DNR: Doing it Right

Transcript

[Upbeat theme music plays]

Dr. Clancy

Welcome to Rounding@IOWA, a continuing medical education podcast developed by and for healthcare teams. I'm your host, Dr. Gerry Clancy, Professor of Psychiatry and Emergency Medicine and Senior Associate Dean for External Affairs here at the University of Iowa's Carver College of Medicine. Today we will discuss guidance for clinicians with their patients and family members in Do Not Resuscitate or DNR discussions. Our objectives include, first, we want our participants to recognize the importance of understanding patients' goals for a more robust code status discussion. Second, we wish to share common barriers in aligning the treatment plan with patients' goals while accounting for the medical reality. And third, we hope to empower our listeners with practical steps to formalize the results of the goals of care conversations. Our experts today are Dr. Carla Pies and Dr. Greg Schmidt. Dr. Pies serves on the supportive and palliative care team within the Department of Internal Medicine here at the University of Iowa Hospitals and Clinics. She is involved in complex patient care across our large hospital. She is an advanced certified hospice and palliative care nurse. She regularly presents her expertise across Iowa, the United States, and internationally. She earned her nursing bachelor's, master's, and doctoral degrees from the University of Iowa. Dr. Greg Schmidt is a professor of internal medicine in the Pulmonary Critical Care and Occupational Medicine Division here at the University of Iowa. He serves as the associate medical officer for the University of Iowa's critical care programs and regularly staffs the medical intensive care unit. He is one of our experts in ECMO. He earned his MD degree, his internal medicine residency training, and critical care fellowship training at the University of Chicago. He edits the well-known textbook, Principles of Critical Care. As an additional benefit to all of us, he is an enthusiastic practitioner and teacher of the benefits of daily exercise and how to achieve this despite busy clinical demands and all that Iowa weather can throw at you. It's great to have Dr. Schmidt back on Rounding@IOWA. So to both of you, welcome to Rounding@IOWA.

Dr. Pies

Thank you.

Dr. Schmidt

Glad to be here, Gerry.

Dr. Clancy

Well, again, thank you both for joining us and thank you for all the work you do across our hospital and across our state. I just provided our listeners your official titles and a summary of your training. To get us started, could you give us a better idea of what a day looks like for you and what a work week might look for you as well? And Carla, let's start with you.

Dr. Pies

So I work on the inpatient palliative care consult service. So on a daily basis, it's seeing new palliative care consults and patients in follow-up. I see patients throughout the hospital, in the ICU, sometimes in the emergency rooms, on our palliative care unit and on all the other adult units. So it's pretty busy. You never know what the day will bring. A lot of family meetings. We also focus on symptom management. So every day is different.

Dr. Clancy

Great. And I imagine you cross paths from time to time with Dr. Schmidt.

Dr. Pies

Yes, we're in all the ICUs, including the medical ICU.

Dr. Clancy

Great. And Greg, what's a work week or a day look like for you?

Dr. Schmidt

I have administrative and academic roles, but relevant to this conversation is my time in the medical intensive care unit. I am one of the attending physicians in the medical ICU, routinely caring for critically ill patients, and sometimes that includes dying patients.

Dr. Clancy

This is not easy work. Could you give us a little bit of insight into how you got interested in doing the work that you do? And Greg, let's start with you.

Dr. Schmidt

I think I was fortunate to, in my training period, to have a mentor who was an outstanding intensivist, but he also was very intentional about goals of care and conversations with patients and their surrogates about those goals of care. And he was one of the first people

that I ever saw carry both of those at the same time. So I was just fortunate to be in the right place to be mentored by someone who knew how to do it right. And to this day, I look back to his guidance and experience for my own role.

Dr. Clancy

Wow. I too had somebody that was a great role model for me in these difficult conversations as well. That's great. Carla, how about you? How did you move toward this work from where you started with all your nursing education that you got?

Dr. Pies

Most of my nursing and nurse practitioner career had been in cardiology, primarily heart failure and pulmonary hypertension. So we were having these conversations along the way. And then when I went back to get my doctorate in nursing, my project was educating hospice and palliative care organizations on treating advanced heart failure. And so that was really my interest and that I wanted to expand more into palliative care.

Dr. Clancy

Great. We're such benefactors of you choosing these pathways. So thank you for both of you for doing that. For our discussion today, let's start with some foundational aspects of our topic. Let's start with a pretty straightforward question. What is a full code and why is it often the default action?

Dr. Schmidt

I'll step in for that one. Full code means that one fully attempts to resuscitate in the event of cardiac or respiratory arrest. It involves processes that include supporting breathing, chest compressions in an attempt to support the circulation, a range of medications that are aimed to stimulate the heart or to reverse whatever the insulting event was in an attempt to restore the patient to life.

Dr. Clancy

Great, great. So let's also define a do not resuscitate or DNR order and its relationship to cardiopulmonary resuscitation or the full code.

Dr. Pies

So I mean, I think a DNR is when the patient or the family usually have requested not to pursue resuscitation and to allow a natural death. I think it kind of came into being more with the, probably in the 70s, but then also with the Patient Self-Determination Act. And I think a lot of general public don't always understand what's all involved in it. I mean, it's

chest compression, shocks, intubation, and it's not really a cafeteria plan or a la carte where people say they just want chest compressions, but they don't want intubation.

