DO YOU WANT EVERYTHING DONE?

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- Trained in Intensive Care in NZ
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College of Emergency Nurses New Zealand
27th Annual Conference

ConnectED
STRONG CONNECTIONS GIANT GAINS

Friday 26 & Saturday 27 October 2018
AENN Day Sunday 28th October

Napier, Hawke's Bay

CASE

- Mr. S -83 year old man
- Presents to ED following fall off push bike
- Triage- responsive but unable to recognise wife
- PMHx
  - Previous traumatic brain injury
  - Previous right cerebral infarct
  - Limited mobility- recent AT&R admission-refused nursing home despite medical and family advice
  - EtoH misuse/Smoker
- EPOA - Brother

CASE

- GCS 13-14/15
- CT shows acute sub-dural
- Surgical Registrar discussed with Neurosurgical Registrar in Wellington
  - Plan
    - For hourly obs overnight.
    - Repeat CT in morning
    - If GCS falls repeat CT sooner

CASE

- Agitated and combative overnight requiring sedation
- In morning GCS 11/15- for repeat CT
- CT revealed further bleed & new midline shift
- Surgical Registrar contacts Neurosurgical Registrar
  - "will accept patient as long as family agree"

CASE

- Surgical registrar meets with family
  - "Mr S. has increased bleed in head and is at risk of dying.
  - Do you want everything done?
  - Do you want him to be resuscitated?"
- Family
  - "Ummmm… yes?"
- Surgical Registrar
  - "Okay then he needs to go to Wellington to have an operation as soon as possible"
- Family
  - "Oh okay" (Family accepts!!)

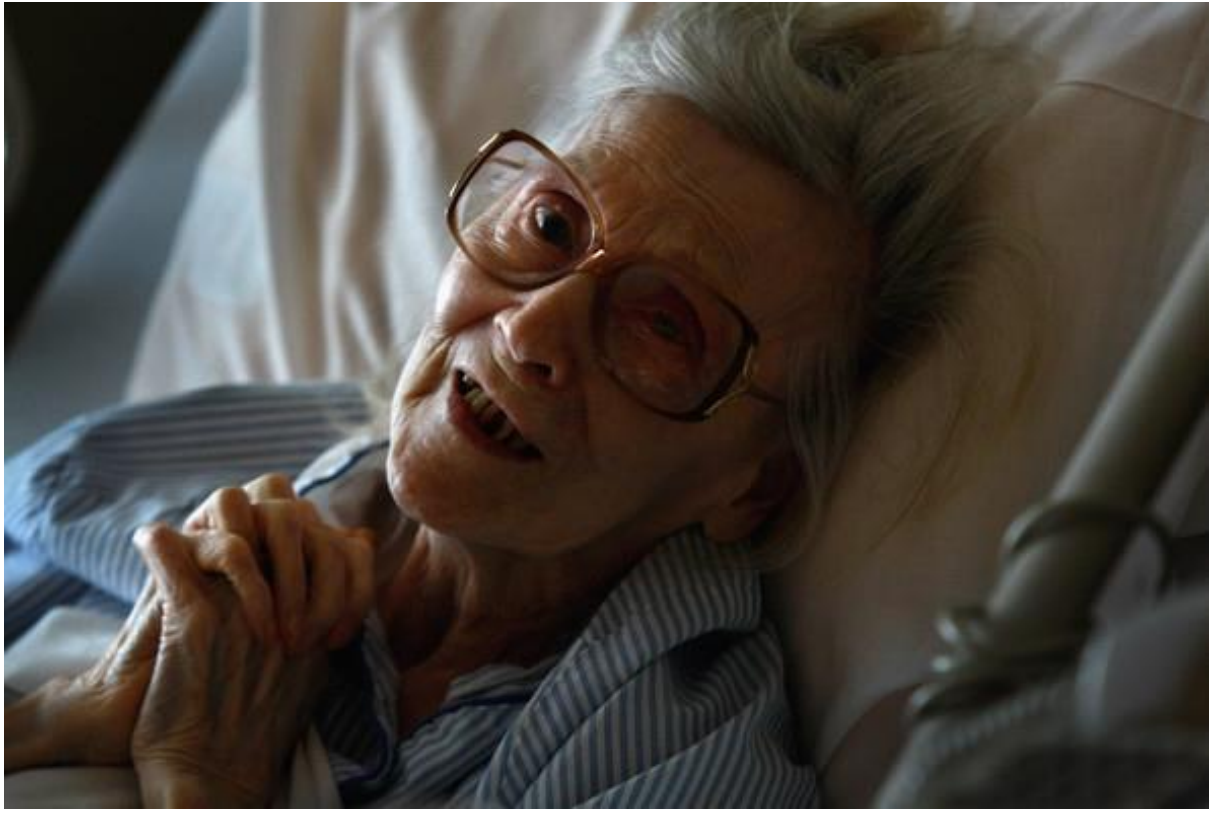
THE BAD QUESTIONS…
WHAT IS WRONG WITH THESE QUESTIONS?

