

Managing Code Status Conversations for Seriously Ill Older Adults in Respiratory Failure

Kei Ouchi, MD, MPH*; Andrew J. Lawton, MD; Jason Bowman, MD; Rachelle Bernacki, MD, MS; Naomi George, MD

*Corresponding Author. E-mail: kouchi@partners.org, Twitter: @Kei097.

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INTRODUCTION

For older adults with serious, life-limiting illness, the decision to initiate intubation is complex and emotional. With seriously ill older adults in acute respiratory failure, emergency physicians are having some of the hardest conversations in medicine. During the last 6 months of life, 75% of older adults visit the emergency department (ED).¹ ED visits are often important points in these patients' illness trajectories, signaling a more rapid rate of decline.²⁻⁴ The incidence of intubation for older adults doubled between 2001 and 2020.⁵ Yet a systematic review revealed that the majority of patients do not possess advance directives in the ED,⁶ meaning that urgent conversations are needed in a time of crisis to ensure that patients receive care that aligns with their goals.⁷ Making these decisions in the ED is challenging. Emergency physicians recognize this pivotal moment to provide goal-concordant care⁸; however, the time-pressured environment, lack of longitudinal relationship with patients, and clinical instability further increase the complexity of these conversations.⁹ A practical method is needed to perform this procedural skill. In this article, we discuss the prognosis of older adults undergoing ED intubation in the context of framing the code status conversations and provide a practical framework to execute these difficult conversations.

FAMILIARITY WITH THE PATIENT'S PROGNOSIS IS ESSENTIAL BEFORE INITIATION OF A CODE STATUS CONVERSATION

Effective code status conversations require emergency physicians to understand the prognosis of seriously ill older adults with acute respiratory failure and rapidly explore what matters most. More than 70% of older adults prefer quality of life rather than life extension.¹⁰ Furthermore, greater than or equal to 60% of older adults consider inability to "get out of bed" or "rely on a breathing machine

to live" as equal to or "worse than death."¹¹ The majority (87%) of seriously ill older adults who are hospitalized express that they would even trade 1 year of a 5-year lifespan to avoid dying in the ICU.¹² Unfortunately, the outcomes after ED intubation among seriously ill older adults are not as good as many patients think they will be, which may be predicted from prognosis calculators.^{13,14} One in 3 older adults dies in the hospital after intubation. The survival characteristics are influenced by age (eg, 50% mortality for individuals >90 years) and comorbid conditions (eg, 40% increased odds of death for those with Charlson comorbidity index score ≥ 4). Among survivors, greater than 80% will be discharged to places other than home.¹⁵ Furthermore, the resulting disability they will likely endure may be considered worse than death. For older adults with mild to moderate physical disability who are admitted to the ICU, a quarter will die, and among the survivors, 54% will develop severe disability even worse than that at their baseline.⁶ Considering prognosis and likely functional outcomes, emergency physicians must determine what patients would consider an acceptable quality of life (Figure 1).

A STEPWISE APPROACH TO THE ED CODE STATUS CONVERSATIONS

As with any procedure, the code status conversations are mastered through deliberate practice of communication skills. We recommend reading the following steps out loud (Figure 2). Furthermore, we encourage emergency physicians to flexibly adjust the order of the following steps because these conversations may not occur linearly.

STEP 1: ESTABLISH URGENCY AND ELICIT UNDERSTANDING

"I wish we had met under different circumstances. Your [father] is very sick and I have to decide quickly about [his] care. What have you heard about what happened today?"