Dr. Clancy

Sure. Greg, anything you want to add to that?

Dr. Schmidt

I think the history of this is very interesting because when chest compressions were first promulgated back in the mid-60s, it was very clear from the American Heart Association and others and the experts who convened in order to promulgate this across the United States and the world that this should be done for limited settings. Those limited settings were things like cardiac arrest or perioperative accidents, anesthetic complications. It was intended as a response to an unexpected death. And those initial publications were explicit that this was not intended for end stage heart disease, end stage liver disease, patients with advanced cancer, and so on. And while that was the initial intent, things then gradually shifted with time and the use of attempted resuscitation was broadened to more and more populations until finally it became the default in the United States, not internationally, but in the United States, it became the default approach. And I think that is very clearly not what some patients want. It's very clearly what many physicians and other caregivers think should not be done for some patients. And so DNR really is just an opportunity to express what patients want, what their surrogates believe is right, and what physicians think is prudent.

Dr. Clancy

So we three all work daily in healthcare. We have significant health literacy. Carla, you touched on it, but let's go a little bit farther. When you interact with those that aren't part of the medical system on a daily basis, what is that public perception of CPR and DNR? Where's that divide? How big is that divide sometimes?

Dr. Pies

Well, I think it can be quite big. I mean, some people kind of understand it, but a lot of people would say give it a shot, and what's that shot going to look like needs to be further explored. Because as Greg said, what it was intended for was the people like the Buffalo Bills player who went down on the field a couple years ago, or the person we otherwise think is healthy that has a sudden event. And I think people have lost sight of why it was intended both maybe in the medical field and in the public. And they see things on TV. Everybody bounces back from CPR on TV. Maybe not everybody, but it's a high success rate on TV.

Dr. Clancy

Yep. I am watching reruns of the 1990s show ER, and they probably do five or six resuscitations during an hour's period. You're right. Most are successful. Yeah.

Dr. Schmidt

And they sometimes show after resuscitation, the victim awakens and has conversations.

[laughter]

That's not the reality of what happens. And for health care providers who participate in this, it's quite a dramatic and traumatic event. There's blood. There are broken ribs. I wouldn't wish it for myself except under unusual circumstances.

Dr. Clancy

Yeah, And there's a difference in resuscitation out in the field and in the hospital as well. Greg, what do you see as far as success rates and how it is done out in the field compared to in the hospital?

Dr. Schmidt

I'm going to start with the public perception, because this has actually been studied in surveys and television shows have been counted in terms of success. And the common view is a success around 70%, right? Otherwise, why would you do this? But the reality is that in-hospital cardiac arrest is attended with a roughly 20% survival to hospital discharge, and a substantial fraction of those patients, the majority of that 20% who survive, will be significantly limited, many of them neurologically profoundly damaged, and others limited in ways where they will never again work, balance a checkbook, or have meaningful conversations with their loved ones. So that's in-hospital arrest with Iowa's is actually 22%. We're pretty good, but that's still a very poor survival rate overall. Out of hospital, it's even worse. From registries, the survival to hospital discharge is on the order of 10%. But if one looks at prospective randomized trials, for example of epinephrine dosage, the survival is 2 to 3% for out of hospital arrest if you look at survival at day 30.

Dr. Clancy

Yeah, I myself did CPR on the floor of the men's restroom at O'Hare International Airport. And it took 20 minutes for an AED to show up. And I could tell this was the odds were stacked against me during that one for sure. And as you mentioned, Greg, it was tough on me as well.

Dr. Pies

And I think also like surviving, there's a difference between living and existing. And so some people, a lot of people would not be able to live independently again.

Dr. Clancy

Yeah. So Greg, let's circle back. At the most basic levels, what is the original intention and function of a DNR order?

Dr. Schmidt

The original intention is to give voice back to the patient, really, and to allow a natural death rather than a death that is attended by chest compressions, intubation, shocks, trauma, being transported across the state, those kinds of things. And so it's a way to formalize that expression of wish on the part of the patient that they would prefer when time is short, when they are of advanced age or advanced disease to have a natural death rather than a traumatic death.

Dr. Clancy

So before that order is written, how would an ideal goals of care conversation go? And both of you work with critically ill patients. What's the best practice here?

Dr. Pies

Well, I think starting out with what the patient and the family understands. And then I think kind of telling them, clarifying any misconceptions. And then I think asking what's most important in the setting of what we know now. Most of us want to live as long as possible, as well as possible, but when living as well as possible isn't in the cards, then what's most important? So kind of resetting those realistic expectations with the medical realities.

Dr. Schmidt

From my stance in the ICU, and admittedly that is not every clinician's view on attempted resuscitation, I see an unusual population perhaps, but many of my patients do have serious limiting diseases and an expectation of a very short survival. And so I teach my trainees 3 key points about that conversation with the patient or the surrogates. And the first is to describe what's wrong and to do that as best as possible in lay terms. The second part, which I find is often omitted, is what I now expect. And I think we often use vague language. Your mother's not doing very well. That's not helpful language. Instead, we need to be concrete and realistic in saying, in cases like this, What I typically see is that patients like your mother do not awaken with time, will not be able to go home, and she's not going to be able to have a conversation with you ever again. So that's the medical term might be

prognosis, but it's important to put it in concrete and patient-centric terms. So two is I tell them what I expect. And the third, and this is where wrapping in what Carla just indicated is important, the third is making a recommendation. And I find that that's an opportunity for many clinicians to enhance their conversations with patients and surrogates. It's to make that recommendation. So for example, if having heard that it was very important to your father to be able to fish and to walk around in his field and to enjoy his dogs, attempting resuscitation is not going to be a bridge to him being able to fish again. Having understood what's important to him, my recommendation would be that we not use extreme measures like chest compression and intubation. Rather, I think we should allow a natural death. So first point, what's wrong. Second point, what I expect. Third point, my recommendation, taking into account your goals.