- Do you want everything done?
- Do you want to be resuscitated?
- If her heart stops, we don't think he should be for CPR, is that okay?

DO YOU WANT EVERYTHING DONE?

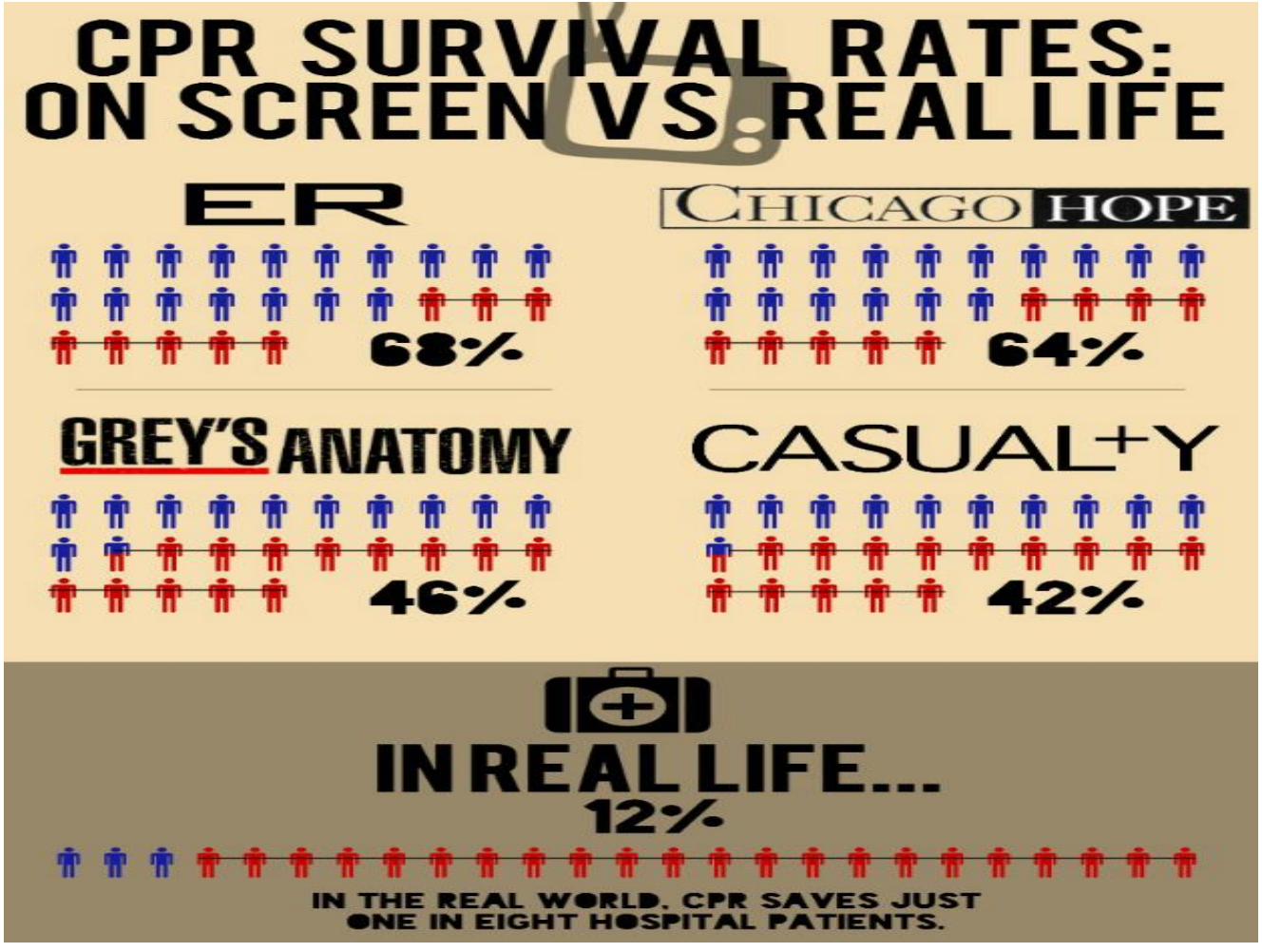
- What is the opposite?
- Do you want nothing done?

