel, in "Bedside Resource Stewardship in Disasters: A Provider's Dilemma Practicing in an Ethical Gap," in this issue of *JCE*, describes the anguish she experienced while in Haiti after the 2010 earthquake, trying to decide whose life, among four patients, she should try to save.⁵ She was there as an emergency physician working night shifts, and relates she was "lucky" to sleep "three hours a day." (This echoes the previous authors' concerns regarding fatigue). Of course, her question is which of the four she should save.

As Jeffrey T. Berger points out in "Resource Stewardship in Disasters: Alone at the Bedside,"⁶ in this issue of *JCE*, peer support can be "critical" when a careprovider feels agonizing moral distress due to having to make the kind of triage decisions alone that Daniel did. Daniel and others might find some comfort in knowing that there may be no "boiler-plate" rubric that is better than the rubric they construct on their own, because their rubric alone is tailored to their own unique context. There might be some comfort in knowing that even with the uncertainty they feel, they are heroic. Although all four of Daniel's patients that one night shift required oxygen, there was only one oxygen tank, and all of the patients had "air hunger."

Daniel raises concerns that she might have been overly influenced because one patient was a nurse—a careprovider like herself—or that she found another patient to be "heart-breakingly beautiful." She asks herself, unsparingly, if she is overly influenced by one of those factors, or both. Deeply hidden biases in our nature, she remarks, can lead even the best-intentioned individual astray.

She, as any of us, could be biased without our knowing it. In an attempt to prevent this, we could consciously shift too far in the other direction. For example, I routinely fear this when I have an opening in my outpatient psychiatry schedule. When I have an opening, I can choose to continue to see a new patient, or I can refer the new patient to another psychiatrist. I fret that I may do one or the other, not for the patient's good, but for my own good. That is, some patients are more "concrete" in their thinking than others—for instance, if you ask such a patient, "What does the phrase, 'People who live in glass houses shouldn't throw stones,' mean?" and the patient might answer, "Well, if you throw a stone, somebody might get hurt." For me, a patient who can be more "abstract" is more likely to be engaging and challenging. Thus, I fear that when making a decision to continue to see a patient or to refer, I may respond more to my own needs than to the patient's.

Likewise, I fear going "a step further" for other members of the careproviding profession. For example, I may consider prescribing a greater number of medications at one time to save a careprovider-patient from waiting as long in line at a pharmacy. This consideration is important. For example, Kay Redfield Jamison, an expert on bipolar illness who has the disorder herself, said, regarding a colleague's doing this for her after her husband died: "My colleague made it easy for me. Instead of my having to call one of my doctors and wait at a pharmacy . . . he took it into his own hands to get a prescription filled. It was a small act of kindness but enormously important."⁷ But, on the other hand, such efforts would be important to any patient.

Daniel, the emergency physician-responder in Haiti, explains that she thought if she gave her patient who was a nurse the oxygen, that morally, if the nurse lived, he might be able to help others to a greater extent, since he was a careprovider. Daniel also thought that since the nurse was a careprovider, he might have, "in the line of duty," taken on more risks on behalf of others, and thus might more deserve to have a chance to live and continue serving others.

Each of her arguments, in and of itself, has ethical merit. But it is important to note that we may use arguments that are sound in themselves to rationalize how we want a situation to come out for other reasons, without knowing it.

Daniel also fears she may have overresponded to the patients' looks. This is a risk to which we are all prone, and it may be greater than we imagine. In one study, even though subjects were not given enough time to clearly see faces that were projected on a screen, their ability to "guess" regarding how they would rate the "attractiveness" of the faces was "surprisingly accurate." More importantly, once the subjects made judgments about the attractiveness of the faces, the subjects became "primed" to make more-positive subsequent judgments about other aspects of the people behind the faces whom they found attractive, even though there was no basis for the accuracy of their judgments. And, interestingly all of the subjects' subsequent judgments were made more quickly than their initial judgement.⁸

Such quickly based judgments may affect how a patient responds when he or she senses that a careprovider may withhold a treatment that the careprovider believes is futile. The human brain may be hard-wired to do this, some believe, because such "thin-slicing" may enable us to make snap judgments useful for survival. A brain that responds in this way may, for example, help us select healthier "mates" and avoid disease.⁹

To return to Daniel's emergency response experiences in Haiti, and to the medical team's analysis of the missile attack during a colonoscopy. What was it that did Daniel not say to her four patients? She didn't tell them that she was determining which one among the four of them would have a chance to live. And her reason is one that we can surmise.