Dr. Pies

And I think that's also the point to emphasize what we will do. I think sometimes these code status discussions aren't so much rooted in the goals, but if your heart stops beating, do you want us to do everything? And the unsaid part is, or what the patient and family thinks is, if you don't do everything, you do nothing. But there's lots of things we can do to keep someone comfortable, die peacefully and naturally with family.

Dr. Clancy

So both of you are positive people. These are sad times for family members. But is there danger in trying to cheer up the family here? Is there the possibility of being positive to the detriment of the actual delivery of the important information?

Dr. Pies

Greg would call that toxic positivity.

Dr. Clancy

Yeah, Describe that for us. What have you seen as far as toxic positivity?

Dr. Schmidt

I learned this term from one of my sons, actually, who's trained in psychology, and toxic positivity is a way of being upbeat in a setting in which upbeat is probably not what the other person needs or wants to hear. And I'm first going to tell an anecdote and then explain why I think it's important. I was rounding just a few days ago with a patient with end-stage liver and heart disease who had come in with an infection that we thought perhaps we could treat. We had treated it, some initial improvement, and then he began to slide back. And I began having the conversation with him about how he was doing and what I expected.

And it became clear to me just from body language that he completely had been a step ahead of me in recognizing what was going on. So there I am with my entire team in the room and the nursing staff. And I turned to the patient and I said, you recognize that you're dying, don't you? And there was a shudder in the room. The whole room shuddered, except that none of the shudder came from the patient, who looked at me very clear-eyed and said, yes, and doc, if you had a pill that you could give me right now to just end this, I would take it. And what struck me about that conversation is that the healthcare providers were all anxious and shuddered and would never of their own accord have been so frank with the patient. But it's what the patient was waiting for. And he gave me that opening in his body language, but we have to be attuned to that possibility. When we confront patients with terminal illness and we don't talk about death, in my view, we are failing them. And I could have gone to that man and said, we are giving you the right antibiotic for your infection. Your creatinine is stable today. Your white count is down. I could have focused on things that frankly don't matter. And that's toxic positivity. It's sort of whistling past to the seriousness of what's going on. And patients have emotional needs too. And when we are in a completely different world from them, it's as if there's a glass wall between us and the patient. And they don't feel heard. They don't feel that their needs are being met. So we need to get over our discomfort and be honest with our patients.

Dr. Pies

Yeah, And I think about the big picture for the patient. that different specialties will come in and give their input on the creatinine's a little better today, but it's hard to kind of help the patient and the family see the whole big picture. Yes, your creatinine's better today, but your kidneys are still significantly impaired.

Dr. Clancy

Yeah. I see that too as a, because psychiatrists, we get called all over the hospital like you do, Carla. And I'm in the intensive care units. And I do see a tendency sometimes for the team, the medical team, to stay safe in the numbers. You know, though, rather than talking about what's really happening here, the clinician may be reviewing with the residents what the phosphorus level is or what the calcium level is. And there's some safety in the intellectualization of the conversations, which I think is damaging as well. As much as being too positive is not good for the patient, I think intellectualizing the conversation is also not helpful. I used to teach the medical student course on how to deliver bad news. And I do remember kind of starting off with the students, letting them know that, of course, patients and family want positive news, but they actually appreciate negative news much better than they appreciate vague news as well. The patients and family were always, it

caused a lot of distress if you were not clear in what was happening and what was going to happen. So.

Dr. Pies

That's a good way to put it. Don't like vague news.

Dr. Clancy

They don't. They're very, very upsetting to everyone. So what fraction of the time do you think the goals of the goals of care conversations go right? And what are some of the barriers for a solid, helpful goals of care conversation to go?

Dr. Pies

I'm not sure I know what percent they go right. I mean, I think there's an often an initial conversation that sometimes has to be dealt with with some urgency for patients. And I think if the patient says do everything, then I think sometimes that's not revisited when we see that the big picture is not going as everyone had hoped or we're not still looking at a meaningful recovery. And I think there's always an opportunity to revisit that. And it needs to be revisited periodically. And I usually start it out by saying, what conversations have you had about resuscitation? And sometimes they say they haven't had any, which they probably had some and didn't remember it. But I mean, my own father was probably 91 in the hospital and listed as full code, even though that was never the intent. So I think it's a default click sometimes.

Dr. Clancy

Yeah. Greg, you have lots of learners with you and people that are trying to develop skills in this area. What do you see as some of the barriers to effective conversation?