"DO YOU WANT TO BE RESUSCITATED?"



DO YOU WANT TO BE RESUSCITATED?

- What does that mean?
  - Not for Intensive Care?
  - Not for escalation of treatment?
  - Not for fluids if hypotensive?
- We tend to only ask the patients we believe will not benefit from CPR whether they would like CPR!
- What are the chances of CPR working?


CPR SURVIVAL RATES:
ON SCREEN VS. REAL LIFE
ER
68%
CHICAGO HOPE
64%
GREY'S ANATOMY
46%
CASUALTY
42%
IN REAL LIFE...
12%
IN THE REAL WORLD, CPR SAVES JUST
ONE IN EIGHT HOSPITAL PATIENTS.

"IF HIS HEART STOPS, WE DON'T THINK HE SHOULD BE FOR CPR… IS THAT OKAY?"

- **W**ednesday,
- **T**hursday,
- **F**riday?
- Why? Do you not care about my loved one?
- That sounds like a raw deal to me…
- Why are you resuscitating that person and not my father??

WHY DO WE ASK BAD QUESTIONS?

- Ease of asking closed questions?
- The need to ask something?
- Inadvertently asked an incomplete question?
- Because death is not an option?
- Death is seen as a failure?

WHY DO WE ASK BAD QUESTIONS?

- To facilitate autonomy?

PEAK AUTONOMY?

- Past
  - Trust that the doctor would do what's best
  - ***Paternalism***

- Currently-
  - Patients and their surrogates demand all aspects of treatment.
  - ***Consumerism***

AUTONOMY

- Aim for professionalism
  - **Patient decides on goals**
  - **Doctor readjusts unrealistic goals, decides plan, seeks assent**
- Everyone has the right to refuse to undergo any offered medical treatment*
- Only the patient should be asked
  - Unless deemed not competent

*New Zealand Bill of Rights Act 1990: 11. Right to refuse to undergo medical treatment

IF PATIENT IS NOT COMPETENT

- Family have no legal right to choose treatment on patient's behalf.
- An EPOA cannot refuse life saving treatment but can convey patients wishes.
  - Question construction important.
- What about Advanced Care Planning?

ADVANCED CARE PLANNING

- ACP not available
- ACP not specific enough
- ACP not relevant to new illness
- Useful if disease is predictable
- Informed consent?

SO WHAT IS A GOOD WAY OF COMMUNICATING?

- The good questions
  - Ask yourself questions
  - Ask the patient questions
  - If patient unable to communicate then, ask the Whanau/family/EPOA questions

THE GOOD QUESTIONS-*ASK YOURSELF*

1. Is the disease or condition reversible?
2. What therapies are required?
3. Will the patient have enough reserve to cope with the stress of therapies required?
4. Which therapies will benefit and which ones will not?
5. What are the risks of the therapies?
6. Will the patient accept the beneficial therapies and any potential outcome?
7. Should the patient be resuscitated?

