“I WOULD RECOMMEND…”
INCORPORATING RECOMMENDATIONS INTO SHARED DECISION MAKING

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DISCLOSURES

• NOTHING TO DISCLOSE
OBJECTIVES

• CASE
• OUR WORRIES/CONCERNS
• STEPS TO INCORPORATE RECOMMENDATIONS
• CHALLENGES (AND PEARLS)
CASE

• MB is a 63yo F with hx of severe pulmonary hypertension, COPD, CAD, HFpEF, T2DM, obesity, NASH cirrhosis, CKD. She presented to the hospital with progressive weakness and dyspnea. She was hypoxic and hypotensive in the ED. She was admitted to the MICU and this is hospital admission day #6. Despite all current therapies, MB is still requiring BiPAP support with difficulty weaning. She is requiring pressor support, will likely need a second pressor in the next few hours if her blood pressures do not improve. She started having a fever in the last 24 hours. Renal function has worsened. Functional status very poor (essentially bedbound) despite care at SNF prior to this hospitalization. This is her 5th hospitalization in 2018. Palliative care consulted because “she says she would want anything that could help her live.”
THOUGHTS?

• WHAT WOULD YOU RECOMMEND?
“Because of your age, I’m going to recommend doing nothing.”
WORRIES AND CONCERNS?

• PATERNALISM VS AUTONOMY
• THE “FINALITY OF IT ALL”
• “WHAT IF I AM WRONG ABOUT PROGNOSIS?”
• OTHERS?
PREPARATION

• NEED TO THINK ABOUT PROGNOSIS AND AVAILABLE TREATMENT OPTIONS
  • CONSULTING WITH SPECIALISTS ON THE CASE
  • THINK: HOW WILL AVAILABLE TREATMENTS IMPACT COMMONLY HELD VALUES (QOL, LENGTH OF LIFE, SUFFERING, ABILITY TO BE AT HOME OR WITH FAMILY, AND TIME SPENT IN THE HOSPITAL OR OTHER INSTITUTIONS)?
  • MANY PATIENTS WANT TO LIVE AS WELL AS POSSIBLE FOR AS LONG AS POSSIBLE
QUESTIONS

• ESTIMATE THE PROGNOSIS
  • HOW MUCH TIME DOES PATIENT HAVE?
  • HOW WILL PATIENT’S FUNCTION CHANGE OVER TIME?
  • WHAT WOULD ONE SHARE IF PATIENT ASKS FOR PROGNOSTIC INFORMATION?

• CONSIDER THE TREATMENTS
  • WHAT TREATMENTS DO I THINK COULD SAFELY BE OFFERED TO THE PATIENT THAT WOULD HAVE A REASONABLE LIKELIHOOD TO BENEFIT?
  • WHAT IS THE BURDEN OF THESE TREATMENTS?

• FORM A VALUE-BASED OPINION
  • WHAT OPTIONS BEST MAXIMIZE QOL? LENGTH OF LIFE?
  • WHAT OPTIONS MINIMIZE BURDEN?
  • WHAT WOULD I RECOMMEND TO MY OWN FAMILY? WHAT VALUES ARE MY RECOMMENDATIONS BASED ON?
STEPS

GET TO KNOW YOUR PATIENT
MEDICAL REVIEW
PROGNOSIS
TREATMENT OPTIONS
MAKE A RECOMMENDATION
ELICITING GOALS

• MB
  • AWAITING BIRTH OF VERY FIRST GRANDCHILD (IN 4 MONTHS)
  • MEANINGFULLY INTERACT WITH LOVED ONES
  • RETURN HOME TO LIVE INDEPENDENTLY, DOES NOT EVER WANT 24/7 DEPENDENT CARE
  • DOES NOT WANT TO BE “STUCK IN A BED OR STUCK TO MACHINES, OR IN A ‘HOME’ TO WITHER AWAY”
  • SHARED THAT HER PARENTS BOTH WERE ON DIALYSIS BEFORE DEATH, SHE DOES NOT WANT DIALYSIS LONG TERM
  • STAYING POSITIVE
  • FIGHTING THE DISEASE
  • PEACEFUL DEATH “NOT IN PAIN”
  • DOING EVERYTHING THAT MIGHT HELP
MAKING SURE WE ARE ON THE SAME PAGE