Dr. Schmidt

It is hard to have these conversations on several levels. One is time, but another is the emotional barriers that we culturally have around death. Inexperience. Lack of mentoring about these topics, I think, impedes many clinicians from having good conversations. I think that many times clinicians are afraid to give bad news. You mentioned earlier training medical students in how to deliver bad news. I think those are great ideas. And Iowa has actually put substantial effort into faculty conversations about how to deliver bad news because of the importance of this. But it takes time. I think many of us fear the sort of Pandora's box of if we ask real questions, there's going to be wailing and gnashing of teeth and anger and things that we can't control. And so many of these conversations, I'm afraid,

are more aimed at keeping control than really exploring honestly what's happening and what's going to happen.

Dr. Pies

I mean, I think both inpatient, I mean, we're talking mostly about inpatient conversations, but these should be had on an outpatient basis as well. In fact, sometimes I think that's a little easier because it's a little more hypothetical. I mean, it's still an important thing, but it's not like it's going to happen tomorrow or next week in our best guess. But they take a lot of time because you don't know what their perceptions are of it. You don't, it just can be exhausting too for the practitioner because you've got other patients to be seen if you're in the outpatient clinic. So it is easier to say, sure, we'll do full code because that's a shorter conversation.

Dr. Clancy

Yeah. I remember with both my parents, when we engaged in the conversation about code status and DNR, both of them were trying to be kind back to the family member and not really bringing it up. And when we did bring it up, they were actually very appreciative of it. So I think people don't always connect those dots that the patient may want to have this conversation and is ready for it more often than not.

Dr. Schmidt

I was fortunate that my own father brought this up prospectively multiple times around medical events and consistently over time so that I well understood his wishes and he had all the right paperwork. And it was remarkable for me that at the end of his life, after a year in a nursing home when he clearly began to deteriorate and I knew that he would die within days, I got a call. So I was planning to go in the morning. I got a call that morning as an update saying his breathing is worse. Would you like us to send him out? And I was stunned because I thought, I know the language. I've made all the plans. My father was so clear. I didn't even know what she meant initially when she said send him out. I was so stunned. And then I realized that I desperately needed to get to my father's bedside to make sure that what happened was what he wished would happen. And I think that I tell that story because it's such a, for me, it's such a poignant example of our culture's difficulty around death. Even in healthcare settings, we don't want the patient to die even when death is what is coming.

Dr. Clancy

Part of this podcast is giving some direct tips on developing skills for our clinicians. So how do you respond when you think attempted resuscitation is inappropriate, but the patient or

family says do everything? What are some tips you have for that conversation to keep going rather than it ends there that the family says or the patient says do everything?

Dr. Schmidt

So Carla actually has some nice wording around this, but I'm first going to step in by saying one of the things that's helpful for me, which I think is knowing what my stance is before I go into the conversation. In other words, being clear in my own mind as to what I think makes good sense, understanding the medical situation and understanding the patient's goals so that I'm ready to make a recommendation rather than going in as if I'm handing them a dim sum menu and saying, would you like some of this and would you like some of that? So I think it's mentally preparing myself to recognize and be able to answer those questions. What's wrong? What do I expect is going to happen? And what should my recommendation be? And then if somebody says, I want you to do everything, Carla's expert in recognizing that that's not the end of the conversation. That's an opening to the next and the next and the next question. So, Carla. . .

Dr. Pies

One, what does do everything, what do they understand about do everything? I think what is a minimum acceptable quality of life for the person? Like what do they absolutely need to be able to do that life is worth living, that sorting that out. When someone says, I never want to be in a nursing home, live in a nursing home, then there are some realistic outcomes of CPR that that's likely where they'll be. So having that conversation, kind of looking for clues. Besides that, sometimes families will say, I just wish he'd give us a sign. Well, then the sign is if his heart stops and he is dead, that is the sign he's sending. So I think listening for clues, kind of watching body language, sometimes it's helpful to have a conversation just with the patient, and sometimes it's helpful to have the conversation with the patient and the caregivers. I mean, for a while, we had access to a video that Dr. Volandes did at ACP Decisions, and we would turn on that video, and either the patient would say, I didn't want that, or more commonly, the family would say, I don't want you to go through that. So I think understanding that if in the off chance it's successful, they're going to be on a ventilator, not able to talk with their family. And also, some people really don't want to die in the hospital. And I think that's probably, when I work for an outpatient, I would say, I'm going to ask you a really hard question. A lot of us won't be able to pick where we die, but if you had to pick, where would it be? And so if they don't want to be in the hospital, it breaks my heart when we find that out, when they're in the hospital on the ventilator and we can't get them home. So I think asking kind of what's important, if you can ask what they think they would like their death to look like, that kind of depends on the patient and where they're willing to go. But I think also, as Greg pointed out, giving them

what we really think is going to happen. And there is a calculator called gofarcalc.org that helps you kind of outline what the chance of surviving with a good neurological outcome to discharge. And sometimes people need that concrete information. But I think kind of just sitting down and exploring with them what they think. I mean, I remember when I did the training for the IPOST and they recommended asking what would be an acceptable outcome of CPR. And I was doing my first IPOST in a cardiology clinic and the patient said she expected to be better than she is now. And so that was clear. Like that was clear like that's not how it's going to work. So kind of seeing what they expect of it because it can be enlightening.

Dr. Clancy

So when a DNR order is in place, and it has been obtained with the right conversation at the right time, and it's ready to be activated, what do you both see as positives for the patient, the family, and frankly, the healthcare system when it works right?