REVERSIBILITY

- Three categories
  - Clearly reversible
  - Clearly irreversible
  - Uncertainty

CLEARLY REVERSIBLE

- Offer appropriate treatments
- Patient has right to refuse (Autonomy)

CLEARLY IRREVERSIBLE

- Do not offer therapies that will not help
- The disease process cannot be stopped and therefore the aim of treatment is to alleviate symptoms.
- Palliative Care

UNCERTAINTY

- With outcome and reversibility uncertainty, the questions we ask need careful consideration.
- Percentage of uncertainty decreases as the doctors gains experience
- We need to ask the whole question at the right time to the right person.
- The important question is:
  - Is the disease or condition reversible in the patient's context?
- Failure to do so can lead to worse outcomes

THE RIGHT CONVERSATION- *TALKING TO THE PATIENT*

- I'm trying to make the best plan for your care but first I need to talk to you and ask some questions…
- Explain the uncertainty
- Explain that the hope is to get the patient back to their usual state
  - *How would you feel if you could not live the way you are living now?*
  - *Would a decrease in independence be acceptable to you*?
- *Barrier*
  - Difficult to initiate
  - Prefer not to talk about bad things
  - Talking about this may cause psychological harm…

WHAT IF THE PATIENT IS TOO SICK OR NOT COMPETENT?

- Need to speak to the Whanau/family

THE GOOD QUESTIONS-WHANAU/FAMILY

- Ideally this conversation should be with the patient but due to their illness, we cannot ask them.
- We look to the family to tell us what the patient would have wanted if they could have spoken to themselves…
- Ask
  - *If your relative could speak for themselves what would they say about this?*
  - *Would your relative accept the risks?*
  - *What would they say if they lost their independence?*

DISCUSSION WITH FAMILY-
THE GOOD CONVERSATION

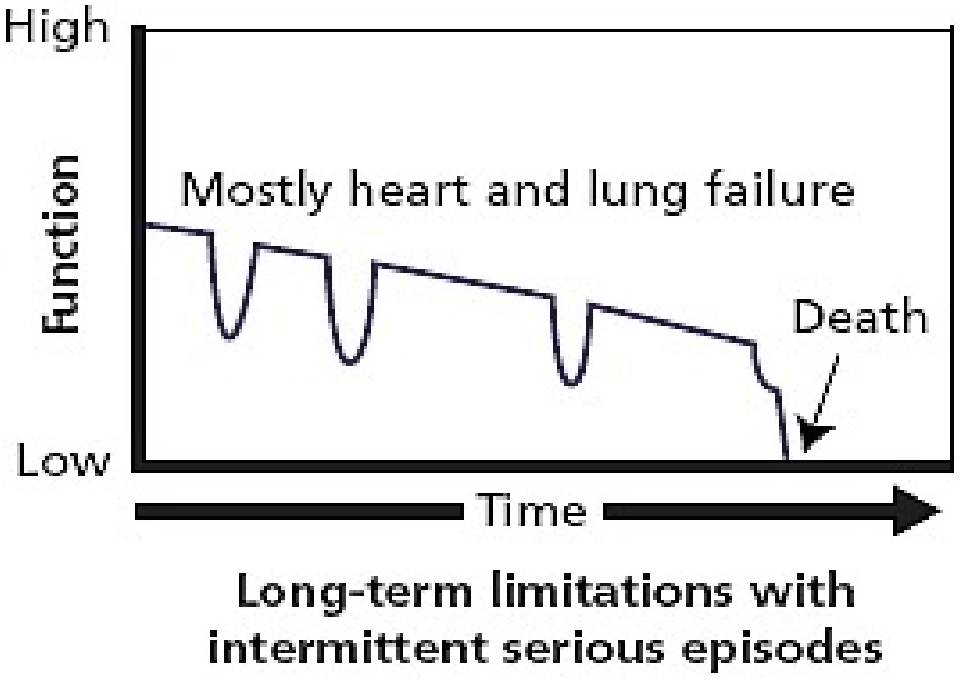
- May have to explain uncertainty
  - *Very sick and we are unsure that our treatments will be effective.*
  - *There is a risk he may continue to get worse despite the therapy.*
  - *If he does survive may not be able to look after himself again*.

