Tailoring Our Response to “Do Everything”
Maintaining Alignment When There is Prognostic Discordance

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Clinical Assistant Professor, University of Washington
VitalTalk Distinguished Faculty
Commercial Financial Disclosures

- None

- Non-Profit Support
  Cambia Health Foundation: Grant Funding
  VitalTalk Faculty: Teaching Stipend
  Honoring Choices Pacific Northwest: Consultant
Session Overview
By the end of this session, you will be able to:

- List commons reasons for **prognostic discordance**
- Explain a **framework** for identifying types of prognostic discordance
- Describe **communication strategies and skills** to maintain alignment
This session works best with you involved!

Open your chat box

- Say hello
- What is your professional role
- What setting/where do you practice

Let’s Chat!
Prognostic Discordance
Q: What is Prognostic Discordance?
“Do Everything!”
“They just don’t get it!”
POLL: What percentage of surrogates express doubts about our ability to prognosticate in critically ill patients?
88% = Surrogates Express Doubts

~50% = Optimistic Prognosis

Zier, White Crit Care Med 2008
White, JAMA 2016
White, Critical Care Medicine 2019
Reasons for Prognostic Discordance
Q: What are reasons surrogates may disagree with our prognosis?
How surrogates prognosticate

- 64% patient’s appearance
- 36% power of optimism, intuition, faith
- 30% unique or intrinsic qualities of their loved one
- 28% previous “track record”
- 13% power of bedside presence
- 4% belief in miracles

<2% rely only on the clinician’s prognostic estimate
Diagnose the Prognostic Discordance
## Diagnose Prognostic Discordance

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*Most of these strategies can be used for any type of discordance, those in each section are just the highest yield for those situations

Framework Created by Caroline Hurd 2021
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Framework Created by Caroline Hurd 2021
Discordance: Information
Cardiology: “If his stroke improves, we MIGHT be able to fix his heart.”
Neurology: “If his heart improves, his stroke MIGHT improve.”
How surrogates prognosticate

- 25% reported at least one inconsistent message
- Of these, ~40% reported this happened multiple times
- ~75% said this occurred within the first 48 hours of ICU stay
- Who is your main source of information? ~75% from the nurse
Share your worry using a headline

Headline = Information + Meaning

J Onc Prac Childers 2017
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“I don’t understand....”  
“What do you mean?” | Outcome             | Assess prior knowledge  
Ask permission  
Reframe/headline (info + meaning)  
Ask-Tell-Ask | Pre-meet: Same page  
Meet as condition changes  
Facilitate specialist messaging  
Interpreters |
| GRIEF     | “I can’t believe this...”  
“This is my fault...”  
“I can’t lose them...” | Outcome > Process   | Respond to emotions  
NURSE, silence, I wish....  
Informed assent | Interprofessional team  
Small check-ins  
Slow process down |

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Framework Created by Caroline Hurd 2021
Discordance: Grief
Daughter: “He was just about to sell his business and retire. They had just bought a new house close to us and their grandchildren.”
NURSE(S) to respond to emotions

**Name**  “It sounds like you’re frustrated.”

**Understand**  “I can only imagine how hard this is.”

**Respect**  “I can see you really care about your mother.”

**Support**  “We are here to support you through this process.”

**Explore**  “Can you tell me more about what’s concerning you?”

**Silence**  Intentional presence
Don’t bury your empathy:
Explicitly acknowledge emotions
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| INFORMATION   | “But we heard....” “I don’t understand....” “What do you mean?”                   | Outcome             | Assess prior knowledge  
Ask permission  
Reframe/headline (info + meaning)  
Ask-Tell-Ask                                      | Pre-meet: Same page  
Meet as condition changes  
Facilitate specialist messaging  
Interpreters                                      |
| GRIEF         | “I can’t believe this....” “This is my fault....” “I can’t lose them....”          | Outcome > Process   | Respond to emotions  
NURSE, silence, I wish....  
Informed assent                                      | Interprofessional team  
Small check-ins  
Slow process down                                      |
| TRACK RECORD  | “But last time....” “They will surprise you....” “They’re a fighter....”           | Outcome = Process   | Tell more  
I wish  
What fighting for  
What hear you saying is: Reflection  
Anticipatory guidance  
Time trial                                      | Clinicians w/ contiuity?  
More family members voices  
Space to disagree                                      |

*Most of these strategies can be used for any type of discordance, those in each section are just the highest yield for those situations*  

