Breaking Bad News
When Sepsis is Terminal

Phyllis Whitehead, PhD, CNS, ACHPN
Carolyn White, FNP, GNP, ACHPN
Thomas Morel, MD
Palliative Care Team
Objectives

At the conclusion of the session, participants will be able to identify steps on how to initiate a conversation delivering bad news to families.
Disclosures

- Dr. Whitehead, Ms. White and Dr. Morel do not have any financial disclosures.
Case Study

- 77 yo male with h/o CAD s/p CABG, DMII, COPD and HTN presents with fevers, productive cough, chills and rigors. Admitted to the ICU after initial evaluation in the ED with VS:
  - BP: 100/40, P 110, RR 28 and O2 Sats 88% on 15 L NRB. Temp 100.6
Case Study

- Eventually required intubation
- Aggressively resuscitated
- Broad spectrum antibiotics
- Vasopressors initiated
Sepsis Background

- 2009: 6th most common principal reason for hospitalization
- 2.1 percent of all U.S. hospitalizations
- Single most expensive condition treated in U.S. hospitals. ($15.4 billion in aggregate hospital costs)
- $25K – 50K per episode

http://www.hcup-us.ahrq.gov/reports/statbriefs/sb122.pdf

Sepsis Background

- **Death rates**
  - Sepsis: 10–20%
  - Severe sepsis: 20–50%
  - Septic shock: 40–80%
- **Estimated > 200K deaths/yr**
  - 10th leading cause
  - Similar to death rates from MI

Sepsis Background

- Sepsis Mortality
  - 41% 1 month
  - 65% 6 months
  - 72% 1 year

- APACHE
  - 12 variables: age, HR, RR, MAP, GCS, HCT, pH, Cr, A-a gradient, Temp, Na, WBC, K
  - Higher score = worse prognosis

Sepsis Morbidity

- Prospective study patients >65 yo
- Infection and 1 organ dysfnc (only 40% ICU)
- Measured 6 ADL’s and 5 AIDL’s
  - ADL: walk, dress, bathe, eat, out of bed, toilette
  - AIDL: prepare meal, shop, phone, meds, money
- Mortality
  - 90 days 41%
  - 5 year 82%

Iwashyna et al JAMA. 2010;304(16):1787-1794.
Sepsis Survivorship

- Long term >12 month effects:
  - Significantly worse
    - Cognition: 3.3x odds of impairment
    - 1.6 new functional limitations
  - Declined faster functionally after
  - Increased caregiver time (avg 40 hr/wk), NH, depression, mortality

Iwashyna et al JAMA. 2010;304(16):1787-1794
Importance

- Most people want to know
- Strengthens provider-patient relationship
- Fosters collaboration
- Permits patients and families to plan and/or cope
- Realistic expectations
What we learned

- The importance of:
  - Honesty
  - Openness
  - Trust
  - Understanding
  - Guidance
- Presence
Be there
Have a plan

It's what you do next that counts.
6-step protocol . . .

1. Getting started
2. What does the patient know?
3. How much does the patient want to know?
4. Sharing the information
5. Responding to patient, family feelings
6. Planning and follow-up
Step 1: Getting started . . .

- Plan what you will say
  - confirm medical facts
  - don’t delegate
- Create a conducive environment
Step 1: Getting started

- Allot adequate time
  - prevent interruptions
- Determine who else the patient would like present
- If the patient lacks medical capacity, determine who is the MPOA (not just who is readily available).
Step 2: What does the patient know?

- Establish what the patient knows
- Assess ability to comprehend new bad news
- Reschedule if unprepared
Step 3: How much does the patient/family want to know? . . .

- Recognize, support various patient preferences
  - decline voluntarily to receive information
  - designate someone to communicate on his or her behalf
- People handle information differently
When family says “don’t tell” . . .

- Legal obligation to obtain informed consent from the patient
- Promote congenial family alliance
When family says “don’t tell”

- Ask the family:
  - Why not tell?
  - What are you afraid I will say?
  - What are your previous experiences?
  - Is there a personal, cultural, or religious context?
- Talk to the patient together
Step 4: Sharing the information . . .

- Say it, then stop
  - avoid monologue, promote dialogue
  - avoid jargon, euphemisms
  - pause frequently
  - check for understanding
  - use silence, body language
Step 4: Sharing the information

- Don’t minimize severity
  - avoid vagueness, confusion
Step 5: Responding to feelings

- Affective response
  - tears, anger, sadness, love, anxiety, relief, other
- Cognitive response
  - denial, blame, guilt, disbelief, fear, loss, shame, intellectualization
- Basic psychophysiologic response
  - fight-flight
Step 5: Responding to feelings

- Be prepared for
  - outburst of strong emotion
  - broad range of reactions
- Give time to react
. . . Step 5: Responding to feelings

- Listen quietly, attentively
- Encourage descriptions of feelings
- Use nonverbal communication
Step 6: Planning, follow-up . . .

- Plan for the next steps
  - additional information, tests
  - treat symptoms, referrals as needed
- Discuss potential sources of support
Step 6: Planning, follow-up

- Give contact information, set next appointment
- Before leaving, assess:
  - safety of the patient
  - supports at home
- Repeat news at future visits
When language is a barrier . . .

- Use a skilled translator
  - familiar with medical terminology
  - comfortable translating bad news
- Consider telephone translation services
When language is a barrier

- Avoid family as primary translators
  - confuses family members
  - how to translate medical concepts
  - modify news to protect patient
  - supplement the translation
- Speak directly to the patient
Step 6: Planning, follow-up . . .

- Plan for the next steps
  - additional information, tests
  - treat symptoms, referrals as needed
- Discuss potential sources of support
Communicating prognosis . . .

- Some patients want to plan
- Others are seeking reassurance
Inquire about reasons for asking
- “What are you expecting to happen?”
- “How specific do you want me to be?”
- “What experiences have you had with:
  - others with same illness?
  - others who have died?”
Communicating prognosis . . .

- Patients vary
  - “planners” want more details
  - those seeking reassurance want less
- Avoid precise answers
  - minutes to hours
  - hours to days
  - days to weeks
  - weeks to months
  - months to years
- acknowledge uncertainty
Communicating prognosis

- Limits of prediction
  - hope for the best, plan for the worst
  - better sense over time
  - can’t predict surprises, get affairs in order
- Reassure availability, whatever happens
Three B’s

- Be There
- Be Quiet
- Be Aware: It’s not about you
Questions
Contact Information

- pbwhitehead@carilionclinic.org
- cwwhte@carilionclinic.org
- tdmorel@carilionclinic.org
References

- Use of Advance Directives in Long-term Care Populations. Adrienne L. Jones, Abigail J. Moss, and Lauren D. Harris-Kojetin, Ph.D. Division of Health Care Statistics. NCHS Data Brief; No. 54, January 2011
References

- Iwashyna et al JAMA. Long-term cognitive impairment and functional disability among survivors of severe sepsis. 2010;304(16):1787-1794