- Barrier
  - Knowledge
  - Experience

DISCUSSION WITH FAMILY

THE GOOD CONVERSATION

- Chronic diseases…



WHY DO WE NEED TO DO THIS?

- 40% of all deaths in Hospital
  - Counties Manukau, Chen et al, NZMJ
- 78% of those dying with palliative care needs are >65yrs
  - M.Gott, Auckland
- Number people >65 yrs predicted to double by 2051

WHY DO WE NEED TO DO THIS?

- Healthcare Commission Report 2007
  - Analysed 16,000 complaints 2004-2006
    - 54% hospital complaints were about care surrounding a death.

WHEN IS THE RIGHT TIME?

- When is the right time to ask?
  - At the GP?
  - Outpatient clinic
  - In the ED
  - When they become unwell?

- Who should be asking the questions?

BACK TO THE CASE

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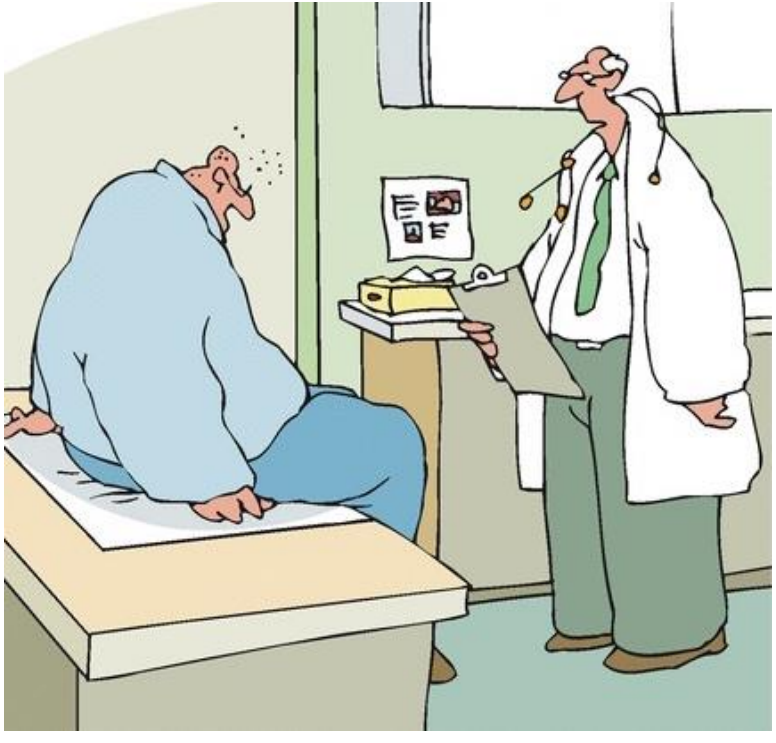
THE GOOD QUESTIONS-*ASK YOURSELF*

1. Is the disease or condition reversible?
    1. In this patient's context?
2. What therapies are required?
3. Will the patient have enough reserve to cope with the stress of therapies required?
4. Which therapies will benefit?
5. What are the risks of the therapies?
6. Should the patient be resuscitated?

TRIAL OF THERAPY -
TO LOOK FOR REVERSIBILITY

- Need clear objectives
  - Timely response to therapy
  - Seek signs of subsequent deterioration or absence of response

OFFER A TRIAL OF THERAPY



"You've only got 3 months to live, but with aggressive treatment we can help make it feel much longer."

