“Do You Want Us to Do Everything?” Teaching Residents to Discuss Resuscitation

Theresa E. Vettese, MD
Wayne State University School of Medicine

Patricia McNally, MD
St. Joseph Mercy Hospital Ann Arbor

Gayle Byker, MD
St. Joseph Mercy Hospital Ann Arbor
Understand the need for more “hands on” training for residents in end-of-life decision making.

Describe the challenges in teaching residents to discuss CPR with hospitalized patients.

Learn strategies to teach residents to discuss resuscitation in the hospital setting.

Exchange ideas and perspectives through the sharing of experiences in teaching residents communication skills in end-of-life decision making.
Residents’ End-of-Life Decision Making with Patients

Theresa E. Vettese, MD
Wayne State University School of Medicine
tvettese@med.wayne.edu
What problems do we have?
The Resident’s Role in the Team
“Discussing resuscitation depends on the dynamics of the team, how strong the people on the team feel about getting a code status. The person who’s on top decides when it is appropriate to talk to patients about code status.”

The Resident’s Training and Knowledge
A survey of graduating FP residents showed that 37% felt that they had “little or no” support or precepting in EOL care.

Who’s Watching Our Learners?

- 62 residents in 4 Canadian ICUs surveyed
- 79% of residents felt they were unprepared to lead family discussions in the ICU
- Majority felt unsupervised, unsupported and without role models in regard to EOL decision making
- 70% of the residents were “never” or “rarely” the primary discussant in family meetings

Who’s Watching Our Learners?

- Large sample of US medical students, medicine and surgery residents, AND faculty
- 40% of residents and faculty felt unprepared to teach EOL decision making
- 33% of residents never received any feedback on their EOL decision-making performances

The Resident’s Critical Thinking Skills
How do you feel when you get up in the morning?

Amazed!
Determinants of DNR

- Telephone survey of 2\textsuperscript{nd} and 3\textsuperscript{rd} year internal medicine residents
- Rationale of DNR decisions
- Futility implicated in 63\% of DNR orders
- Residents misused futility argument both quantitatively and qualitatively

DNR Meaning

- 155 medicine/surgery residents with DNR patients
- Exact treatment plans after a DNR order was written in chart
- Variability in interpretation of withholding therapy outside DNR
- Many residents substituted DNR as EOL treatment plan with shifts toward comfort care

Resident Attitudes

Attitudes = Values + Comfort
Attitudes: What are Barriers to Addressing DNR Discussions?
Barriers to Addressing DNR Discussions

- Lack of time (!)
- Lack of training
- Personal discomfort with dying patients
- Personal discomfort with uncertainty
Barriers to Addressing DNR Discussions

- Personal emotional problems
- Fear of harm to the doctor-patient relationship
- Challenging family dynamics
- Lack of continuity relationships
Barriers to Addressing DNR Discussions

- Patient perceived as not sick enough
- Expressing one’s own feelings about a patient’s death
- The hospital culture and the hidden curriculum
Communication Skills
Standardized interview with closed questions IM residents and attendings

Both quantity and quality of discussions flawed:

- Interns only discussed code status 17% of the time despite sick study population
- When resident said CPR had been discussed most patients said that it had not
- Residents agreement with the patients’ preferences for CPR at end-of-life only fair
Self-administered survey

101 internal medicine residents

Experience with and attitude towards DNR discussions

- 94% of residents said they discussed with all seriously ill patients and virtually all of them stated that they did a “good” job; one-third had never been observed
Coded analyses of discussions conducted
Residents did not give enough information for informed consent
Only 10% discussed patient’s values and goals
Residents often framed treatment options and did almost all of the talking

Other Important References

Death and Dying

What is our own comfort level?
Observe Your “Teachers” and “Learners”

Example: Patient with multiple failed extubations, recurrent aspiration, regarding re-intubation and/or PEG tube placement:

“Would you like to keep fighting? Or would you rather let go…?”
Our Curriculum-SJMH

- Respecting Choices Curriculum
  - 1 day multidisciplinary workshop
  - On-line modules prior to workshop 3-5 hours
  - Licensed from Gunderson Lutheran Hospital
- Role-play Retreat
  - Half-day retreat, twice during residency
  - Feedback by trained faculty, peers
- Direct Observation and Feedback
  - Ward attendings
  - Palliative Care team
Role-Play Retreat

- ½ day long
- 5-7 residents per session
- Once as an intern, once as PGY2 or 3
- Intro: 45-60 minutes, interactive
  - Overview of approach
  - List of Do’s and Don’ts
- Standardized patients
- Feedback: peers, faculty, standardized patients
- Observe and Learn from one another
Retreat: Must Include