• MEDICAL REVIEW
  • MB HAS A CHRONIC PROGRESSIVE ILLNESS
  • SMALL CHANCE (?) OF LEAVING THE HOSPITAL ALIVE WITH EVEN WITH INVASIVE TREATMENT
PROGNOSIS

• THE “SURPRISE” QUESTION

• UNCERTAINTY IS EXPECTED
  • MB: “I KNOW I AM GOING TO DIE AT SOME POINT, BUT THEY TOLD ME THEY CAN’T PREDICT EXACTLY HOW LONG”

• MORE THAN JUST A TIMELINE, BUT ALSO ABOUT PROJECTED FUNCTIONAL DECLINE

• WHAT DO YOU THINK MB’S PROGNOSIS IS?
  • BEST/WORST/LIKELY SCENARIO?
TREATMENT OPTIONS

- SPECTRUM OF CARE WE CAN PROVIDE
  - AGGRESSIVE
  - LIMITED MEDICAL INTERVENTIONS
  - COMFORT-BASED CARE
  - OR IS THIS A “BUFFET OF OPTIONS”
MAKING A RECOMMENDATION

  • 90% prefer decision making that included physician opinion, 10% prefer surrogate make final decision (value-laden decisions, ie: life support)
  • 99% prefer decision making that includes physician opinion, 1% prefer surrogate makes final decision (biomedical decisions, ie: choice of antibiotics)
Making a Recommendation

  - Physician recommendations enhance rather than detract from shared decision making
MAKING A RECOMMENDATION

MAKING A RECOMMENDATION


  • The “enhanced autonomy model”
  • Exchanging ideas, negotiate differences, share power and influence to serve the patient’s best interests
  • Recommendations are offered that promote and intense collaboration between patient and physician so that patients can autonomously make choices that are informed by both the medical facts and physician’s experience
MAKING A RECOMMENDATION

• MAKE A RECOMMENDATION BASED ON THE PATIENT'S PRIORITIES MOST COMPATIBLE WITH THE LIKELY PROGNOSIS AND AVAILABLE TREATMENT OPTIONS

• MB
  • TREATMENTS THAT MIGHT HELP MB REACH HER GOALS
    • CONTINUED BIPAP, PRESSOR SUPPORT, DIURESIS, IV ABX WHILE WAITING FOR CULTURES, TUBEFEEDS, ? TRIAL OF DIALYSIS?
    • IF CONTINUES TO WORSEN, TRANSITION TO COMFORT CARE AT THE HOSPITAL
  • RECOMMEND AGAINST NON BENEFICIAL TREATMENTS
    • NO CPR/INTUBATION
CASE

• AFTER 2 MORE DAYS IN THE MICU, MB BECAME DELIRIOUS WITH WORSENING RESPIRATORY STATUS DESPITE ALL SUPPORTIVE MEASURES. SHE REMAINED ON BIPAP. ANOTHER FAMILY MTG TOOK PLACE, AND HER FAMILY DECIDED TRANSITION TO COMFORT CARE

• 24 HOURS LATER, MB DIED PEACEFULLY IN THE HOSPITAL SURROUNDED BY HER FAMILY MEMBERS
CHALLENGES

• HOW DO I OFFER OR INTRODUCE A RECOMMENDATION
  • “WOULD IT BE HELPFUL IF I OFFERED A RECOMMENDATION?”
  • GIVEN WHAT YOU HAVE TOLD ME ABOUT WHAT IS IMPORTANT TO YOU, I WOULD RECOMMEND…”
CHALLENGES