Dr. Schmidt

Carla and I shared a patient just last week who was in her 50s, had end-stage cancer, and was clearly dying. But she was fighting. She wanted to fight. She'd been fighting. And she turned to me and she said, I have a 16-year-old son. And it's very easy for me as the clinician in that circumstance to just back off, right? Because isn't she telling me what she wants? But Carla you had further conversation with her.

Dr. Pies

I think, I asked specifically how that 16-year-old son was doing with all this, and would he be able to ask questions or kind of talk about things? Because 16-year-old boys don't always talk about things. And so we had a long conversation about that, and she was able to take comfort that his sisters, who were older than him, would be supportive of them and would help them. And the patient took a lot of comfort in knowing that he would be taken care of. So I think sometimes family saying they'll take care of each other is very comforting to people.

Dr. Schmidt

And this patient, after a decision was made to limit life-sustaining interventions, she relaxed. And we both had the sense that she looked 10 years younger. And she said, I have been fighting this for so long. I'm tired of fighting. I'm done fighting. And at that point, she and we were able to focus on comfort and dignity and those conversations that she wanted to have. That is how things should go. Not with an endotracheal tube, chest compressions, and a futile attempted resuscitation.

Dr. Pies

I will say, and with that patient, I was talking to her about kind of there weren't the options that she kind of came here for, those burdens and risks of those interventions outweighed the benefits. And I talked about focusing on comfort and family, and she was all aboard. And then I said, so that would mean that we're not going to do chest compressions, shocks, the ventilator. She goes, you mean a DNR? And I said, yes, or allowing a natural death. And she said, but I always wanted everything done. I said, and that's when I went into, you wanted everything done when the hope was a bridge to recovery. And that's not where we are now. Things have changed. And then she was able to wrap her head around it. But I think people get a little focused on the words DNR versus do everything, not kind of what that's going to look like for them in each case.

Dr. Clancy

Got it. So Carla, you've kind of touched on this, but let's go a little bit farther when people put limitations on what the CPR would be. You know, I want a little bit of CPR. How do you handle that conversation?

Dr. Pies

It's all or none. I mean, I'm pretty straightforward. It's all or none. It's not 10 minutes. Like this is what it's going to look like. I mean, when people are set on that, and have been asked it a few times, sometimes I'll say, are you open to hearing the team's recommendation when we think this is not going to be successful at all, and it's only going to add to your suffering. And most people are open to that. And that kind of opens the door for the next day, the next week, the next month, saying, we're at this point. Or a time-limited trial if they're on a . . . I mean, sometimes there's very young people that kind of are going to go full court press, but kind of like, what's their acceptable quality of life or minimum acceptable quality of life, and then talking about a time-limited trial so we're not in the ICU in two weeks with something that's not going to be a bridge.

Dr. Schmidt

One other tool that I wanted to raise is this term potentially inappropriate to describe certain interventions which are very unlikely to provide meaningful benefit for patients or where the burdens greatly outweigh the benefits. That often pertains to patients with end-stage or chronic diseases, advanced malignancy, when we're talking about intubation or attempted resuscitation. And that term, potentially inappropriate, comes from a five-society consensus of intensive care societies and nursing societies. And it's partly intended to overcome something that we are not very conscious of. And that is when we ask patients, do you want us to attempt to restart your heart? We are implying that we can

restart their heart and that we should restart their heart, even if that's not what we think. And we're not intending to say that, but it's often what people hear. Defaults are often assumed to be the best course. So when we think we're asking a neutral question, do you want attempted resuscitation? The patients think they should say yes. So to say attempting resuscitation is potentially inappropriate, and of course I would provide to the patient or surrogate the foundation for that, but saying in this circumstance, attempting resuscitation is potentially inappropriate. And then I might follow with my recommendation. Therefore, I would recommend that we not use an endotracheal tube and that we not do chest compressions.

Dr. Pies

I do think there's always the opportunity, like if you haven't had a robust conversation, there's always the opportunity to, without badgering, go back to the next day and say, you know, we had this conversation yesterday. I want to be completely transparent. I've been thinking about it a lot that I think this is going to not be successful and that this might be a time you want to focus on being comfortable and talking with your family as long as possible. I think there's always that opportunity to circle back.

Dr. Clancy

I agree. And reassurances about what you can do as far as being comfortable as well. Sometimes patients don't have the knowledge base to know the capacity we have for helping someone keep comfortable as well.

Dr. Pies

It really got emphasized during COVID when people were on a lots of support that when CPR was thought to be less successful to really start out with what we can do.

Dr. Clancy

Yeah. Greg, when we add up the medical intensive care unit and the cardiovascular intensive care unit and our surgical intensive care unit, we probably have 100 critical care beds here.

Dr. Schmidt

Yes.

Dr. Clancy

Yeah. And they're full most of the time.

Dr. Schmidt

Almost always.

Dr. Clancy

And oftentimes, if CPR is at least initially successful, the individual will be transferred to one of the intensive care units, right?

Dr. Schmidt

Yes.

Dr. Clancy

Yeah. But then, as you said, potentially inappropriate, what is the strain that you have picked up on access to critical care beds when the DNR process that we're recommending here and the goals of conversation, goals of care conversations don't happen. How much of a . . . what impact does this have on access to critical care for those that need critical care access?

