Decoding the Code

Palliative Medicine
Banner Health

Objectives

- Understand why it is important to develop the skills to talk with patients about CPR
- Role Play CPR discussions
- Review CPR success rates for hospitalized patients

- https://www.youtube.com/watch?list=PLzViUx1Kacvxj3XthM2S3VJLWbjr8uCRZ&v=8qaLdHGpoW4&feature=player_embedded

Elephant in the Room

"I'm right there in the room, and no one even acknowledges me."

Why are we so hesitant about discussing CPR?

Questions:

- Do end of life conversations help or harm patients?
- What is the evidence?

Medical Care Received in the Last Week of Life by End-of-Life Discussion

Table 3. Medical Care Received in the Last Week of Life by End-of-Life Discussion

	No. (%)			Adjusted OR (95% Confidence Interval)[a]	*P* Value
	Total (N=332)	End-of-Life Discussion			
		Yes	No		
Medical care received in the last week	332	123 (37.0)	209 (63.0)		
ICU admission	31 (9.3)	5 (4.1)	26 (12.4)	0.35 (0.14-0.90)	.02
Ventilator use	25 (7.5)	2 (1.6)	23 (11.0)	0.26 (0.08-0.83)	.02
Resuscitation	15 (4.5)	1 (0.8)	14 (6.7)	0.16 (0.03-0.80)	.02
Chemotherapy	19 (5.7)	5 (4.1)	14 (6.7)	0.36 (0.13-1.03)	.08
Feeding tube	26 (7.9)	11 (8.9)	15 (7.3)	1.30 (0.55-3.10)	.52
Outpatient hospice used	213 (64.4)	93 (76.2)	120 (57.4)	1.50 (0.91-2.48)	.10
Outpatient hospice ≥1 wk	173 (52.3)	80 (65.6)	93 (44.5)	1.65 (1.04-2.63)	.03

Abbreviation: ICU, intensive care unit; OR, odds ratio.
[a] The propensity-score weighted sample was used for these analyses. Logistic regression models were also adjusted for patients' treatment preferences, desire for prognostic information, and acceptance of terminal illness.

Wright, A. A. et al. JAMA 2008;300:1665-1673.

JAMA

What do patients want to know?

- Studied extensively in Western world
- Mostly cancer – although other diseases represented
- Patients want
  - Realistic, truthful information
  - *What* will happen is as important as *time*
  - *How* they are told is as important as *what* they are told
  - Hope, optimism

How one is told

- Loved ones present
- Adequate time
- Acknowledgment of emotional, spiritual, existential impact of having a life-limiting disease
- 'Attitude' of the clinician
- Respect for patient's emotional state

Hagerty Ann Onc 2005. Clayton Supp Care CA 2005. Curtis J Palliat Med 2008.

Hope and Optimism

- Qualitative research:
  - Clayton *Cancer* 2005: Explored with advanced cancer patients n=19 (& caregivers) how can clinicians can foster hope when they talk about future.
  - Major themes
    - Emphasize what can be done
    - Emotional support, care, dignity, listening, non-abandonment
    - Practical support (help in home)/Discuss day-to-day living
    - Truth-telling but ‘not blunt,’ leaving space for the unanticipated

Hope & Optimism – What generates hope?

- The top 4 hope-destroying actions by physicians
  - Appeared nervous or uncomfortable
  - “Gave my prognosis to my family, then gradually told me”
  - Used euphemisms
  - “Avoided talking about the cancer and only discussed treatment”

Hagerty J Clin Oncol 2005

Hope & Optimism

- "Hope" =
  - a sense of receiving good care…"best" care – all the right things are being done,
  - non-abandonment,
  - confidence and warmth with the physician,
  - completeness of information,
  - *And NOT being told unambiguously "There is no hope of recovery"*
- These themes far out-shadow the way preserving hope is often conceived: half-truths, concealing information, only positives

Setting the Stage

Why discuss the future?

“DO YOU WANT US TO DO EVERYTHING?”

Discussions About Code Status

Case 1: RF

- A 68 yo man is newly diagnosed with metastatic hepatocellular cancer, alcohol related liver failure, and impending kidney failure.
- Because of his poor functional status (ECOG 3-4) and organ failure, he is not a candidate for chemotherapy. The oncologist told him this.
- Prognosis: days to a weeks
- Medicine Team: "He seems to have unrealistic expectations. I asked him "Do you want us to do everything? and he said "Yes". So he's a full code."

CPR- How effective is it?

