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Posted: 11/04/2009

Physicians Are Talking About: A Death Foretold

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The premonition of impending death makes for dramatic moments in fiction, film, and anecdotal experience. Yet, is it a contraindication to surgery? Contributors to Medscape's Physician Connect (MPC), a physician-only discussion board, exchanged animated views about whether to heed a patient's premonition.

"I would reschedule if it were an elective case. Definitely," says a vascular surgeon. "No one should go into an elective operation with that mind set -- the patient or the surgeon."

"Unless there was imminent threat to life or limb, I would cancel the case until such time as these emotional issues are resolved," says a surgeon, adding that a foreboding of death is not a typical case of nerves. "When patients say they're going to die, they're often right!"

An anesthesiologist suggests that **hypnosis**, as part of the psychiatric consult, could be useful for defusing the patient's premonition of death. "Placebo response implies a subconscious control over the power to heal or the power to drive disease. A self-fulfilling prophecy leading to death may have the same quality. The placebo effect is accessible using **hypnosis**, and it may emerge that **hypnosis** can provide a tool that permits a patient to understand the prophecy's purpose, and provide understanding and fulfillment of the purpose without danger to the person as a whole."

"I have personally had the experience of a patient in the holding area for surgery state he didn't feel right before he went to the operating room for his gallbladder removal," says a surgeon. "I assured him things would be fine, and he would be okay. He coded on the table and died 3 days later. I have heard other patients state that they think they are going to die and it happens. So, if a patient says that to me now, surgery is cancelled."

"Cancel the case? You guys must be kidding," says an anesthesiologist. "If we anesthesiologists can't cancel for a urinary tract infection how can we cancel for a premonition?"

"Fear is something that needs to be managed well," says a surgeon, "not something that should cloud rational decision making."

"I tell the patient that this is a wrong mind set," says an internist. "I explain the risks and benefits of surgery and tell him that I don't believe in intuitions." A surgeon responds, "When you've seen enough of these, you will!"

A surprising number of physicians posting on MPC report that they have had patients who accurately predicted their death. Of the more than 100 contributors to the discussion, 13 have had patients die after a premonition of death, and 9 have experienced such an event multiple times.

Several physicians chalk up the numerous reports of foretold deaths to nothing more than confirmation bias, a tendency to remember information that confirms preconceptions or hypotheses. "It is hard to find a person who doesn't have fear of death before undergoing major surgery," says a surgeon. "When everything goes well, no one remembers -- neither the patient nor us. But one out of a thousand comes true and the patient dies, then it sticks in our minds

forever." A pediatrician adds, "Confirmation bias also is reflected by posters confirming the theory, and people who can't confirm it not bothering to post."

A plastic surgeon argues that the recall of such cases is not a matter of selective memory. "It is not a common statement, and I take it seriously. We are not talking about the common fear of dying that surgery patients express frequently. The difference is the chillingly casual way in which a patient tells you he or she is going to die, sometimes without much anxiety."

Although most physicians would not go so far as to cancel surgery, the majority agree that a patient's fears must be addressed and precautions taken before proceeding with surgery. An internist says that he would listen to the patient's concern and confirm that there are no identifiable factors -- either preventable or treatable -- contributing to the patient's feeling of foreboding. "Thus, reassurance becomes heartfelt, and not condescending."

Several contributors recommend having a colleague talk to the patient to find out why he or she expects not to survive the surgery. "Sometimes patients forego procedures because they have doubts that they are embarrassed to express except under circumstances and to individuals of their own choosing."

An internist suggests that a patient's premonition of death may be an indication for a more thorough evaluation. "Two months ago," says the internist, "an obese patient came in for prep for a second knee replacement. She simply voiced a bad feeling about the surgery. We decided to cancel. On review of systems, the patient had a little bit of stomach discomfort, which turned out to be renal cell carcinoma. Listen to patients, as they are sometimes on the right track."

Other contributors comment that a psychiatric consult may be useful to rule out suicidal ideation or major depression that might require treatment before the patient undergoes elective surgery. An anesthesiologist suggests that **hypnosis**, as part of the psychiatric consult, could be useful for defusing the patient's premonition of death. "Placebo response implies a subconscious control over the power to heal or the power to drive disease. A self-fulfilling prophecy leading to death may have the same quality. The placebo effect is accessible using **hypnosis**, and it may emerge that **hypnosis** can provide a tool that permits a patient to understand the prophecy's purpose, and provide understanding and fulfillment of the purpose without danger to the person as a whole."

In the end, a patient has the right to refuse surgery, but some MPC contributors argue that cancelling surgery may not be the best practice. "I do not think that a patient's apprehension should drive our decision-making process," says a surgeon. "I do not see evidence-based medicine in such a situation."

Evidence of the relationship between psychological factors and surgical outcomes, although not conclusive, has been assessed in patients undergoing cardiac procedures. A review of the literature^[1] found that depression and, to a lesser degree, anxiety are associated with worse outcomes after coronary surgery. One small study evaluated state anxiety (short-term anxiety, which might arise in response to a threatening situation) and trait anxiety (long-term anxiety, such as neurosis) in 94 patients 24 to 48 hours before cardiac surgery. The authors found that acute preoperative anxiety was significantly associated with adverse outcomes, acting as an independent risk factor for postoperative morbidity and mortality.^[2] Whether state anxiety and premonition of death are linked is unclear.

"People die simply because they are convinced that they will, or want to!" says an anesthesiologist. "What's the mind-body connection up to here?!" A surgeon replies, "The longer I am in this field and the more life experience I acquire, the more I realize the mind functions in ways we do not fully understand."