Matthew Hunt, Christina Sinding, and Lisa Schwartz, in "Tragic Choices in Humanitarian Health Work," in this issue of *JCE*, suggest that it may seem "cruel" to people in a catastrophe when they learn that they had not been chosen to receive treatment.¹⁰ Even so, when this kind of information is accurate and involves whether a patient lives or dies, a patient may want to

know about it. Is it plausible that a patient might, in some way, understand a careprovider's plight, so that the patient could appreciate it when a careprovider shared this kind information?¹¹ Such candor might be something that a careprovider could offer to a patient under these most terrible circumstances.

Should a careprovider choose not to disclose this kind of information, it could "count" as a type of *paternalistic omission*—and an omission that is quite likely to be ethically justifiable. In Daniel's situation, she did not choose to prioritize treating her patients as persons by enhancing their autonomy, by telling them about her choice and how she made it. This suggests that optimal ethics may begin with acknowledging how we, as humans, are most likely to respond to these kinds of terrible situations.

Should We Tell Patients Why, When We Do Not Support Their Interests?

In this issue of *JCE*, in "When Negative Rights Become Positive Entitlements: Complicity, Conscience and Caregiving," Andrew G. Shuman, Adam A. Khan, Jeffrey S. Moyer, Mark E. Prince, and Joseph J. Fins discuss a patient who understands that his condition is terminal, but still wants to be able go home, where he will have no assistance, to die.¹² In the hospital, the patient required "near-constant nursing attention for wound care, positioning, airway/secretion management, hygiene/toileting, and pain control." Further, he couldn't speak. But once his careproviders understood what he wanted, they sought to find a way they could fulfill his wishes—thus providing the highest imaginable quality of care.

Such situations may require careproviders to imagine what a patient may most want, either because the patient won't say what that is, or perhaps the patient can't understand what that is, herself or himself. This is often the case with incompetent patients, but may be the case for even competent patients. For example, I think of a patient who wanted to leave the hospital against medical advice (AMA). Even though it is legal for a patient's doctor to sign a patient out of a hospital AMA, to help protect

the hospital legally, this patient's doctor refused to do so. He imagined that if he signed his patient out AMA, the patient would feel betrayed by him, and abandoned (even though it was the patient's wish to leave). On this basis, the doctor strove to maintain the alliance he had established with the patient—and still had—and refused to sign the patient out AMA, although this was the usual policy at the hospital. The patient left anyway, but the physician continued to provide care to the patient.

These kinds of choices may erode patient/careprovider relationships in other contexts, as well. Psychiatrists may have this kind of concern, for example, when they consider whether they should ask a suicidal patient to sign an anti-suicide contract. Even though the contract may or may not affect the likelihood that the patient will try to commit suicide, when a psychiatrist requests such a contract, it may negatively affect their prior patient/careprovider bond.¹³

The physicians in the case described by Shuman and colleagues, who did not want their patient to go home alone to die, were committed to the patient, and even courageous, as was the doctor of my experience who refused to sign his patient out of the hospital AMA. But what happens when careproviders are not this committed or courageous? Should they tell a patient that they aren't willing to go this far? Should they share that they won't do something that they believe is in the patient's best interest because they have concerns for themselves? To do so would, no doubt, be rare. But there still may be something to be said for this approach, although it would probably be one of the most difficult decisions a careprovider could make.¹⁴

In any event, it is not uncommon for careproviders to make decisions that are based on their own needs and fears. According to one study, the percentage of clinicians who acknowledged that they had, at some time in their practice, done what was best for themselves, despite believing that this wasn't what was best for a patient, was 85 percent.¹⁵

To repeat a point made above: careproviders may not respect a patient's autonomy to the greatest extent possible when they believe this

is what is best for the patient, what I have called *paternalistic omission*. This same value priority, while it may tend to remain hidden, may be warranted, as when a patient or loved one wants a treatment that a careprovider considers "futile." Rather than prioritizing enhancing the patient's or loved one's autonomy in these situations, a careprovider may instead ask what will work best for the patient. We shall consider this now.

