The Elephant in the Room: Facilitating Communication at the End of Life

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To identify and achieve a dying patient's wishes, resolve any lingering conflicts, and reach closure at the end of life, open and effective communication is essential. This narrative describes a case involving a dying patient in which the family was in agony due to a failure of communication. As a palliative care consultant, I was able to address this problem, relieve some of the distress within the family, and achieve some closure before the patient's death.

The patient that I was consulted to see was a 63-year-old male named Larry who had been in the hospital for 6½ weeks (including 3 weeks in the MICU) and was dying of advanced multiple myeloma. At my initial evaluation, Larry was alert but unable to communicate verbally. He appeared cachetic, had cool extremities, and was tachypneic. I suspected that death would occur within the next few days to a week. His wife Karen and son George were present and appeared tense and stressed. During this initial meeting, I noticed that Karen did not stand close to or even touch Larry. When I approached her, she indicated that she did not want to talk to me in the patient's room. After stepping into the hall, she told me that she was unable to talk to Larry about his imminent death. She stated, "I know he is dying, but I am telling him that he is going to get better and go home to Colorado."

Knowing that her opportunity to express her feelings to Larry while he was still alive was soon going to be lost, I tried to help Karen resolve her conflict. I did this by taking advantage of an opportunity that arose while talking with her to gently ask, "Do you think that your husband needs to hear you say that you will be okay, no matter what happens?" Karen did not answer my question or appear receptive to my suggestion. After completing the initial consultation, I discussed it with the chaplain, who had been present, and subsequently with the palliative care team. I felt that intervention in this situation would probably be limited to beginning a conversation about the end of life. Any further attempts to intervene seemed unlikely due to the late stage of illness and the family's resistance to discussing the patient's imminent death. In fact, I had initially hesitated before asking Karen about talking to her husband about his death because she had been so adamant during the initial conversation. I was concerned that pushing this conversation might ultimately interfere with any further communication efforts.

I was surprised, on follow-up the next day, to observe that Karen and George were calmer and more receptive to our presence in the room. Karen explained that she had talked all night with Larry and that she had told him it was okay for him to go and that she and George would be okay. She told me, "Larry has taken such good care of us and provided for us. We really will be okay—no matter what." We continued to interact with Larry, his medical team, and his family until he died, apparently comfortable and surrounded by his family, 2 days after the initial palliative care consult. Several days after his death, a member of Larry's family ran into me at the hospital and shared with me that being able to say goodbye had meant so much to them and that they were relieved to have had that opportunity. She went on to say, "There is not enough money in the world to pay you for what you did for our family." While I perceived my efforts in Larry's care to be rather minimal, Larry's family viewed it quite differently and as quite significant to their enduring perspectives of his death.

It's hard to talk about death, even for health care providers. In fact, many patients, caregivers, and providers intentionally avoid mentioning death or dying, even when the patient's suffering is significant and the prognosis is poor.[1] Facilitating

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this communication becomes even more important at the end of life, as there is little time for the patient and family to have these exchanges. Studies have repeatedly shown that end-of-life conversations are essential to achieve a "good death" for the patient and closure for the family.[2-5]

As this case illustrates, end-of-life discussions do not have to be time-consuming or extensive, but facilitating them is an important skill for all health care providers. Skills-based training to improve providers' ability to communicate with dying patients and their families is needed.[6] Providers need to know how to acknowledge feelings, seek clarification with open-ended questions, use silence with active listening, and communicate nonverbally.[7] It is unfortunate that these skills are so rarely taught in most medical education and continuing medical education curricula.[3]

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