Older Adults with Serious Illness: Prognosis and Function after ED intubation

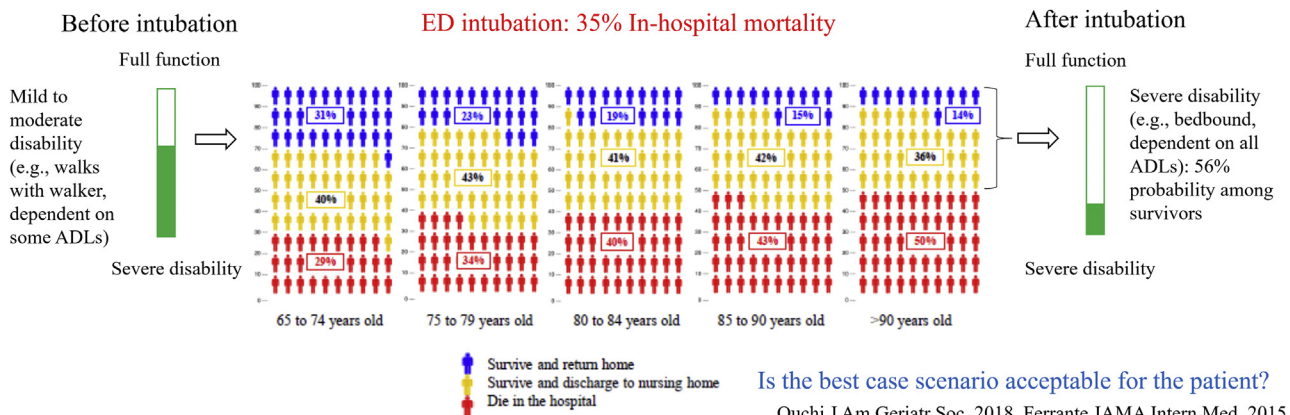


Figure 1. Older adults with serious illness: prognosis and function after ED intubation.

Explicitly describe the situation clearly and build rapport. Asking what the surrogates have heard allows them to express their understanding and not be redundant (Video E1, available online at <http://www.annemergmed.com>).

STEP 2: BREAK BAD NEWS

For seriously ill older adults, the development of respiratory failure requiring intubation is “bad news” (Video E2, available online at <http://www.annemergmed.com>).^{15,16} To allow the patient or surrogate to grasp the severity of the situation, 2 steps are needed:

- Asking for permission: “I am afraid I have serious news. Would it be OK if I talk about it?”
Asking for permission enables the patient or surrogate a moment to emotionally prepare. Most important, it gives a sense of control in a situation that may feel out of control.
- Disclose the headline: “Your [father] is having a very difficult time breathing because of [severe pneumonia]. With his serious health issues, I am worried that things may not go well, and it is possible [he] could even die.”

The news is delivered with little jargon. Using phrases such as “I am worried...” allows physicians to be candid about the prognosis without being emotionally distant. Emergency physicians must recognize that emotions may manifest in the form of a medical question (eg, “What medications and treatments are you giving him?”). Rather than answering only cognitively (eg, “The drug that we use for pneumonia is...”), respond directly to the patient’s or surrogate’s emotions (eg, “I can imagine that this is upsetting to hear”).¹⁷

STEP 3: DEVELOP THERAPEUTIC ALIGNMENT

“We need to work together quickly to make the best decisions for [his] care.”

Therapeutic alignment is key to building trust, which is necessary to make a patient-centered recommendation. Alignment is cultivated by using “we” statements, by eliciting input from the patient or surrogate, and by responding to the patient’s or surrogate’s emotions (Video E3, available online at <http://www.annemergmed.com>).¹⁷

STEP 4: ASCERTAIN BASELINE FUNCTION

“What type of activities was [he] doing day to day before this illness?”

To estimate functional outcomes after critical care, physicians need to ascertain the patient’s baseline function. A patient’s baseline health status before the onset of acute respiratory failure is necessary to inform the functional prognosis in the best-case scenario (Video E4, available online at <http://www.annemergmed.com>).

STEP 5: EXPLORE THE PATIENT’S VALUES AND GOALS, AND THEN SUMMARIZE

- “Has [he] expressed wishes about the type of medical care [he] would or would not want?”
- “How might [he] feel if treatments today led to inability to return to [his] favorite activities or inability to care for [himself] as much as [he] does?”
- “What abilities are so crucial that [he] would not consider life worth living if [he] lost them?”
- “How much would [he] be willing to go through for the possibility of more time?”²⁵
- “Are there states [he] would consider worse than dying?”