Framework Created by Caroline Hurd 2021
Discordance: Experience
Daughter: “They said he would never walk again after his last stroke, but he did.”
Evaluation of Time-Limited Trials Among Critically Ill Patients With Advanced Medical Illnesses and Reduction of Nonbeneficial ICU Treatments

Dong W. Chang, MD, MS; Thanh H. Neville, MD, MSHS; Jennifer Parrish, DO; Lian Ewing, MSN, RN; Christy Rico, BA; Liliacna Jara, BS; Danielle Sim, MS; Chi-hong Tseng, PhD; Carin van Zyl, MD; Aaron D. Storms, MD; Nader Kamangar, MD; Janice M. Liebler, MD; May M. Lee, MD; Hal F. Yee Jr, MD, PhD
Components of Time Trials

- Time Frame
- Signs of Improvement
- Signs of Worsening
- Plan based on outcome of trial

Change et al. JAMA Internal Medicine 2021
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Reframe/headline (info + meaning)  
Ask-Tell-Ask | Pre-meet: Same page  
Meet as condition changes  
Facilitate specialist messaging  
Interpreters |
| GRIEF | “I can’t believe this...”  
“This is my fault...”  
“I can’t lose them...” | Outcome > Process | Respond to emotions  
NURSE, silence, I wish....  
Informed assent | Interprofessional team  
Small check-ins  
Slow process down |
| TRACK RECORD | “But last time....”  
“They will surprise you...”  
“They’re a fighter...” | Outcome = Process | Elicit lived experience  
Reflection Statements  
“It sounds like....”  
Best/worst/most likely  
Road Map: Anticipatory guidance | Time trials  
Scheduled, regular intervals  
Keep an open mind |
| DISCRIMINATION DISTRUST | “Why are you....”  
“Are you sure....”  
“Is this because...”  
Vigilance  
Might not hear/see anything | Process>>Outcomes | Name unspoken fear  
Partnership, Support  
Legitimize  
Acknowledge discrimination exist  
Respect thank you....  
apology  
Explore/spirit of curiosity  
Lived experience  
Set agenda  
Alignment | Enlist trusted partners  
Less emphasis on info delivery  
Relationship |

*Note: The framework can be applied to other discordance, the rows above are just the guidelines for those situations.
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                    “I don’t understand....”  
                    “What do you mean?”          | Outcome            | Assess prior knowledge  
Assemble information  
Ask permission  
Reframe/headline (info + meaning)  
Ask-Tell-Ask | Pre-meet: Same page  
Meet as condition changes  
Facilitate specialist messaging  
Interpreters                                                                 |
| GRIEF              | “I can’t believe this....”  
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NURSE, silence, I wish....  
Informed assent | Interprofessional team  
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| TRACK RECORD       | “But last time....”  
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Road Map: Anticipatory guidance | Time trials  
Scheduled, regular intervals  
Keep an open mind                                                                   |
| DISCRIMINATION DISTRUST | “Why are you....”  
  “Are you sure....”  
  “Is this because....”  
  Vigilance  
  Might not hear/see anything        | Process (Trust)  
>>  
Outcome  | Respect/affirmation statements  
Apologize: “I’m sorry for....”  
Acknowledge discrimination overtly  
Earn Trust  
Emotional responsiveness  
Align with hope | Set aside agenda  
Advocate for best care possible  
Continuity w/ clinicians of trust  
Community/trusted allies  
Actions over words  
Be transparent  
Small/frequent visits  
Cultural Navigator  
Consistent/consolidated info  
Consensus on Rx options                                                                 |
| VALUES/BELIEFS     | “Any life is worth living....”  
                    “God will decide....”  
                    “We believe....”       | Process             | Assurance no stone unturned  
Emphasize what we are doing  
I hope/wish – I worry  
Values triad                                                                 | Framework Created by Caroline Hurd 2021                                                                 |

*Most of these strategies can be used for any type of discordance, those in each section are just the highest yield for those situations *
Discordance: Discrimination
Daughter: “Is this because you need the bed? Is this because of money?”
“Why aren’t the nurses washing his face....”
“Many of the staff are amazing, but some barely acknowledge us....”
“Why is the team avoiding us, they don’t round in the afternoon anymore....”