Dr. Schmidt

Well, there have been surveys of clinicians, physicians, and nurses practicing in intensive care units in the United States and internationally, just asking them, of your patients, what fraction of them do you think have no potential for benefiting from the ICU? And those numbers are right around 20%. That is, that's a lot of beds. Imagine if you could free up 20% of your beds for the patients who . . . I am an intensivist. I do believe in critical care. And I've seen remarkable saves, including from CPR. So I don't want to communicate the idea that I think we should never attempt resuscitation. But I think that we need to have a more intentional approach to deciding for whom it's appropriate. And just as Carla mentioned with her father, there are many patients in outpatient and inpatient settings who from the doorway should not be full code. Advanced age, dementia, cachexia, frailty of age, end stage heart and liver disease, advanced cancer. These patients, by and large, should probably not be subjected to something that is not going to be a bridge to a better life for them.

Dr. Clancy

Yeah, there is that personal impact, there is that family impact, but there is the health system impact as well. I think I've told you this, Greg, our medical intensive care unit is one of my most favorite honored places to be because of what can be done and what happens there. And the team, the expertise, the nurses, the physicians, it's amazing what happens up there and what the capability of it, but you bring up a great point of when the time is right

for the right patients. So circling back a little bit, again, kind of the skills needed to have these conversations, what advice do you have as far as ways to further the conversation when things may be struggling a little bit?

Dr. Pies

Well, I think some of that is somewhat nuanced on each situation because I have had patients that felt badgered about it. Sometimes they were choosing full resuscitation based on cultural, spiritual values. So I think it is somewhat nuanced. I think it depends on is the patient in the hospital or if it's an outpatient situation. I think outpatient setting, you have more time to circle back like with each change in status after every admission. I think inpatient, it's a little more nuanced. And I think just sometimes it helps me to build a little more rapport with the patient and wait to go back and have some trust with them so they'll listen to my recommendations. I try to ask permission before I give a recommendation. That often helps. I think if someone says, what would you do if this was your mother or your brother, I think I don't have any problems giving that recommendation, but I do watch the discomfort in other people when they ask for that and say, I can't answer that. It's not my mother, but I do think this is a medical procedure for the most part that we need to give our recommendations on this. And I know Greg has talked about that, but I think he often says, if you're hoping they say DNR, then it's your job to go in there and give that recommendation.

Dr. Schmidt

I find also that slowing down the conversation can be very helpful. And what I mean by that is take the time to sit down. When delivering information, pause, to look for that body language, to provide openings, for the patient to begin to respond. If you are spending the majority of the time actively speaking, you're missing big opportunities to move the conversation forward because it has to be a conversation. And so checking in with the patient's understanding, checking into their emotional state, it's sometimes remarkable what they will tell you when you say, How are you feeling about what I've just shared with you? And to have a pace that is a pace that's aligned with their energy in the moment and not my need to go see the next patient. So I think sometimes it's time that can help establish the trust. It's time that can establish the emotional connection between clinician and patient or surrogate that allows everyone to take a step forward.

Dr. Clancy

Yeah. My only tip, kind of alongside your slow it down a little, relates back to that I'm called in a fair amount of time to help with decisional capacity. Is this person able to think through and really cognitively, are they able to make a decision like this? And I find sometimes

morning rounds with so many different teams around and so many learners with me is not the right place and time for that conversation. I actually come back at 5:30 in the evening. That's my favorite time to have the… the slowed down conversation because the pace of the hospital has slowed down a little bit as well. And I find a big difference from what happens at 8:30 in the morning versus what can happen at 5:30 in the evening as far as busyness of the environment around me. I want you both to put on your health system quality improvement hats for a minute. Carla, you help staff the palliative and supportive care team. Greg, you staff the medical intensive care unit where do not resuscitate conversations are not uncommon. And as Carla, as you've pointed out, you know, as the disease progresses, the conversation comes back. But you've also both received patients where a DNR decision and an order may have already been made, are there particular high-risk care settings where greater attention to the DNR process can be improved? You as receivers of those patients earlier in the progression of the individual's illness, do you see areas of the hospital, areas of the health system where we could promote these goals of care conversations to the betterment of the system and to the betterment of the patients and families?

Dr. Schmidt

I think some of this is cultural, because the earlier this moves, the earlier this happens, the better for everyone. The fact that my father could share with me what he wanted, made everything simpler for the next, he lived thirty-five years after initiating that conversation with me, but it eased my and my sibs' mind, and it meant that my sibs and I were all on the same page when in fact he entered the terminal phase of his life. So I think a lot of this is a cultural thing. But I also want to go back to something that Carla kind of hinted at earlier, which is this is not just about DNR. And even when the patient comes with the DNR, we really should be thinking about goals. DNR is one expression of that. But for many, again, frail, terminal, advanced cancer patients, not only should we not shock them and intubate them, they probably shouldn't be in ICU as often. Maybe they should be at home. Maybe they should be in hospice. There are options, there are opportunities, and having the ICU be sort of last rites for dying patients is not really in their interest or in their family's interest.