- Inpatient setting:
  - 40% survive the CPR effort
  - 1/3 survive to leave the hospital (i.e. 14% of total)
  - *So 86% of patients who code in hospital die in the hospital*
    - More successful if CPR is in OR, ICU, Cath lab
- Depending on study, 7-26% survive a CPR effort

MH Ebell et al. J Gen Intern Med. 1998 (Meta-analysis); Tresch D et al. JAGS 1994; Warner SC and Sharma TK. Resuscitation 1994.

CPR-How effective is it?

- Low likelihood of survival if:
  - Sepsis
    - 1/73; 0/42 survived CPR effort
  - Metastatic cancer
    - 0-14% survived CPR effort
    - A more recent study stated only 1.9% on an average survived
    - The average number of patients in the same study over the age of 80 was 3%
  - Renal failure
  - Need for vasopressors or inotropes
    - 2/55 survived CPR effort (both had reversible conditions, i.e. AMI, arrythmia)
- Nursing home residents
  - 0-1.7% survive CPR effort

References 30-38, 41

Outcome of CPR in the ICU Setting

- 114 MICU patients underwent CPR
- Mean age 59
  - 25% malignancy, 18% vascular disease, 7% chronic liver disease, 5% ESRD, 5% COPD: 34% sepsis, 20% PNA
  - 33% had been housebound or bedridden prior to admission
- 44% survived initial effort, **BUT…**
- Only 31% with CPR effort survived >24 hours, and….
  - 1/29 malignancy; 1/39 sepsis survived effort
- Only 5% survived to discharge.
  - 6 patients survived to hospital D/C (5% patients)
    - 4/6 died in one year; 2 had severe disabilities and were alive at 1 year
- *Patients with chronic medical conditions undergoing CPR even in an ICU setting seldom survive to discharge…*

FJ Landry et al. Arch Intern Med 1992

Problems that arise in DNR discussions

- Expecting patients to make decisions without adequate information (i.e. *un*-informed consent)
  - Diagnosis
  - Treatment options
  - Prognosis
- CPR discussions *MUST* be framed in terms of the overall goals of care and care plan, not in isolation
- Weigh benefit/burden of each treatment option
  - *Can we do it? Should we do it?*

Communication

- Common phrases:
  - “What would you like us to do if your heart stops?”
  - “Do you want us to restart your heart if it stops?”
  - “Do you want us to do everything?”
  - “You don’t want us to break your ribs, and shove a tube down your throat, and hook you to a breathing machine, do you?”

Barriers to patients accepting DNR

- DNR *only* refers to this medical intervention
- Many patients and families fear that

  DNR="No Care"
- Unfortunately, medical teams often reinforce this fear:
  - *We can't take him to the ICU if he's DNR*
  - *He can't get antibiotics if he's DNR*
  - *We think the best thing is to "withdraw care"*

Steps for Discussion of CPR

- Quiet setting; clarify goals for the meeting
- Determine decisionality- make sure right people are at meeting (team/decision maker)
- Clarify in your mind beforehand what is best medical care
- Who is this person? "Tell me about your Dad. I have all the medical information, but want to know more about him as a person. Can you tell me a little about him, and how things were going before he came into the hospital?"

Steps for Discussion of CPR

- Ask patient/family what they know about medical condition- make no assumptions!
- Present medical information; clarify misunderstandings
- “Have you ever thought about what your wishes would be if you were ever in this situation?” or “ Has your father ever talked about what would be most important to him if he was ever in this situation?”

Helpful Communication Phrases

- Make recommendation in terms of overall plan of care
  - *"Given that your cancer is growing and not responding to chemotherapy, I think the best plan would be that we don't use any more chemotherapy."*
  - *"Your father is very sick. His heart, liver and kidneys are failing, despite our best medical efforts. He is dying."*
- Judge whether the time is right to talk about CPR, or whether this would best be left to another discussion
- These discussions are often a process….

Helpful Communication Phrases if Team Believes DNR is *Not* Appropriate

- I want to talk about something that's hard to discuss.
- When someone's heart and breathing stop, in other words when they die, we have a lot of things we can do to attempt to try and reverse this. This is called cardiopulmonary resuscitation, or CPR.
- In patients who are very sick as you are, CPR has a low likelihood of working. In other words, patients rarely survive the CPR effort, and if they do, it's extremely rare to make it out of the hospital.

Helpful Communication Phrases

- CPR may just prolong the dying process, cause suffering and not bridge you to getting better, because it doesn't fix the cancer (or whatever underlying process is present).
- I would recommend that we protect you from CPR, which will only harm you and not offer benefit, and not do this when that time comes. This is what's called "Do Not Resuscitate."