• FORMULATING A RECOMMENDATION WHEN PATIENT HAS DIFFERENT PRIORITIES
  • MB HAD SEVERAL PRIORITIES
    • RECOMMENDATIONS WERE MADE BASED ON THE ESTIMATED PROGNOSIS, AND WHAT TREATMENTS
      WOULD OFFER THE MOST SIGNIFICANT BENEFIT BASED ON ASSESSMENT OF PATIENT’S PRIORITIES
CHALLENGES

• SHOULD I EXPLICITLY DISCUSS AND RECOMMEND AGAINST ALL THE TREATMENTS I THINK ARE NON-BENEFICIAL
  • DON’T OFFER A BUFFET OF OPTIONS, AND THEN TELL THE PATIENT WHAT HE/SHE CANNOT EAT!
  • CPR MAY BE THE EXCEPTION, AS OUR CPR IS THE DEFAULT OPTION IN OUR MEDICAL CULTURE
CHALLENGES

• WHAT HAPPENS IF THE PATIENT/FAMILY/SURROGATE DOES NOT ACCEPT THE RECOMMENDATION
  • PATIENTS ALWAYS HAVE THE RIGHT TO DECLINE YOUR RECOMMENDATION
  • EXPLORE REASONS – PATIENTS ARE OFTEN STUCK IN THEIR RIGHT BRAIN
    • OFFER SUPPORT
  • STATEMENTS OF NON-ABANDONMENT
    • “WE WILL CONTINUE TO FIGURE THIS OUT TOGETHER…”
    • “I KNOW YOU WANT TO STAY POSITIVE, YOU HAVE BEEN SO STRONG. I KNOW THIS IS DIFFICULT TO TALK ABOUT. ON THE OTHER HAND, I WORRY THAT THINGS ARE CHANGING MEDICALLY, AND I WANT US TO BE PREPARED. CAN WE TALK MORE ABOUT WHAT IF THINGS DON'T GO AS WE HOPE?”
CHALLENGES

• WHAT IF THE PATIENT/FAMILY/SURROGATE DOES NOT SEEM READY TO MAKE A MEDICAL DECISION
  • THESE DISCUSSIONS CAN BE DRAINING (ESPECIALLY PROGNOSIS)
    • “I CAN SEE THAT THIS IS DIFFICULT AND SAD” –INVITE REFLECTION
    • “GIVEN WHAT IS HAPPENING, AND HOW OVERWHELMING ALL OF THIS IS, I WONDER IF IT WOULD BE HELPFUL FOR ME TO OFFER A RECOMMENDATION…”
  • IF NON-URGENT, OKAY TO RETURN FOR FOLLOW UP VISIT FOR CONTINUED DISCUSSION
CHALLENGES

• WHAT IF I FEEL UNCOMFORTABLE MAKING A RECOMMENDATION
  • WE WANT TO RESPECT PATIENT AUTONOMY
    • PATIENT AND SURROGATE DECISION MAKERS WANT THEIR PHYSICIANS TO TAKE SOME OF THE
      RESPONSIBILITIES FOR MEDICAL DECISION MAKING BY MAKING A RECOMMENDATION
CHALLENGES

• MAKING A RECOMMENDATION IS A SKILL THAT CAN BE LEARNED WITH PRACTICE

• SOME EASIER SCENARIOS
  • PATIENT ASKS YOU FOR RECOMMENDATION – “WHAT WOULD YOU DO IF …”
  • YOU HAVE A CLOSE RELATIONSHIP WITH THE PATIENT AND HE/SHE TRUSTS YOU
  • THERE ARE LIMITED OPTIONS, AND YOU FEEL STRONGLY THAT THERE IS A BEST COURSE OF ACTION
  • THE DECISION IS RELATIVELY LOW STAKES: TRY RECOMMENDING YOUR PATIENT TALK TO THEIR HEALTH CARE AGENT ABOUT THEIR GOALS AND VALUES
CONCLUSION

• PATIENT AUTONOMY SHOULD NOT BE A BARRIER TO CLINICIANS MAKING TREATMENT RECOMMENDATIONS

• THIS IS A COMMUNICATION SKILL THAT CAN BE LEARNED