A DIFFERENT APPROACH

The three cases described above illustrate that there may be situations in which the usual, "logical" ethical priorities may not apply because most patients, as human beings, couldn't bear the result. Generally, our "lesson" in this, then, is that when careproviders face an ethical conflict, they might do well to always start with considering a patient's emotional, human limitations. They may base what they choose to do on their best estimate of what most patients could bear to hear. The alternative would be to ask a patient to hear what is "too much" to bear, which is most likely not going to "work," emotionally.¹⁶ To consider a patient's or loved one's emotional limitations is an approach that careproviders might consider when a patient or a loved one wants an intervention that the careprovider sees as being futile.

Futility: The Present Practice

When a patient or loved one requests a futile treatment, careproviders commonly explain why they believe that the treatment requested is futile.¹⁷ All too often, this approach fails. As I mentioned above, a stronger approach may be emerging, in which careproviders increasingly make decisions by themselves. The practice of *informed assent* is an example: using this approach, a careprovider might say, "Unless anyone disagrees, I'd like to write in her chart that if her heart stops, she not be resuscitated."¹⁸ But, all too frequently, these new approaches also fail; although the futile treatment isn't provided, the patient or family may remain embittered.

Why might this happen? A recent study offers one possibility. Researchers studied how

participants' brains responded when they saw one person purposefully harm another, or accidentally harm another. The researchers found that exceptionally fast nerves within the brain automatically recorded the kind of action that the study participant observed (that is, purposeful harm or accidental harm). That the "early engagement" experienced by the study participants was evoked by their exceptionally fast perception suggests to the authors that "affective processes precede cognitive evaluative processes," or that "intentionality judgments both precede and guide moral cognition."¹⁹

A possible implication of these findings is that, once careproviders try to persuade a patient or loved one to accept their view regarding the futility of an intervention, a "warning bell" may go off somewhere in the patient or loved one's brain, and the resulting fear may prevent him or her from ever changing his or her mind. Is there yet another alternative?

Futility: A Different Approach

In a presentation at the 2012 annual meeting of the American Society of Bioethics and Humanities (ASBH), Erinn Nakahara, a counselor for an organization called Vital Decisions, presented what that organization sees as a "unique approach" for responding to patients with "advanced illness." Medical insurance companies contract with Vital Decisions, and insurers inform their insureds with advanced illness that a counselor working for Vital Decisions may call. When a person with this insurance has a medical condition and a counselor may help, a counselor calls. The counselor identifies him- or herself and makes clear that there is no agenda whatsoever, other than to give the patient more control over choices—if the patient wants this—by giving the patient, in an ongoing way, information that may be relevant, and the opportunity to discuss the information. The patient and the counselor can discuss, over the phone, over time, the patient's concerns, fears, and preferences. The result? Vital Decisions reports satisfied patients as well as economic savings.

After 15,000 consultations, the program reports a 9:1 return on program investment when

costs were compared in the last three months of the patients' lives,²⁰ which is not surprising: if there were not demonstrated savings, the insurance companies would not contract with Vital Decisions for very long. As for patients' satisfaction—the main point of this discussion—the "primary driver" of the savings, Nakahara reported, is patients' increased selection of palliative/hospice care earlier in their disease, for longer periods.²¹ The counselors that work for Vital Decisions relate three very important insights.

First, they assume that all individuals differ. They know that if a patient feels safe enough for a long enough time, the patient is likely to share her or his more idiosyncratic preferences, and her or his personal views.

Second, the counselors assume, and so inform the patient, that although the patient may have what he or she regards as a clear, static view at any one time, new preferences may continue to emerge over time. This second point is pricelessly made by Marc Tunzi in his article in this issue of *JCE*, "Incapacitated Patient Decision making: The Clinical Standard of Surrogate Empowerment."²² He calls this, quoting Lachlan Forrow, "The Green Eggs and Ham Phenomena": until an individual has experienced a situation for some time, the person may not know what she or he really wants, and, thus, "an individual's initial response may not be that individual's ultimate response."

Third, and most important of all, the counselors discuss futile treatments, but do not try to influence the patient in any way—which is more difficult to do than it may appear. For example, Tunzi offers superb verbatim examples of how careproviders can speak with surrogate decision makers: "After all, you are the person [the patient] asked to make decisions for him/her [or: "After all, you are the person with the closest relationship to (the patient), so he/she must trust you a great deal]." But the use of the words "after all" could be seen as persuasive, and may trigger the alarm response that I describe above. The approach taken by Vital Decisions is, all in all, paradoxical, in that it moves the patient to not choose futile care, but not by *advising* that. Rather, the counselors

start wherever the patient is, and go wherever the patient wants to go.