Helpful Communication Phrases

- *Instead*, I would recommend that we make sure you are comfortable, as pain free as possible, and well cared for as you are dying.
- What are your thoughts about this?

Communication

- Remember it often takes several discussions; people are processing tough information; give people time (if possible) and space
- Respond to *affect* with *affect*
  - *I can see this is hard for you to hear (*reflect on emotion in the room*).*
  - Silence: *Can you tell me what your thoughts are? Have you thought about this before?*
  - Allow silence; let patient determine tempo of discussion
    - *To patient, this is an out-of-control situation. Try and give back as much control as possible*

Communication

- If you take something “off the table”, put something back on:
  - Symptom control
  - Family support
  - Hospice care
  - Other
- *Reassure non-abandonment*
- “Even though we can’t fix the illness, there is a lot we can do to help you and your family in this time. I want to hear what is most important to you and your family”

Does the order make sense?

- Don’t let the sun set on a code status order that makes no sense
  - Only cardioversion (in a patient who will die a respiratory death)
  - Only one shock, then stop
  - Only for 5 minutes, then stop
  - Chest compressions without cardioversion
  - “He wants intubation, but he doesn’t want to be on a ventilator…”

Summary

- EOL discussions can benefit patients and families in real ways; do not cause harm
  - May take a series of discussions…
- EOL counseling should optimally start *before* a crisis
- EOL discussions can help *ensure* patient autonomy, not take it away
- Communication skills training is needed to help clinicians
  - Major education focus of Palliative Medicine team: medicine residents; oncology, geriatric and pain fellows.
  - Better communication skills=less anxiety for HCP's?

References

1. Hofmann JC et al. **Patient preferences for communication with physicians about end-of-life decisions.** *Ann Intern Med 1997;127(1):1-12.*
2. Teno JM et al. **Family perspectives on end of life care at the last place of care.** *JAMA 2004;291(1):88-93.*
3. Reilly BM et al. **Can we talk? Inpatient discussions about advance directives in a community hospital. Attending physicians' attitudes, their inpatients' wishes, and reported experience.** *Arch Intern Med. 1994;154:2299-308.*
4. Haas JS et al. **Discussion of preferences for life-sustaining care by persons with AIDS. Predictors of failure in patient-physician communication.** *Arch Intern Med. 1993;153:1241-8.*
5. Shmerling RH et al. **Discussing cardiopulmonary resuscitation: a study of elderly outpatients.** *J Gen Intern Med. 1988;3:317-21.*
6. Frankl D, Oye RK, Bellamy PE. **Attitudes of hospitalized patients toward life support: a survey of 200 medical inpatients.** *Am J Med. 1989;86(6 pt 1): 645-8.*
7. Teno JM et al. **Association between advance directives and quality of end-of-life care: a national study.** *JAGS 2007; 55:189-94.*
8. Engel SE et al. **Satisfaction with end-of-life care for nursing home residents with advanced dementia.** *JAGS 2006; 54:1567-72*

References

9. Zhang B et al. **Health Care Costs in the Last Week of Life: Associations With End-of-Life Conversations.** *Arch Intern Med.* 2009;169(5):480-488.

10. Wright AA et al. **Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment.** *JAMA 2009;8(300):1665-1673.*

11. Weeks JC et al. **Relationship Between Cancer Patients' Predictions of Prognosis and Their Treatment Preferences.** *JAMA 1998;279(21):1709-1714.*

12. Hanchate A et al. **Racial and Ethnic Differences in End-of-Life Costs: Why Do Minorities Cost More Than Whites?** *Arch Intern Med 2009;169(30): 493-501*

13. Phelps AC et al. **Religious Coping and Use of Intensive Life-Prolonging Care Near Death in Patients With Advanced Cancer.** *JAMA 2009;301(11):1140-1147*

References

14. Murphy DJ et al. **The Influence of the Probability of Survival on Patients' Preferences Regarding Cardiopulmonary Resuscitation.** *NEJM 1994; 330:545-549.*

15. Volandes AE et al. **Using video images of dementia in advance care planning.** *Arch Int Med 2007; 167:828-833.*

16. Volandes AE et al. **Health literacy not race predicts EOL preferences.** *J Palliat Med. 2008; 11: 754-62.*

17. Volandes AE et al. **Overcoming educational barriers for advance care planning in Latinos with video images.** *J Palliat Med. 2008; 11: 700-6.*

18. Prigerson HG**. Socialization to Dying: Social Determinants of Death Acknowledgement and treatment Among Terminally Ill Geriatric Patients.** *J Health Soc Behavior 1992;33:378-395.*

