

The Case of Breaking Bad News Badly

Case Written by Dr. Stephen Singh, MD, CCFP

"I'm not sure that went so well..." William said to Sally. William was a first-year off-service resident rotating through emergency medicine. Sally, a third-year emergency medicine resident, was reviewing the case with him.

"I think.... I think the patient and his wife are upset with me..." William continued. The patient was Mr. Theodore Smith, a 78-year-old gentleman with stage four prostate cancer with metastases to the bones. He had come to the emergency department in a pain crisis, and a decision had been made to admit him to hospital to optimize his pain control.

"Why do you think that?" probed Sally, a budding medical educator. She had encouraged William to discuss the patient's end-of-life goals, using the hospital's 'Code Status' form as a prompt to open the discussion. She had even asked William if he was comfortable with the discussion, and he had stated he felt very confident, as he had just finished his in-patient internal medicine rotation.

"Like you asked, I was trying to get them to complete the code status form, to make it easier for the admitting team. But it sounds like no one had discussed this before with them," William explained.

"How did you bring it up?"

"I asked them if they wanted everything done if something bad happened," William explained. "They seemed confused, so I went through the checklist on the sheet, and that seemed to confuse them more. They wanted to know what this had to do with alleviating his pain, and why I was asking them these questions. Mr. Smith started to cry, and his wife asked me why I had to put him through more suffering. They then demanded to speak with the 'real doctor.'"

Sally understood as she had had a similar experience when she was a first-year resident. Though able to empathize with William, she reflected that she was not well equipped to help sort this out now that there was clearly an issue between William and his patient. Not wanting to complicate the situation for the busy Senior Medical Resident, she and William come to you as the supervising staff emergency medicine physician and explain the situation.

Case

Dr. Stephen Singh, MD, CCFP

Objectives:

Dr. Teresa Chan

Expert Responses

Dr. Ashley Shreves

Dr. Susan Shaw

Curated Community

Commentary

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Questions for Discussion

1. How should questions about a patient's 'code status' be brought up?
2. Who is responsible for helping to determine a patient's goals of care?
3. How can one "repair" the physician-patient relationship after a code status or goals of care discussion goes awry?

Competencies

ACGME	CanMEDS
Professional Values (PROF1) Patient Centered Communication (ICS1)	Professional Communicator

Intended Objectives of Case

1. Discuss and identify reasons for engaging in end-of-life care discussions in the emergency department.
2. Describe an approach for end-of-life care discussions in the emergency department.
3. List specific things that should and should not be done when seeking end-of-life care discussions in the emergency department.
4. Describe situations that may warrant involvement of other parties (e.g. consulting services, admitting services, nursing and other allied health professionals) in the discussion around treatment goals and end-of-life care discussions.

Confusion about Code Status

by Ashley Shreves MD

Many physicians have been traumatized by the experience of performing futile resuscitations on terminally ill patients, feeling that their medico-legal milieu has forced them into a position of doing physical harm to vulnerable, fragile individuals in the last moments of their lives. The fall-out has been a medical profession obsessed with the topic of code status, but with little training dedicated to communication surrounding what can be an emotionally challenging subject. (1) Not surprisingly, studies have demonstrated that such conversations are too brief and lacking in key content.(2) The result is that patients and families often make decisions that are inconsistent with their goals and values. Doctors are frustrated by what they perceive to be poor choices. Everyone loses.

What does code status mean?

Patients' decisions about code status tell doctors whether a resuscitation should be attempted, in the setting of a cardiopulmonary arrest. A DNR order should not guide any other medical care that the patient receives and yet, studies have shown that it does.(3) Disturbingly, DNR status alone is strongly associated with refusal of care by the ICU team.(4) Does code status need to be addressed in the ED? The short answer is rarely. Emergency physicians, like the one in this case, may feel that they're doing their inpatient colleagues a favor by broaching a topic so important to other physicians. The reality is that very few of our ED patients are at risk of suffering a full cardiopulmonary arrest in the ED or in the first 24 hours of their admission. This conversation takes time, skill and real knowledge of the patient's underlying condition. As this case study demonstrates, having this conversation quickly and poorly is worse than not having it at all.

What happens when patients with advanced illnesses "code"?

Only about 10% of patients who experience an out of hospital cardiac arrest survive.(5) In those with advanced terminal illnesses, the outcomes are much worse. In one study of patients with metastatic cancer opting to be "full

code", not a single patient survived an expected cardiac arrest.(6) Those who are "successfully" resuscitated are at often high risk of having a prolonged dying experience in the ICU.

What is most important to patients?