Dr. Pies

And I think that's where the IPOST, which is our POST form, comes into play, because that really helps clarify further treatment preferences, not just code status. It talks about artificial nutrition, like do you want to come back to the hospital, kind of full court press, limited interventions. And sometimes people want to come back to the hospital, but not ICU. And so that kind of needs to be written in on the IPOST because the IPOST, limited interventions, does include the ICU. So I think having that conversation and it's appropriate

for lots of illnesses upstream when the patient can contribute. Parkinson's, dementia, any progressive neurological condition, heart and lung problems, like if someone's already been intubated, do you want that again? So there's lots of opportunities to have these conversations before the patient gets to the hospital, because the ER is not probably the time to have a robust conversation, mostly because they're busy, extremely busy.

Dr. Clancy

Yeah. So when some of these more difficult conversations are really not going well, when might you ask for help, Greg, from Carla or from me, a psychiatrist? When does bringing in more troops, when is it warranted?

Dr. Schmidt

I'm going to step in first because I partly am going to recommend someone like Carla, someone who's truly expert. And I think what all practitioners should recognize is that in this business, there are experts. And I'm repeatedly impressed by the way that Carla and her colleagues can make connections that I sometimes struggle to do. She and they find phrases and words that find this beautiful middle ground where the phrase just didn't occur to me. I just, I don't have the, I didn't have that language and they do this all the time. They have the language. They know how to take the patient who says, I want everything done and turn that into a meaningful conversation instead of an order that says full code.

Dr. Clancy

Carla, your opinion on that question of bringing in help?

Dr. Pies

I mean, I think it's always, we're always happy to help with these conversations. I think it is something we recognize that not everybody has the time to do. And I think kind of sitting down and hearing what they value most, what's most important, kind of, you might not get the code status changed right away, but you also know what's important to them. And maybe changing the code status isn't in line with their goals, but I think having a conversation. I think often when someone's inpatient and I looked at, they've been DNR, some admissions, full code, some admissions, which I call sometimes referred to as flip-flopping or they haven't been, it hasn't been a conversation each time. And that's sometimes when we need you, Gerry, because we don't know if they're able to make those decisions. I mean, we can try to sort that out, but there's some people that it's hard to sort out their decision-making capacity on this. And I think flip-flopping is changing their mind, not being consistent is always something I worry about, that they don't have the capacity. But I think, I guess, I think that anytime you really don't feel like you're able to connect with

the patient or have the time to kind of sort out their goals, then it's time to give us a call for goals of care, because that's really how we want to have the conversation.

Dr. Clancy

Yeah. Well, I think seeing it from my vantage point, I'm going to strongly agree with Greg that the palliative care team is really good at this and has a level of expertise and a level of comfort in this, and it goes really well. We do have some patients who have lower levels of health literacy and knowledge. Do you have any tips for that? Is there any additional aids that can help the family and the patient understand sometimes when this highly complex environment that they're in is too much for them? Do you lean on anything else out there, Carla? Is there videos? Are there written materials that sometimes are helpful?

Dr. Pies

There is a brochure that we have in the hospital. Do I want CPR? Should I have CPR that we give to people? And that's kind of part of the honoring your wishes movement or advanced care planning initiative. I really liked when we had access to that ACP decisions video. So there are videos out there. They're just not, I don't know of any free ones.

Dr. Clancy

Greg, any guidance when you worry about the patient and family not really understanding the situation?

Dr. Schmidt

Yeah, that's. It is a challenging situation, even not at end of life issues, right? And I'm a verbal person, so my own approach, there's no technology that I typically rely on. My approach is to try to explain. I think there are, you know, some people are able to break things, break complex, topics down simply. I actually think we all can do that if we take the time to do that, right? Because we learn, we were lay people at one point. And anyone who's in a teaching environment learns to recognize when the learner doesn't have the foundation to understand what's being told or taught. And I think any good teacher and a lot of people at Iowa are good teachers. We pride ourselves in that. We should be able to teach our patients and their families. And so I would just urge people to, don't necessarily think about it as a medical conversation. Just go in there as the teacher.

Dr. Pies

And I also think sometimes getting to know the patient and what their occupation is, sometimes that offers an avenue to kind of present information to them that they can relate to.

Dr. Clancy

Yeah. You know, some of my tips sometimes is if there is a health employed person in the family, they can be a quite helpful aid sometimes in coming back and helping the conversations. And another thing that I do sometimes is I pull out a whiteboard or a piece of paper and I diagram some of what's happening as well. Sometimes people are visual learners that way and it can be just a different way to help them absorb what's going on as well.

Dr. Pies

I would second that, like on the whiteboard in the rooms for the patients with organ failures, kind of drawing that disease trajectory and asking them where they think they are now. Most patients know, and just like Greg said, the patient knew he was dying. Sometimes the patient is the first person to know that they're dying. And so one of my colleagues, when she's giving news and things about prognosis, asks them if that is surprising to them. And 80% of the time, they say no.

Dr. Clancy

Yep. So as we get close to finishing up, and Looking to the future, do you see policy changes? Do you see advances on the horizon for how we do these these goals of care conversations and DNR orders? Is there any trends or movement at that policy level that we can look forward to?