BUT WHAT IF TRIAL OF THERAPY FAILS?

- Change the focus of care
  - Providing ongoing care is always the right thing to do.

CASE

- Unanswered question:
  - Will the patient accept the beneficial therapies and any potential outcome?
    - Cannot discuss that with patient
    - Will need to speak to the family

TALKING TO FAMILIES

- Want you to care for their loved one.
- Assurance that their loved one will not get a raw deal.
- Want real and honest information in a timely manner.
- Explain likely outcomes not unknown therapies.
- Want certainty.
- What you to continue to look after their loved one even if things do not improve.

THE GOOD DISCUSSION-WHANAU/FAMILY

- *Only discuss the therapies you are prepared to offer*
- *Start off by telling them what you will do*
  - *Care for him.*
  - *Our aim is to get him back to his usual state.*
  - *We want to start treatments that we believe will help.*
  - *We do not want to start treatments we know will not help*
  - *Real risk that treatments will not work.*
  - *Risk that he may die despite treatment.*
  - *If his disease progresses to the point that his heart stops- there is nothing else we can do that will help.*

THE GOOD DISCUSSION-WHANAU/FAMILY

- *Explore patient's goals*
- *Seek assent not consent*
  - If Mr.S could talk to us what would he say?
  - Would he accept a reduction in independence?
  - Would he accept nursing home care?

CASE-DISCUSSION WITH WHANAU/FAMILY

- Explained current situation
- Explained the therapies that were offered
- Explained likely outcomes
- Asked what Mr. S would say if he could speak for himself?
- Asked family what do you think his goals would be?

CASE-WHANAU/FAMILY RESPONSE

- "I want him to live but I know he would not want this"
- "he would rather die than be left unable to do the things he currently enjoys"
- "He was recently assessed during his stay in rehab but he refused to go to a nursing home. Even though we wanted him to go there…"
- "In our eyes the decision to treat was made. We presumed the treatment was in his best interests and that it would get him back to his usual self… No one discussed outcomes or what he'd want"
- "We never had an opportunity to talk…"

CASE-CHANGED THE FOCUS OF CARE

- *Seek whanau/family assent*
- *"Aim now is to avoid prolonging his dying."*
- *"Withdraw therapy to allow a natural death"*
- Relieving symptoms with analgesia/anxiolytics becomes a priority
- Mr S. was commenced on a Opioid/Benzodiazepine infusion
- Passed away peacefully with his family present

17 June 2014 Last updated at 14:33

Legal duty over resuscitation orders

By Michelle Roberts
Health editor, BBC News online

David Tracey, husband: "The fact that her death has led to greater clarity in the law gives us all some small comfort"