- Code survival statistics!!
- General approach to discussion
- General do’s and don’ts
- Power of suggestion and word-smithing
- The Role-Play!!
Efficacy of Inpatient Codes--Knowledge

- Rule of Thumb: 17 – 5X rule
  - Start with estimated 17% survival to d/c
  - Subtract 5% for each sick organ system
  - Result: estimate of survival to discharge

- Consider morbidity in the survivors

- Avoid number crunching in patient discussions

- This is for Code Blue (not elective intubation)
58 y.o. man with End-stage liver disease, systolic and valvular CHF with EF 45%, admitted with increased ascites, dyspnea, anasarca, acute renal failure with creatinine 2.5

Chances of surviving to d/c if coded:
- 3 organ systems X 5% per system
  17- (5 x 3) = 2% chance of survival to discharge
Morbidity if survives must also be considered
General Approach to Discussion (Communication Skills)

- Know the facts!
- Break the ice
- Assess what they know
- Get everyone in family up to speed on status
- Assess patient’s goals
- Assess patient’s wishes
  - From patient when possible, family when not
- Relate goals to wishes
  - Point out conflicts when wishes mismatch with goals
Important “Do’s”

- Discuss global picture before code status (for higher level end-of-life discussions)
- Families: frame around PATIENT’S wishes
- Talk to the PATIENT when possible
- Use the “D” word!
Avoid euphemisms

- “Pass On”, “Go to sleep”…

Avoid emotionally charged buzz-words

- “Fighter…Let go…Give UP…Do Everything”

Don’t say “The next step is…intubation/PEG tube/MICU transfer” if in fact those things are optional or inappropriate.
Top “Don’t”

“Hey Baby, do you know YOUR code status!!??”
The first option verbalized by us is the option interpreted as the recommendation

- If you as healthcare provider feel the most “aggressive” option is the least appropriate, then offer the “least aggressive” option FIRST

Assessing goals: “What things make life meaningful for you?”
Resident Attitudes

- **Culture**
  - Assess cultural diversity in your own residents
  - Consider “Ethics 101” Discussion
  - Offer support for struggling residents

- **Religion**

- **Family**

- **Previous training**

- **Attitudes of mentors**
The Role-play

- Standardized patients/family
- Chronically ill patient with superimposed acute, life-threatening illness
- Each resident plays “physician” in role-play
- Emphasis on Overall Big Picture discussion (not just code status)
- 360-degree feedback in real-time
Anecdotal Discoveries

- Recurrent lapses in Critical Thinking Skills
- Misunderstanding of DNR
  - DNR ≠ Do Not Treat
- Misconceptions regarding outcomes of patients who are electively intubated
  - 17 minus 5 rule is for Code Blue only
  - “He might never get off the vent”
Role-play Feedback and Evaluation

- **Feedback**
  - Self Reflection in front of the group
  - Peer feedback
  - Trained faculty feedback

- **Evaluation**
  - Check-list
Our Experience

- After 3 years of data, survey results reveal residents feel significantly more motivated to conduct code discussions and feel significantly more confident in doing so.
- Anecdotal evidence from observation on the wards would echo this.
After H&P, and discussion of plan for acute problem:

- Ask patient or family what his/her/their understanding is of chronic medical problem(s) including prognosis
- Fill in gaps in understanding of chronic disease and clarify prognosis
- Ask: “Given what we have discussed I would like to know what your goals are for the rest of your life…. OR What things are important to you now?”
Make transition statement: “I’d like to talk to you about another aspect of treatment which is CPR (cardiopulmonary resuscitation). Do you know what CPR is?”

Clarify misconceptions and chance of surviving CPR e.g. : “Most people on TV who receive CPR are young and end up surviving, however in real life most people are older and sicker like yourself. If your heart stopped or your breathing failed the chances of you surviving CPR is about ___ %. The chances of recovery to your current state are even less likely.”
MAKE A RECOMMENDATION: “Given your goals, I would recommend that we do not perform CPR as it is very unlikely to be successful and is more likely to cause you harm.”

Reinforce that DNAR status does NOT mean you are giving up on the family and does NOT mean that you are stopping other treatment, e.g. “I want to say again that DNR does not mean that we will stop any other treatments that you are receiving and that could potentially help you.”
Always finish by asking if the patient has any questions
If the patient or family says “we need to think about it.” SET A TIME TO RE-DISCUSS!