Goal: Make patient-centered recommendations regarding intubation for patients who may be at high-risk for poor outcomes. After establishing that <u>advance directive does not exist</u> , complete the following steps:	
Steps	What to say
Elicit Understanding	I wish we met under different circumstances. Your [father] is very sick and have to decide quickly about [his] care. What have you heard about what happened today?
Break bad news	Ask Permission: I am afraid I have serious news. Would it be OK if I share? Disclose: Your [father] is having a very difficult time breathing due to a [severe pneumonia]. With his serious health issues, I am worried that things may not go well, and it's possible [he] could even die.
Align	We need to work together quickly to make the best decisions for [his] care.
Baseline function	To decide which treatments might help [his] the most, I need to know more about [his]: What type of activities was [he] doing day to day before this illness?
Values <i>Use question(s) as appropriate</i>	Has [he] expressed wishes about the type of medical care [he] would or wouldn't want? How might [he] feel if treatments today led to: Inability to return to [his] favorite activities? Inability to care for [himself] as much as [he] does? What abilities are so crucial that [he] wouldn't consider life worth living if [he] lost them? How much would [he] be willing to go through for the possibility of more time? Are there states [he] would consider worse than dying ?
Summarize	What I heard is that your [father] considered ___ most important, and that [he] would consider treatments that result in ___ unacceptable. Did I get that right?
Recommendation	Based on what you've shared with me, we would recommend: <ul style="list-style-type: none"> Intensive treatment focused on comfort; or Intensive treatment focus on recovering from illness <p>We will use all available medical treatments that we think will help [his] recover from this illness. For [his], this means:</p> <ul style="list-style-type: none"> Supporting [his] body in recovering from this illness without treatments that could make [his] more uncomfortable, while do everything we can to assure that [he] is comfortable and peaceful; or Supporting [his] body in recovering from this illness with intensive treatments, including ventilators, while also doing everything we can to assure that [he] is as comfortable as possible. I worry that even with maximum care, [his] body may still tire out. The admitting teams will support you over the coming days with upcoming decisions. <p>Does this sound ok?</p>
Document the conversation	

Figure 2. ED code status conversation guide. See Appendix E1, available online at <http://www.annemergmed.com>, for how this guide was developed.³³⁻³⁶

Patients may value particular scenarios differently (eg, avoidance of certain health states). The goal of exploring patient values is to understand the previously expressed wishes and reasoning behind that decisionmaking. Determine what the patient may consider acceptable quality of life. When a patient's values are not clear, questions about trade-offs, such as how much more he or she would be willing to go through for the possibility of more time²⁵ or what states would be considered worse than dying, may be required to explore the minimal quality of life a patient may consider acceptable (Video E5, available online at <http://www.annemergmed.com>).

STEP 6: SUMMARIZE

Once patient values are explored, physicians can reflect on what they heard about the baseline function and values and then reframe the information in a way that accurately reflects the patient's desired health status (Video E6, available online at <http://www.annemergmed.com>). "What I heard is that your [father] considered spending time with [his] grandchildren the most important, that [he] has been too tired to do so for a while, and that [he] would consider treatments that result in [his] being bed bound unacceptable. Did I get that right?"

STEP 7: MAKE A RECOMMENDATION

“According to what you’ve shared with me, we would recommend

- intensive treatment focused on comfort; or
- intensive treatment focused on recovering from illness. We will use all available medical treatments that we think will help [him] recover from this illness. This means
- supporting [his] body in recovering from this illness without treatments that could make [him] more uncomfortable while doing everything we can to ensure that [he] is comfortable and peaceful; or
- supporting [his] body in recovering from this illness with intensive treatments, including ventilators, while doing everything we can to ensure that [he] is as comfortable as possible. I worry that even with maximum care, [his] body may still tire out. The admitting teams will support you during the coming days with upcoming decisions. Does this sound OK?”