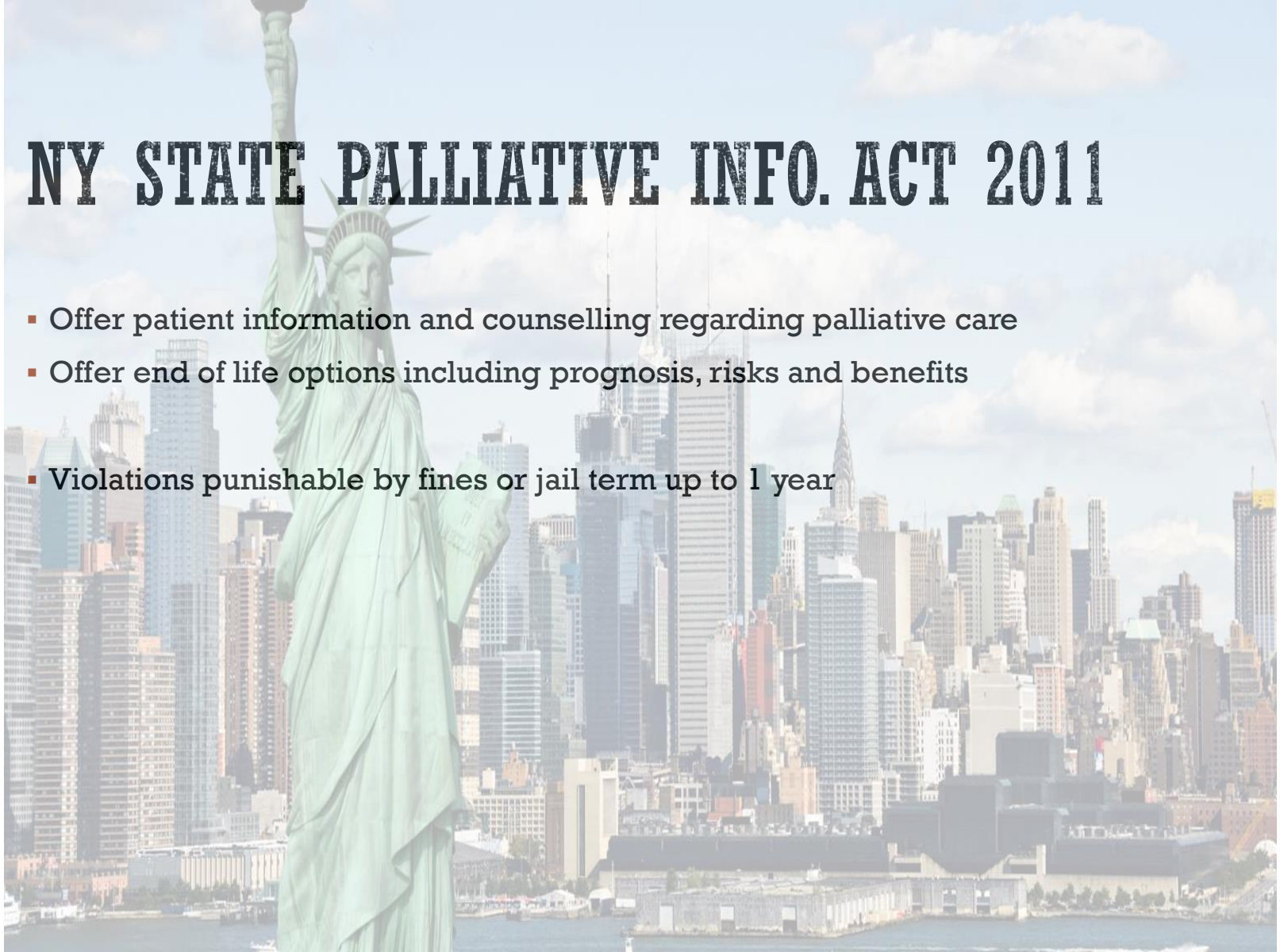
Doctors now have a legal duty to consult with and inform patients if they want to place a Do Not Resuscitate (DNR) order on medical notes, the Court of Appeal in England ruled.

The issue was raised by a landmark judgement that found doctors at Addenbrooke's Hospital, in Cambridge, had acted unlawfully.

Related Stories

Ruling in 'no resuscitation' case

'Clarity needed' over



NY STATE PALLIATIVE INFO. ACT 2011

- Offer patient information and counselling regarding palliative care
- Offer end of life options including prognosis, risks and benefits

- Violations punishable by fines or jail term up to 1 year

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GOAL

- Our goal for young people is to help them live long and healthy lives; our goal for older patients should be to maximise their function

- I want to die peacefully in my sleep, just like my grandfather….
- Not screaming and yelling like the passengers in his car.

QUESTIONS??

WHY DO PATIENTS DETERIORATE?

- Disease progression
- Wrong diagnosis & treatment
- Treatment failure
- Treatment effect
- New illness

DO YOU WANT TO BE RESUSCITATED?

- Ron Paterson (NZ H&D Commissioner 2000-2010)
  - "When the patient has an opportunity to talk about their illness, their treatment, their values, discussion about how we die, often using the words "allow a natural death", this is far more comfortable for patient and doctor, rather than baldly asking "Do you want to be resuscitated?""