While doctors are often most focused on the delivery of medical interventions like CPR, patients are more concerned about the outcomes that can be achieved by undergoing such treatments. When presented with a scenario in which the outcome of illness is severe cognitive or functional impairment, 90% and 79% of patients with advanced diseases, respectively, say they would want no treatment at all.(7) Understanding then, what the patient considers an acceptable quality of life is one of the essential components to any conversation about goals of care.

Roadmap for the end of life conversation

Some patients do present to the ED critically ill and decisions about the use of many life-sustaining treatments (LST) need to be made promptly. Following the roadmap below can help ensure that patients and families make decisions that best reflect their goals and values, rather than poor doctor communication.

- Do your homework. Before you approach patients about the use of LST, make sure you have a good sense of their underlying condition, including their prognosis with and without LST.
- Learn a little about the patient. This helps refocus physicians on the person behind the patient and helps establish trust with families. "Can you tell me a little bit about your husband?"
- Find out what the patient/family understands about their condition. Patients who don't believe or understand that they have a terminal disease will be confused when asked about code status. "What have the doctors told you about your illness?" It can become clear in this step that patients and families are in significant denial about the terminal nature of their illness. That is usually a red flag suggesting that establishing goals of care will be complex and require



About the Expert

Dr. Shreves completed her emergency medicine training at St. Luke's-Roosevelt Hospital. As an EM attending, she had many challenging end-of-life cases and felt woefully unprepared to manage them. She consequently decided to do a palliative medicine fellowship at Mt. Sinai and since completing it in 2012, she has split her clinical time between the inpatient palliative care consult service and ED. Additional areas of interest include EBM. Dr. Shreves is the co-producer of the monthly Annals of Emergency Medicine podcast and formally contributed to the SMART EM podcast. She is now an Assistant Professor, Emergency Medicine & Geriatrics and Palliative Medicine, Mt. Sinai in NYC.

Expert Response

significant time, beyond that available in the ED. Move on!

- Give patients/families your best summary of the medical facts. Keep this piece focused on the big picture and minimize jargon. If you think the patient is dying, say "I'm worried that he is dying." Be honest about the limitations of our medical technology and science. "His cancer is so advanced that I don't have any more treatments that will make him better." Let the patient/family know if you think that death could come soon. "I'm worried that time may be short."
- Ask about what the patient is hoping for, given this new information. "What is most important to you, knowing that time is short?" "How do you want to live your life with the time that you have?" For the family, "What would your husband tell us is most important to him, if he knew his doctors thought he was dying?"
- Assimilate all the above pieces of information to formulate a recommendation for the patient/family.(8) DO NOT ask what treatments patients/families want. This presumes a level of health literacy that few lay people have. Instead, based on the above conversation, the best path forward should become relatively clear. "Based on what I'm hearing from you and what we know about his advanced disease, I think it makes the most sense now to refocus on his comfort and quality of life for the time that he has."
- Once the foundation above has been laid, addressing the use of specific LST like intubation and CPR is typically a 30 second discussion. Literally. "I don't recommend placing him on a breathing machine (or life support) or using other invasive treatments like this as it will only prolong his dying process." "Along those lines, when his heart stops, I think we should allow him to have a natural death."(9) "If that's ok with you, I'll let the other members of the team know that you've made this decision by placing a DNR order."

Patients and families have not been asked if they "want everything done." They haven't even been asked if they want chest compressions or to be shocked. The patient and family have been engaged in a discussion that allowed them to share their priorities, values and goals and the physician, the person in the room with the highest health literacy, has made a recommendation to them about the best medical path forward, based on that information.

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Expert Response

Conversations about Code Status

by Susan Shaw MD, FRCPC

William isn't alone in his experience described in the case study. As a critical care doctor, I meet many patients and families who have been asked versions of the question, "Do you want us to do everything?" While well intended, this is a very poorly worded question. Most patients or their families will answer a resounding "yes" as, for the most part, they do want you to do everything possible that makes sense to them, based on their personal values, goals, and clinical situation, AND based on your clinical expertise. The challenge facing physicians, patients and families is the need to have what can be a difficult conversation that explores both what makes sense to you and to the patient.

Conversations about end of life care including "code status" should ideally occur as a series of conversations between a patient and his or her main doctor or healthcare provider. The patient's family ideally would be a part of these conversations (if deemed appropriate by the patient) so that the family can best speak on his or her behalf should the patient become unable to do so. An advanced care directive, or living will, if well written, can also be an effective way to let a family or future care providers be aware of a patient's preferences for care.

