Approaching Serious Illness

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HOSPICE AND PALLIATIVE MEDICINE

Delivering Serious News

- Challenging for patients / families

- Challenging for physicians

- Is there a way to have a "good" bad conversation?

- Are there consequences to breaking bad news "badly"?

The Conversation Roadmap

S

P

I

K

E

S

The Conversation Roadmap

S: Set the Scene

P: Gain Perception and Preferences

I: Get an Invitation / Give a "warning shot"

K: Share your Knowledge

E: Empathize / Respond to Emotion

S: Summarize / Strategize

The Conversation Roadmap

S: Set the Scene

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Set the Scene

- Are the key "stakeholders" present?

- Environment conducive to conversation

- Minimize distractions

- Greetings / introductions

The Conversation Roadmap

S: Set the Scene

P: Gain Perception and Preferences

I

K

E

S

Gain Perception and Preferences

- "What is your understanding of where you are with your illness?"

- "How much information about what is likely to be ahead with your illness would you like from me?"

- "Would it be helpful to hear an estimate of how much time you may have?"

The Conversation Roadmap

S: Set the Scene

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K

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S

Get an Invitation / Give a Warning Shot

- "Is now an OK time to talk?"

- "Is it OK if I share my understanding of your illness?"

- "Unfortunately, I have bad news…"

The Conversation Roadmap

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Share Your Knowledge

- Give the "bad news"
  - ❑ Disease progression
  - ❑ Prognosis (if desired)
  - ❑ Anticipated setbacks

- Don't "bury" the message

- No jargon

But I Don't Use Jargon!

Bad	Good
"We've seen some growing lesions in a few places on your CT scan"	"Despite the new chemo, your cancer is getting worse"
"The creatinine has been rising, the O2 sats have been going down, and we had to add a third pressor for low blood pressure"	"Your grandmother's organs are failing and she is dying"

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Address the Elephant in the Room

NURSE Tool!

N: <u>N</u>aming   "I can see…"

U: <u>U</u>nderstanding   "I can/can't imagine…"

R: <u>R</u>especting   "You've done all we asked…"

S: <u>S</u>upporting   "We'll be checking in throughout the day…"

E: <u>E</u>xploring   "Tell me more about…"

- Examine your goals
  - ❑ Intent of acknowledging emotion is <u>not</u> to prevent or control the other person's response

  - ❑ Goal: facilitate processing of the news, help the patient feel heard

- Avoid trying to "sanitize" the bad news with an "upshot"
  - ❑ E.g "At least…"

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Summarize / Strategize

- Offer your medical <u>recommendation</u>
  - Extended goals of care conversation?
  - Chemo / XRT ?
  - Complete a MPOA /POLST document?

- Set a time to follow up

- Let patient / family know how to reach you

DEMO I

Thoughts?

DEMO 2

- What was different?

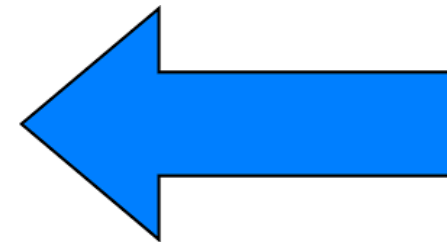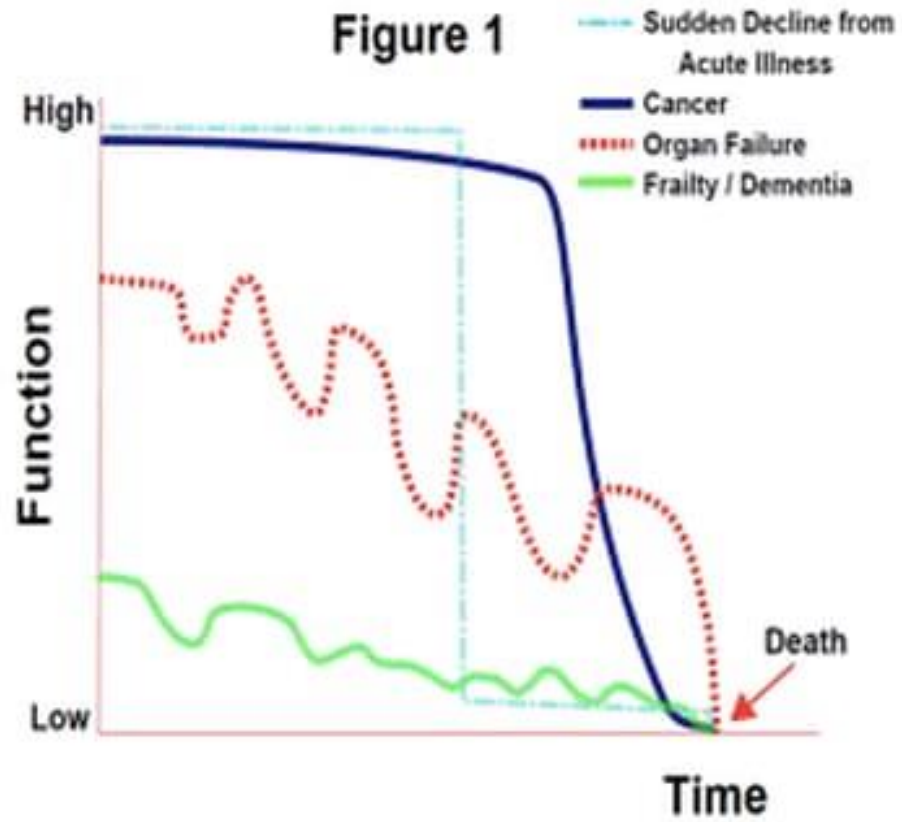- What seemed to make the patient trust the doctor this time around?