To make an empathic and goal-concordant recommendation, integrate the baseline function and values with knowledge of the patient’s prognosis (Video E7, available online at <http://www.annemergmed.com>). Ask yourself whether, in the best-case scenario, this patient would be able to achieve the minimal quality of life worth living for [him] after intubation or an ICU stay. If this answer is a clear no or the likely outcome would be considered worse than death for the patient, emergency physicians can confidently make a recommendation to focus the treatment on the patient’s comfort. If the answer is unclear (eg, the surrogate may not know the minimal quality of life that the patient would consider acceptable) or the likely outcome would be an acceptable quality of life worth living, emergency physicians can make a recommendation to focus the treatment on recovering from the illness (Figure 3). Emphasize what you will do (eg, focus on ensuring the patient’s comfort). Consider explaining why you would not recommend certain therapies in the context of the baseline function and values. Introduction of a time-limited trial may also be helpful.^{18,19}

PITFALLS: PROBLEMATIC APPROACHES

Nationally, only approximately half of emergency medicine residencies report teaching trainees primary palliative care skills.²⁰ Most emergency physicians report that these skills are important, but they are not comfortable with them.^{21,22} In the time-pressured ED, our trainees are taught to use binary logic (eg, sick or not sick). In the absence of formal training in code

status conversations, many physicians try to simplify these into similarly binary questions (eg, “Do you want us to do everything for your loved one if his or her heart stops?”). These well-intended questions can be traumatizing to patients and surrogates and also may seem impossible to answer during an acute health crisis. We categorize the patterns of well-intended yet clinically ineffective communication approaches into the following:

1. Describer: “If your heart stopped, would you want us to crack the ribs with chest compressions and put a breathing tube in the lungs?” It is physicians’ natural tendency to ensure that the patient or surrogate can visualize what invasive medical interventions involve. The description worsens anxiety and distracts from the patient’s goals in quality of life, which ultimately hinders his or her decisionmaking.²³
2. Informer: “The chance of surviving and returning home is 25%.” Trained in informed consent, physicians want to ensure that patients and surrogates understand the scientific information about chance. Explaining the survival probability distracts from focusing the conversation on the patient’s desired quality of life. Furthermore, human beings misinterpret the probability in highly emotional circumstances.^{23,24}
3. Decision Presser: “I want to make sure you realize that if we stop this now, your father will die; is that what you want?” Emotions peak when one is pressured to make decisions. We want the patient or surrogate to assume responsibility for our actions or inactions.

In the absence of formal training, many trainees continue to use code status scripts such as these, and subsequently pass them on to future generations of residents.

LIMITATIONS

The ED code state conversation guide does not fully convey all of the complexity of code conversations, much as advanced cardiac life support (ACLS) pocket cards²⁵ do not provide clinicians with mastery of cardiology. Rather, both are designed to provide expert-based guidelines that help ensure standardization of care. Unlike the ACLS guidelines or the original Serious Illness Conversation Guide that our guide is based on,^{26,27} our guide has not been tested to demonstrate improvement in outcomes. Many models to execute code status conversations exist, and we encourage emergency physicians to seek further training to master