Thaddeus Mason Pope and Melinda Hexum offer, in “Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment,” in this issue of *JCE*, by far the best approach to advance directives, to date.²³ As they note, there remains “significant concern with abuse,” as POLST may be implemented in “a coercive and manipulative manner,” and they provide an example. Yet they also indicate that patients can complete POLST in any way they want, and that 23 percent of patients in one study chose “full treatment.” When a patient chooses full treatment, and full treatment would be futile, careproviders could opt to implement the approach that Vital Decisions uses.

The initial success reported by Vital Decisions suggests that careproviders might want to approach “ethics” by attending first to where patients or their loved ones actually “are,” even when this sometimes seems to be a place that is extremely irrational. There may be a reason for the irrationality; recent studies indicate that patients in intensive care units may be very significantly traumatized by the experience.²⁴ Other studies indicate that patients who have had breast cancer may be—and stay—greatly traumatized, but may do much better after therapy.²⁵ Our task, then, would be to get patients who have been traumatized by an ICU visit into therapy. This might be done best by “starting” with patients right where they are, which is what Vital Decisions does.²⁶

CONCLUSION

More than many may realize, careproviders make paternalistic decisions by omission for patients based on their beliefs or intuitions on what will do the patients the most good. Careproviders agonize over what to do when patients and loved ones want interventions that are futile. Most careproviders respect patients’ autonomy by telling them that the preferred treatment is futile. There may be a case, though, for increased paternalistic omission. Careproviders may tell a patient what they feel the patient wants or needs to know, but stop short of giv-

ing the patient advice (although they may need to tell the patient what he or she should expect to experience up the line).

The cardinal principle, the general emotional, human paradox involved, has been known for some time. More than a decade ago, Elliott Aronson, an eminent psychologist, put it this way: “. . . very little can be gained if someone tells us how we are supposed to feel. How we are supposed to behave or what we are supposed to do with our lives . . . a great deal can be gained . . . if we understand the wide variety of options available to us.”²⁷

NOTES

1. Regarding informed assent, see J.R. Curtis, “ETHICS CASE/ The Use of Informed Assent in Withholding Cardiopulmonary Resuscitation in the ICU,” *Virtual Mentor/ American Medical Association Journal of Ethics* 14, no. 7 (July 2012): 545-50, 546. Regarding selective paternalism, see B.C. Drolet and C.L. White, “Selective Paternalism,” *Virtual Mentor/American Medical Association Journal of Ethics* 14, no. 7 (July 2012): 582-588, 583.

2. S. Malnick, O. Faraj, and A. Jotkowitz, “Endoscopy during a Missile Attack: A Military Dilemma for Physicians,” in this issue of *JCE*.

3. Ethics during warfare, not infrequently, raises different ethical questions. A physician’s primary loyalty to a military mission (howsoever that is defined) or to the tenets of the medical profession—if and when the two moral obligations conflict—may (like the duty of the doctor doing the colonoscopy) be seen as varying, depending on whether the country itself is under attack.

Michael Gross, a philosopher in Israel, for example, holds that when duties to the greater society and those of the medical profession conflict, careproviders should give priority to the needs of their country. He states that if one can substantiate a supremely important goal and is convinced that the state’s interests are at risk, professional medical obligations emphasizing the priority of the patient should fall to collective survival. M.L. Gross, *Bioethics and Armed Conflict* (Cambridge, Mass.: MIT Press, 2006), 331.

4. A. Wertheimer, “Is Payment a Benefit?” paper presented at the PRIM&R Advancing Ethical Research Conference, Gaylord National Harbor, Maryland, 1 December 2011.

5. M. Daniel, “Bedside Resource Stewardship in

Disasters: A Provider's Dilemma," in this issue of *JCE*.

