COMMENTARY

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A Trip to Egypt: De-Nile

Denial of reality has become commonplace these days. Take, for instance, the number of patients and families who are refusing effective and safe coronavirus disease 2019 (COVID-19) vaccination even in the face of hospitalization of family members in our COVID intensive care unit. Reasons for not getting the vaccination range from fear of adverse reactions to ludicrous comments such as the following: "I know that Bill Gates is working with the government and putting computer chips into the vaccine so that the feds can hear every word I say." Even when family members die of COVID complications, I have heard family members relate that the patient did not die from a COVID infection because the whole pandemic story is made up by politicians and does not really exist. As cited in the title to this commentary, a dear colleague refers to this kind of reasoning as a trip to Egypt on the great de-Nile (L. Mackstaller, personal communication).

Perhaps, it is my imagination or just happenstance, but it seems that I have been encountering a lot more denial in our university hospital these days than I had been accustomed to. In the last month, I have been involved in the care of 3 patients with end-of-life heart failure, all with left ventricular ejection fractions less than 10%, rising blood creatinine and troponin values, incipient cachexia, and florid clinical findings of biventricular failure each of whom refused palliative care recommendations for inpatient or home hospice. Each of these 3 individuals also refused to accept do not resuscitate or comfort-care only designations. The patients related that they knew that they would get better eventually despite many careful and detailed explanations that this would not happen. And, of course, given their presence in a university hospital, each of these individuals had undergone extensive evaluations including 1 or more cardiac catheterizations with coronary arterial angiography, cardiac magnetic resonance imaging (MRI) studies, and innumerable blood tests. Our heart failure specialists had seen each of these patients more than once and offered the same detailed explanation and poor prognostic outlook. Once again, I saw each of these individuals as demonstrable examples of rigid and unyielding denial.

Some months ago, I helped care for a patient that involved a particularly sad and disturbing example of total denial. The patient was a 62-year-old man with extensive metastatic gastric cancer. Over the last 2 years, he had received a wide variety of cancer therapeutic agents. At this point, the oncologists told him that there was nothing more that could be done, and palliative care consultation reiterated the same message. He said he understood everything that was said and that he wished to go home to be with his extended family for his final days. An adult daughter was staying with him in the hospital and repeatedly denied that he was dying and that nothing more could be done for him. Every day, our ward team and the palliative care physicians reiterated that there was nothing more we could do for the patient except control his pain and keep him comfortable. The patient was so weak that he could no longer chew and swallow food. His daughter continually told us that she knew he would get better if we could put a tube into his stomach and feed him despite multiple reassurances from our gastroenterology consults that this could not possibly be done. Eventually, he became unresponsive and so home transport was no longer possible. He died the morning of his 18th hospital day. His daughter asked why we had not tried to resuscitate him. This was one of the most remarkable examples of denial that I had ever seen in my long clinical career.

What if anything can be done in the face of such remarkable examples of denial? I understand that things might have gone better had these individuals formed a long-term relationship with a primary care or subspecialty physician who might have been able to dissolve some of the denial, thereby allowing the patients to die quiet and comfortable deaths preferably in a more supportive environment such as an inpatient hospice or home. Indeed, most patients accept our advice, and I have personally become a huge fan of our hospice personnel here in Tucson. This was particularly the case when my 96-year-old mother died here 10 years ago in one of our inpatient hospices. The support she received

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during her final days from this group of caring and knowledgeable professionals still lives in my mind as an example of how excellent clinical care should be delivered. When talking these days with hospice personnel about one of our patients, I jokingly tell them that "if there really is a heaven, you folks are going to be the first to enter."

In the end, I believe that the advice of Dr. Alejandra Vasquez, JD, CT,[1] a certified grief counselor, seems the best that physicians can do when faced with strong and fixed denial:

1. Explain what's happening. Sometimes it seems as if your words are falling on the ears of someone who simply doesn't want to know the truth.
2. Encourage discussion. Knowing how to talk about death begins with finding an appropriate time to have this conversation.
3. Offer support. Helping someone who's in denial also includes offering your support wherever needed.
4. Listen to nonverbal cues. Death and dying affect everyone differently. Grief reactions can manifest in many ways that may not seem immediately recognizable.

As always, I enjoy hearing from colleagues about this or any other commentary at jalpert@email.arizona.edu.

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