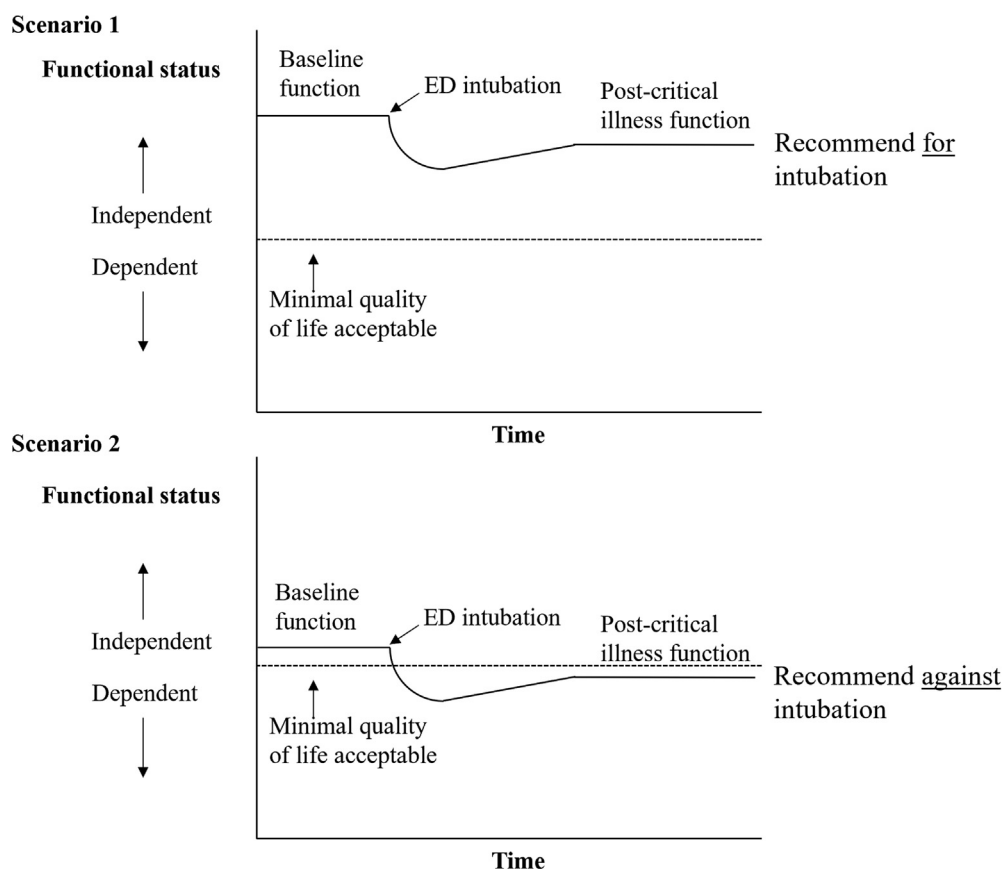


Figure 3. Recommendation based on quality of life acceptable to patients.

these communication skills in established serious illness communication programs.²⁸⁻³⁰ This article does not address decisionmaking for other invasive procedures (eg, cardiopulmonary resuscitation, vasopressors), yet we hope that our approach will be adapted to those situations. Regardless of clinicians' masterful communication skills, the decisionmaking may be equally influenced by patients' or surrogates' readiness to accept the difficult reality of an end-of-life situation.

CONCLUSION

Emergency physicians are expected to provide goal-concordant care during acute health decompensation for seriously ill older adults. Prognosis must be conveyed in a patient-centered manner: the survival probability is only important for emergency physicians to internally predict the best possible outcome should a patient survive. The ED code status conversation guide allows emergency physicians to succinctly make patient-centered recommendations for intubation decisions.

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Author affiliations: From the Department of Emergency Medicine (Ouchi, Bowman) and Division of Palliative Medicine, Department of Medicine (Lawton, Bernacki), Brigham and Women's Hospital, Boston, MA; the Department of Emergency Medicine, Harvard Medical School, Boston, MA (Ouchi, Bowman); the Serious Illness Care Program, Ariadne Labs, Boston, MA (Ouchi, Bernacki); the Department of Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, Boston, MA (Lawton, Bernacki); Harvard Affiliated Emergency Medicine Residency, Brigham and Women's Hospital/Massachusetts General Hospital, Boston, MA (Bowman); and the Department of Emergency Medicine, Center for Adult Critical Care, School of Medicine, University of New Mexico, Albuquerque, NM (George).

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