6. J.T. Berger, "Resource Stewardship in Disasters: Alone at the Bedside," in this issue of *JCE*.

7. K.R. Jamison, *Nothing Was the Same* (New York: Vintage Books, 2009), 123.

8. I.R. Olson and C. Marshuetz, "Facial Attractiveness is Appraised in a Glance," *Emotion* 4, no. 4 (2005): 498-502.

9. J. Pincott, "What's in a Face?" *Psychology Today* 45, no. 6 (November/December 2012): 52, 55.

10. M. Hunt, C. Sinding, and L. Schwartz, "Tragic Choices in Humanitarian Health Work," in this issue of *JCE*.

11. S.H. Imbus and B.E. Zawacki, "Autonomy for Burned Patients When Survival Is Unprecedented," *New England Journal of Medicine* 297, no. 6 (11 August 1977): 308-11.

12. A.G. Shuman et al., "When Negative Rights Become Positive Entitlements: Complicity, Conscience, and Caregiving," in this issue of *JCE*.

13. M. Goodman, T. Roiff, A.H. Oakes, and J. Paris, "Suicidal Risk and Management in Borderline Personality Disorder," *Current Psychiatry Reports* 14 (2012): 79-85.

14. I know careproviders who have, for the interests of their patients, spent time in jail (for contempt).

15. R. Krawitz and M. Batcheler, "Borderline Personality Disorder: A Pilot Survey About Clinician Views on Defensive Practice," *Australas Psychiatry* 14 (2006): 320-2.

16. "Resistance . . . is often seen as a nuisance, a barrier to overcome, a culprit that allows one to blame others. . . . [It suggests, though] . . . a re-evaluation of the course of action and urges changes toward a sustainable project." G. Sammut and M.W. Bauer, "Social Influence: Modes and Modalities," in *The Social Psychology of Communication*, ed. D. Hook, B. Franks, and M.W. Bauer (New York: Palgrave Macmillan, 2011), 102-3.

17. D. Mukherjee, G.R. Spill, P. Tarsney, and J. Hauser, "Disability and Do-Not-Resuscitate: Teaching Difficult Conversations," Representing Bioethics," paper presented at the 14th Annual Meeting, of the American Society for Bioethics and Humanities, Washington, D.C., 19 October 2012.

18. "A few minutes later, the nurse who had been in the family meeting approached him. 'You didn't give the family a chance to choose,' she said angrily. 'You just decided for them. What if after CPR she bounces back? It's happened before.'" See note 1, above, p. 545. If this careprovider responded angrily after the family meeting, loved ones well might, too.

19. J. Decety and S. Cacioppo, "The Speed of Morality: A High-Density Electrical Neuroimaging Study," *Journal of Neurophysiology* 108 (2012): 3068-72, 3071-2.

20. E. Nakahara, "Representation for Advanced Illness Patients: An Innovative Approach to Improve Communication and Decision-Making Processes at End-of Life," paper presented at the 14th Annual Meeting, of the American Society for Bioethics and Humanities, Washington, D.C., 20 October 2012.

21. *Ibid.*

22. M. Tunzi, "A New Standard for Incapacitated Patient Decision Making: The Clinical Standard for Surrogate Empowerment," in this issue of *JCE*.

23. T.M. Pope and M. Hexum, "Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment," in this issue of *JCE*.

24. At follow up, 55 percent had psychological morbidity. D.M. Wade et al., "Investigating Risk Factors for Psychological Morbidity Three Months After Intensive Care: A Prospective Cohort Study," *Critical Care* 16, no. 5 (15 October 2012): PMID 23068129.

25. D. Von Ah et al., "Advanced Cognitive Training for Breast Cancer Survivors: A Randomized Clinical Trial," *Breast Cancer Research and Treatment* 135 (2012): 799-809. These patients' and other patients' responses to cancer is most likely difficult or impossible for those who haven't had this to accurately imagine. "Like health itself, the loss of such a thing [as one's voice] can't be imagined until it occurs." C. Hitchens, *Mortality* (New York: Twelve/Hachette Book Group, 2012), 47. "On a much too regular basis, the disease [cancer] serves me up with a teasing flavor of the month. On the less good days, I feel like that wooden-legged piglet belonging to a sadistically sentimental family that could bear to eat him only a chunk at a time. Except that cancer isn't so . . . considerate." *Ibid.*, 46.

26. K.A. Calderwood, "Adapting the Transtheoretical Model of Change to the Bereavement Process," *Social Work* 16, no. 2 (April 2011): 107-18.

27. E. Aronson, *The Social Animal*, 8th ed. (New York: Worth Publishers/W.H. Freeman and Company, 1999), 418.