Debrief

- Longer, double the time, 2 mins → 4 mins
- Sitting
- Asking permission
- Empathy
- Silence
- Non-medical terms, not confusing terms like 'lesion'
- Breaking down why we did the testing and explaining what we found and what it meant.
- Responding to "Am I going to die?" by acknowledging that we don't have the information, but simultaneously validating the emotion behind the question. "I know this is scary"
- Breaking down the workup in simpler terms "Sample with a needle" vs biopsy with IR, "cancer doctors" instead of Hem-Onc

Code Status

DR. MASOOD KISANA

Illness Trajectories

Figure 1

Legend:
- Sudden Decline from Acute Illness
- Cancer
- Organ Failure
- Frailty / Dementia

Axes: Function (High / Low) vs Time, ending at Death

Many opportunities to talk about care preferences over the course of an illness, both inpatient AND outpatient

Ways to Document Care Preferences

- Advance Directives

- POLST Form

- Out-of-Hospital DNAR Form

- Code Status

We will focus on Code Status, but information on the other forms is available in the patient fact sheet being handed out that is available for free online and can be printed and provided to patients

Code Status

- Full Code

- DNR/DNI

- DNR/OK to Intubate

- OK for compressions/DNI (not preferred, should <u>not</u> be offered routinely, requires education)

What is the point of CPR?

- CPR is intended for patients whose hearts are the **first** thing to fail, not the last thing!

- When a patient is admitted to the hospital, the code status is an instruction from them to the medical team about what the medical team should do if they have a cardiac or respiratory arrest, i.e. if they die or their heart and/or lungs fail.

- This does not affect the care they receive BEFORE their heart stops, i.e. code status does not affect PRE-ARREST care. It only determines what resuscitative measures the patient will receive if they have cardiac arrest and/or respiratory arrest

CPR Survival Data

- Survival to hospital discharge was 22.4% of 33,874 <u>adult pulseless in-hospital cardiac arrests</u> at 328 hospitals in Get With The Guidelines 2020 data.

- Among survivors, 79.5% had good functional status (Cerebral Performance Category 1 or 2) at hospital discharge.

https://www.ahajournals.org/doi/10.1161/CIR.0000000000001052#d1e670

CPR in Chronic Illness

- Study: 358,682 CPR recipients

- Patient with chronic disease were less likely to survive to discharge (14.8% in advanced COPD, 11.3% in the advanced malignancy group than patients without chronic illness (17.3%)

- Among discharge survivors, the median long-term survival was shorter in patients with chronic illness (eg, 5.0, 3.5, and 2.8 months in the advanced COPD, malignancy, and cirrhosis than without (26.7 months)

- Although 7.2% of CPR recipients without chronic disease were discharged home and survived at least 6 months without readmission, ≤ 2.0% of recipients with advanced COPD, CHF, malignancy, and cirrhosis met these criteria.

- Most subgroups with chronic illness had lower hospital discharge survival

- Among discharge survivors, most were discharged home less often, experienced more hospital readmissions, and had worse long-term survival.

- Older CPR recipients with any of six underlying chronic diseases investigated generally have much worse outcomes than CPR recipients without chronic disease.

Stapleton RD, Ehlenbach WJ, Deyo RA, Curtis JR. Long-term outcomes after in-hospital CPR in older adults with chronic illness.
Chest. 2014 Nov;146(5):1214-1225. doi: 10.1378/chest.13-2110. PMID: 25086252; PMCID: PMC4219338.

Outcomes of in-hospital cardiopulmonary resuscitation for patients with end-stage liver disease

- A total of 177 533 patients underwent in-hospital CPR, of which 1474 (0.8%) had ESLD.

- Patients with ESLD had lower rates of survival to hospital discharge compared to patients without ESLD (10.7% vs 28.6%, $P< 0.01$).

- Among survivors of in-hospital CPR, ESLD patients had a significantly lower chance of discharge to home compared to patients without ESLD (3.2% vs 8.0%, $P< 0.05$).

- Patients with ESLD also had lower rates of survival to hospital discharge compared to those with metastatic cancer (10.7% vs 15.5%, $P< 0.01$).

Ufere, NN, Brahmania, M, Sey, M, et al. Outcomes of in-hospital cardiopulmonary resuscitation for patients with end-stage liver disease. *Liver Int*. 2019; 39: 1256–1262. https://doi.org/10.1111/liv.14079

Break for Lunch!