19. Schneiderman LJ et al. **Effects of Offering Advance Directives on medical Treatments and Costs.** *Ann Intern Med 1992;117:599-606.*

20. Kessler DP and McClellan MB. **Advance directives and medical treatment at end of life.** *J Health Econ. 2004 Jan;23(1):111-27*

21. Teno JM et al. **Association between advance directives and quality of end-of-life care: a national study.** *J Am Geriatr Soc. 2007 Feb;55(2):189-94*

References

22. Weeks WB, Kofoed LL, Wallace AE et al. **Advance directives and the cost of terminal hospitalization.** *Arch Intern Med 1994;154:2077–2083.*

23. Chambers CV, Diamond JJ, Perkel RL et al. **Relationship of advance directives to hospital charges in a Medicare population.** *Arch Intern Med 1994;154:541–547.*

24. Molloy DW, Guyatt GH, Russo R et al. **Systematic implementation of anadvance directive program in nursing homes: A randomized controlled trial.** *JAMA 2000;283:1437–1444.*

25. Degenholtz HB, Rhee Y, Arnold RM. **Brief communication: The**

relationship between having a living will and dying in place. Ann Intern Med 2004;141:113–117.

26. Teno JM, Lynn J, Phillips RS et al**. Do formal advance directives affect resuscitation decisions and the use of resources for seriously ill patients? SUPPORT Investigators. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments.** *J Clin Ethics 1994;5:23–30.*

27. Teno JM, Lynn J, Connors AF Jr et al. **The illusion of end-of-life resource savings with advance directives. SUPPORT Investigators. Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment.** *J AmGeriatr Soc 1997;45:513–518.*

28. Hancock K et al. **Truth-telling in discussing prognosis in advanced life-limiting illnesses: a systematic review.** Palliat Med. 2007; 21:507-517.

29. Mark H Ebell, Lorne A Becker, Henry C Barry, and Michael Hagen. **Survival After In-House Cardiopulmonary Resuscitation: A Meta-Analysis.** *J Gen Intern Med. 1998 December; 13(12): 805–816.*

References

30. Saklayen, M et al. **In-Hospital Cardiopulmonary Resuscitation: Survival in 1 Hospital and Literature Review.** *Medicine 1995; Volume 74(4): 163-175.*

31. Faber-Langendorf K. **Resuscitation of patients with metastatic cancer: is transient benefit still futile?** *Arch Intern Med 1991;151:235-239.*

32. Vitelli CE et al. **Cardiopulmonary resuscitation and the patient with cancer.** *J Clin Oncol 1991;9:111-115.*

33. Rosenberg M et al**. Results of cardiopulmonary resuscitation: Failure to predict survival in two community hospitals.** *Arch Intern Med 1993;153:1370-1375*

34. Bedell SE et al. **Survival after cardiopulmonary resuscitation in the hospital.** *JAMA 1985;253:1370-1375*

35. Murphy DJ et al. **Outcomes of cardiopulmonary resuscitation in the elderly.** *Ann Intern Med 1989;111:199-205.*

36. Appelbaum GE et al. **The outcome of CPR initiated in nursing homes.** *J Am Geriatr Soc 1990;38:197-200*

37. Awoke S, Mouton CP, Parrott M. **Outcomes of skilled cardiopulmonary resuscitation in a long-term care facility.** J Am Geriatr Soc 1992;40:593-595

38. Francis J. Landry; Joseph M. Parker; Yancy Y. Phillips. **Outcome of Cardiopulmonary Resuscitation in the Intensive Care Setting.** *Arch Intern Med 1992;152:2305-2308.*

References

39. Grigoriyan A et al. **Outcomes of cardiopulmonary resuscitation for patients on vasopressors or inotropes: A pilot study.** *J Critical Care 2009;24:415-418.*

40.Hwang J et al. **Survival in cancer patients after out-of-hospital cardiac arrest.** Support Care Cancer 2009;epub

41.Ehlenbach WJ et al. **Epidemiologic Study of In-Hospital Cardiopulmonary Resuscitation in the Elderly.** *NEJM 2009;361(1):22-31*

42.Tresch D et al. **Cardiopulmonary resuscitation in elderly patients hospitalized in the 1990's: a favorable outcome.** *J Am Geriatr Soc 1994;42:137-141.*

43. Warner SC, Sharma TK. **Outcome of cardiopulmonary resuscitation and predictors of resuscitation status in an urban community teaching hospital.** *Resuscitation 1994;27:13-21.*

- Thank you! Questions?