Dr. Schmidt

Well, some things I think have not taken hold that could have helped. One is for a while there was the idea of relabeling DNR as DNAR, do not attempt resuscitation as a way to convey more accurately that usually we don't resuscitate the patient. I also think that things that you and I both alluded to earlier about training medical students and other clinicians in how to have difficult conversations, including role play. Role play in those sessions is really important because it forces us into uncomfortable situations in which, for me, the first thing is recognizing what a terrible job you're doing and what opportunity there is for improvement with practice, with training, with mentoring, and with experience. Artificial intelligence has been used to try to identify and label patients in terms of what their goals of care are likely to be when they are unable to speak for themselves. But I personally am highly skeptical that in my lifetime, that will be any kind of reality.

Dr. Clancy

Carla, anything you see as far as policy trends that could be helpful here?

Dr. Pies

Well, I do think using the IPOST as a tool is helpful, and completing that when you're having a conversation, because people will show up in the in the ICU, and then they'll see that IPOST in the chart, because at least when they're done here, they're scanned in the chart. Not all institutions do it that way. But I do think that can be a stop to pause saying, where are we at here? This is what they at least wanted at one time. So I do have a lot of faith in the IPOST as an effective tool. I mean, it's been around 15 years. I feel like it's gaining a little momentum. It's, I mean, in Iowa, it's a may follow, not a must follow, but it does let us know what the patient was thinking at one time, especially when the patient's not able to participate. I do think like talking about things like in terms of allowing a natural death rather than DNR is somewhat helpful for some patients.

Dr. Clancy

Yep, doesn't carry all that additional expectations with it. Yes, absolutely. Great. I want to circle back on one thing that Greg pointed out, that sometimes he doesn't have the words and Carla has the words. One of the things I do with our residents and our medical students when we're doing rounds across the hospital is before we go in the room, I ask the student or the resident, what are you going to say? And actually have them truly verbalize the sentences they're going to use. And that helps them practice ahead of time, sometimes getting those words out. And I've done this for years. I used to have to give big time speeches in a previous job. And I would always read my speech ahead of time out loud so that it actually, I trained my mouth to actually say the words in a confident way and it made a difference.

Dr. Schmidt

I like that advice and I do something similar with my trainees for many of these situations. I'll invite them to estimate the probability the patient will leave the hospital alive. And then once they do that, I say, now what are you going to recommend to this patient? And most often I get a deer in the headlights kind of look because they actually haven't planned ahead. And so I made this point early on is that you really should be intentional. You should have thought through before you go in the room what's wrong, what you think is going to happen, and what your recommendation is going to be. And while the patient's goals are important in bringing that all together, you bring the medical expertise, you know the prognosis, and you have to bring that to the table. But to bring it to the table, you have to understand it yourself and you have to have made yourself conscious of it.

Dr. Pies

Yeah. And I think initially when people are starting these conversations, they need to give themselves a little grace because it's clunky at first, and you're not going to get a hole in one on every conversation and you can circle back and say, and I think also sometimes it's helpful to take another person in there if like sometimes it is hard for people to say you're dying. I think you're dying. I'm worried you're dying. Kind of have a buddy backup that someone else can communicate that if while you're learning how to have these conversations, you need help and that's okay.

Dr. Clancy

Yeah, very much so.

Dr. Schmidt

Carla taught me a really important phrase, which is, I'm concerned that time is short, as a gentle way to communicate your prognosis, but it invites them into the conversation because the natural next question is, given that time is short, how do you envision spending that time? What's important to you in that time? So I think that phrase can be a really, really helpful phrase.

Dr. Pies

And I think always saying, I worry or we're concerned or I wish things were different. This is where we are now is probably better than saying, I'm sorry, you know, but I think kind of communicating that you are kind of on the path with them and that so they feel like it's more of a partnership.

Dr. Clancy

Yeah, I have one that is helpful and I use I want you to recognize that things have changed as well, that I want you to recognize that it's different compared to where we were two days ago or so sometimes.

Dr. Pies

That's good. I usually say things have changed, so I want you to recognize that's helpful. And I think that would resonate well with families too.

Dr. Clancy

We're just at about our hour. As we close, what are some of the take-home points you'd like to leave with our participants? And Carla, we'll start with you.

Dr. Pies

I guess my take-home point is these conversations are hard, they take time, but they can be very rewarding when you get able to do them and are more comfortable doing with them. And that it's probably really the best way to help align the patient's goals with the interventions we're offering. And I think it certainly offers some peace of mind to families and patients that when conversations are had up more upstream than at the end. So I think I would encourage people to keep working on these conversations because they do get easier.

Dr. Clancy

Yeah, excellent, excellent advice. Greg, how about you? Some take-home points.

Dr. Schmidt

When you're in the ICU, your patients are thinking about death. They are afraid of dying. They're afraid of suffering. They're afraid of pain. They're concerned for their loved ones, those who they're going to leave behind. They're concerned about their affairs. These things circulate in the minds of our patients. And if we walk into the room and focus only on the creatinine, we have not done a full job. So my major message is you got to do the whole job. You've got to be honest with your patients and break down that glass wall between you and the patient. It's not going to be as scary as you think.

Dr. Clancy

Yeah, I agree. Well, thank you both, Dr. Schmidt and Dr. Pies, for joining us on Rounding@IOWA and really for the work you do in easing suffering for our patients and for our families.

[Upbeat theme music plays]

For our listeners, you can access instructions for continuing education units within our show notes. And as always, we hope you join us again for another session of Rounding@IOWA.