Hospital-based doctors frequently find themselves in a difficult position. Important conversations must occur and treatment plans must often be created with seemingly little opportunity to develop a strong relationship with a patient and his or her family. We can be better prepared for such conversations if we know what is valued by seriously ill patients and their families: trust, open communication, and to not be kept alive by life support when there is no or little hope for recovery.

We can also be better prepared by training ourselves and our students to take a more human approach to such conversations. Our shared goal is to better understand what is happening, what is likely and what the patient wants to achieve from his or her treatment. We will be more likely to reach this goal if we take some simple steps

to have a more meaningful (and useful) conversation than just asking "Do you want us to do everything?"

Try to create a space to talk by either drawing the curtains or moving, if possible, to a quieter place. Sit down and make eye contact. Make sure the patient or his/her family (or designated substitute decision maker) understands who you are and what role you play in the patient's care. Try to learn something about who the patient is as a person. Ask questions such as: What is important to him or her? How does he/she spend his/her time? and What gives his or her life meaning?

Focus your conversation on goals rather than the technical aspects of care. Qualitative studies demonstrate doctors focus on a checklist of interventions, more readily finding words to describe CPR, defibrillation, intubation and mechanical ventilation. But patients tell us they want to better understand what can or will be accomplished, how likely success (as defined by the patient) will be, and what recommendations the doctor would make.

The last thing William should do is avoid his patient and the patient's wife. He should work with the attending emergency physician to plan a second conversation. I would map out a plan with William and then the two of us would re-approach Mr Smith and his wife.

Say, "I'm sorry I upset you. I chose my words poorly. I want to make sure that we both understand what your goals are for your care and life you have ahead of you. I want you to understand what my concerns are, and I would like to share my thoughts with you on how best we can work together to achieve your goals. I understand that you are in a lot of pain right now from the spread of your cancer. We can work together to improve your pain control. I do want to make sure that I, along with the rest of your medical team, understand what treatments or medical interventions are most appropriate for you."

Then *listen*.

Expert Response

A spectrum exists in medical decision-making between paternalism, shared decision making, and informed choice. Paternalism places all the decision-making in the hands of the physician while informed choice places patients and families in what is now recognized to be an unfair and unsupported position of being asked to make important and sometimes irreversible decisions without having sufficient information or context to truly be able to make a "best choice." Shared decision making is much more bidirectional: the physician provides medical information, the patient contributes information about personal goals, values, preferences. This is the approach I aim to take when discussing our treatment plan

We can better equip ourselves by seeking out wisdom and expertise from our colleagues and published experts. Residents and medical students should join as many family meetings as possible to both observe different styles and try out different approaches. I have been at this for almost 20 years and I am continuously finding new phrases and approaches that either work or don't. Life is a continuous experiment in how to improve!

Many family doctors, internists, and surgeons have already had such conversations with their patients but in an emergency, we often don't have the time to seek out their knowledge. However, when even small amounts of time are available I know I've learned much about how best to provide care to some of my patients by calling the family physician, respirologist, neurologist, or surgeon who has known the person in front of me for years, often through crisis and recovery.

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About the Expert

Dr Shaw practices critical care medicine & anesthesiology as a faculty member of the University of Saskatchewan. Susan has experience as a department head and leader at a provincial level particularly relating to quality improvement and large scale change. She currently is board chair for the Health Quality Council. While Susan loves her job, the best part of her day is always the time spent at home with her family.

Curated Community Commentary

By Sarah Lockett-Gatopoulos MD, FRCPC (candidate)

This case generated thoughtful discussion about the way we approach goals of care conversations with patients in the emergency department. While there was no consensus regarding where or how goals of care discussions should take place, some common themes arose.

Understanding goals of care is much more than getting a 'code status'.

In the present case, William, a medical student, felt he should get the code status sheet filled out to help the admitting team. Medical student Eve Purdy reported getting 'unhappy looks' from residents when she had not 'gotten a code status' while admitting patients as a clinical clerk. Residents Lindsay Melvin and Tamara McColl acknowledge that there is a culture in many hospitals that prioritises quickly establishing a 'code status', a task that often falls to junior learners in the emergency department.

Despite the pressure to quickly 'get a code status' in the emergency department, there was unanimous agreement that understanding goals of care requires thoughtful and considered discussion, not merely filling out a checkbox or applying terms like 'Do Not Resuscitate' or 'Allow Natural Death'. ICU physician Shankar Sivanathan describes an approach that requires '...ask[ing] about the patient/family's understanding of their disease and prognosis' before moving on to establishing what the patient's wishes would be should he or she become sicker, emphasizing that the health care team wants to 'have the patient's wishes in mind when coming up with a treatment plan'.

We can and should initiate goals of care discussions in the emergency department.

Most commenters agreed that goals of care discussions can be initiated in the emergency department, but that the urgency in establishing patient wishes depends on the clinical picture. Loice Swisher suggested that it is reasonable to 'find out if the patient/family has any wishes already. If not and it is not emergent, I suggest that they could consider designating a medical decision maker in the family or reviewing with their doctor...in case they are involved in a sudden serious event'. Sameed Shaikh agreed that not all patients require emergent discussion of code status, and that understanding the urgency of the patient's current clinical picture may guide when it is best to broach conversations surrounding goals of care. On Twitter, Simon Oczkowski suggested that 'The overnight code status discussion is just to document patients who have already decided'.

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

Twitter

Alvin Chin (@AylC1989)
Tamara McColl (@mccoll_tamara)
Lindsay Melvin (@LMelvinMD)
John Neary (@jddneary)
Simon Oczkowski (@Simon_Ocz)
Julian Owen (@JulianOwenEM)
Kaif Pardhan (@twoscoopspk)
Ben Tam (@BenTam)

Blog Comments

Colin Bell
Michael Beyak
Kyla Caners
Teresa Chan
Alvin Chin
Tamara McColl
Lindsay Melvin
Eve Purdy
Sameed Shaikh
Shankar Sivanathan
Loice Swisher
Krishan Yadav

In instances where patients are acutely ill or medically unstable, the consensus was that goals of care should be established early, if practical. In these instances, Dr. Shaikh acknowledges that we are 'working against the clock' and may need to ask questions like, 'your family member is really sick. We are doing everything we can and I think they might do ok, but there is a very real possibility things could get worse - did they ever say what they would want? If not, what do you think they would want?' Resident Kyla Caners echoes Dr. Shaikh, adding that 'it's important to express that your discussion comes from a place of genuine care, but to also express the urgency'.

There was agreement that not all goals of care discussions need to be completed in the emergency department. Tamara McColl says, 'I always hold the emergent goals of care discussions immediately but usually defer the rest to the admitting team due to time constraints and concerns regarding patient flow'. Loice Swisher states that she 'opens the door' for the conversation by saying something like 'I'm going to admit you to the hospital. When the medical team comes to write your orders they will automatically ask about medical directives including what we call code status which is when the heart stops.' On Twitter, Ben Tam concurred that 'complex decisions need time. Sometimes role of junior is to introduce ideas overnight, then AM followup.' Others agreed that broaching the topic in the emergency department can allow patients and families to consider their wishes and engage in a more definitive discussion with admitting practitioners later.

A skilled and experienced provider is the best person to discuss goals of care with patients and their families.

Curated Community Commentary

While many in this discussion acknowledged that 'getting the code status' is often delegated to junior members of the team, most agreed that more senior practitioners are the more appropriate choice. On Twitter, emergency physician and intensivist Julian Owen commented that the discussion may be initiated by '...med student + senior/MRP' stating that it is '...hard to commit to vent support/CPR [without] experience.' Alvin C, a medical student, agrees that he 'wouldn't even dare approach this conversation alone with a patient'. Colin Bell advocated that, 'frankly, the person who should begin the conversation is the person dedicated to the process, giving it the time and sensitivity it deserves.'

With that in mind, the reality is that sometimes inexperienced learners are tasked with initiating goals of care discussions, and Lindsay Melvin suggested that 'the very best thing for [patient and families] is to have discussion [with] someone who cares, regardless of training level'.

Patients often want guidance in making goals of care decisions.

On Twitter, resident Kaif Pardhan suggested that 'most [patients] want guidance and to make final decision. Always couple at ends of spectrum: "Yes Dr" and "What do you know?"' Krishan Yadav notes that it is reflexive for inexperienced learners to offer all options to patients, and families, but that ideally these options should be tailored to what is reasonable given the patient's medical status and expectations: "For example, do not offer chest compressions to an end-stage cancer patient with multiple comorbidities and severe acute illness, because they will not survive a cardiac arrest and thus a 'heroic measure' is more likely to just simply inflict further harm on the patient. Michael Beyak

reminds us that, 'this is not the time to stop being an expert...you need to provide your best advice and then see how that matches up with the wishes and values of the patient.'

When goals of care discussions go awry...

Most agreed that it is reasonable to bring in someone new and revisit the conversation from the beginning.

Listing of links and references mentioned in the online discussions

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About

The Medical Education In Cases (MEiC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

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