Team/Staff: “The family is difficult, don’t they see he is suffering....”
Attending: “We are just going to turn off the dobutamine and not tell the family.”
Experience of Discrimination → Racially Charged or Vulnerable Moment

- Further activates provider bias and inaccurate stereotypes of non-compliance

Biased Response
- Shifts in attention
- Express negative stereotype
  - Defensive
  - Anxious
- Avoid discussions of racism

DISTRUST DISTRESS DISENGAGEMENT

Canter et. al. BMC Medical Education 2020
Emotional [Responsiveness]

Displaying empathy, respect, validation, and concern for the patient.
Experience of Discrimination

Racially Charged or Vulnerable Moment

Promotes Positive Attitudes
Reduces Prejudice
Builds Connection

Emotional Responsiveness
- Mindfulness
- Acceptance
- Convey understanding
- Validate

TRUST ENGAGEMENT SATISFACTION

Canter et. al. BMC Medical Education 2020
P – Partnership
E – Empathy
A – Apology
R – Respect
L – Legitimation
S – Support

Discordance: Values/Beliefs
“The daughter refuses to hear prognosis,” concluded my attending. “It’s classic: she listens, but she doesn’t hear. The chance of a good outcome is zero; we're flogging this man with futile medicine. She’s hoping for a miracle.”
Values Triad

Longevity

Function Abilities

Comfort

Fried Arch Intern Med 2011
Rubin JAMA Internal Medicine 2016
Kaldijian Am J Hosp Pall Care 2009
## Values Triad

<table>
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<tr>
<th>Medical Treatment</th>
<th>Patients</th>
<th>Families</th>
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<tr>
<td>Focus solely on comfort</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>Initial attempt, if not improving switch to comfort, no CPR</td>
<td>30%</td>
<td>28%</td>
</tr>
<tr>
<td>Full medical care, no CPR</td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td>Full medical care to prolong life at all costs, want CPR</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>Unsure</td>
<td>8%</td>
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12 acute care hospitals in Canada, patients ≥ 80 yrs, 278 patients, 225 family members

Heyland CARENET JAMA Intern Med 2013
Discussion
Q: What are situations you’ve faced related to prognostic discordance?
Resources
VitalTalk makes communication skills for serious illness learnable.

Our evidence-based trainings empower clinicians and institutions.

Grow as a CLINICIAN
We equip clinicians with expert strategies.

Join our FACULTY
We develop clinicians into advanced educators.

Strengthen your INSTITUTION
We build your capacity to provide patient-centered care.
IMPACT-ICU (Integrating Multidisciplinary Palliative Care into the ICU) is a communication skills training program to integrate palliative care into the ICU by training and supporting bedside nurses.

**VitalTalk Introduces IMPACT-ICU Toolkit**
Tools for ICU nurses to be more effective communicators and to improve nurse-physician collaboration.

**IMPACT-ICU Resources:**

- **Tools for Nurse’s Role:**
  - 1 Video
  - Tools for the Crucial Roles in ICU Palliative Care

- **The 3 Conversations:**
  - 3 Videos
  - Watch bedside nurses skillfully navigate discussions with patients and physicians in family meetings.

- **Coaching:**
  - 1 Video
  - Supporting Primary Palliative Care at the Bedside
Graduate Certificate in Palliative Care
Building Interprofessional Communities of Practice

PALL
- Blending the Patient & Family Story
- Addressing Symptoms
- Workshops: Mind & Body
- Anxiety & Coping
- Spirituality
- Caregiver Support
- Pain Management
- Resilience

WINTER
- Facilitating Family Conferences
- Supportive Interventions
- Workshops: Stress & Resilience
- Conflict Management
- Advance Care Planning
- Quality Measures
- Education & Training
- Interventions for Pain & Symptom Management

SPRING
- Stakeholder Engagement
- Design Thinking
- Change Management
- Interprofessional Practice
- Quality Improvement
Workshop 3: Making our Work
Communication and Billing

IMPORTANT DATES
Applications Due
May 1, 2020
July 15 (space permitting)

Workshop dates for Cohort 2020-2021
Seattle (Adult track):
October 15-17, 2020
January 21-23, 2021
May 13-15, 2021

Portland (Adult or Pediatric track):
October 15-17th, 2020
January 21-23, 2021
May 13-15, 2021

Boise/Tricities (Adult track):
October 22-24th, 2020
January 28-30, 2021
May 20-22, 2021

Contact Us
pctc@uw.edu

www.uwpctc.org
Diversity, Equity, and Inclusion Resources

AAHPPM is committed to educating and building a community that embraces diversity, equity, and inclusion. The following resources are intended to provide education and learning opportunities and are not officially endorsed by AAHPPM.

If you have questions on AAHPPM’s DEI initiatives or resource suggestions, please contact AAHPPM Member Services at info@aaahpm.org.

Practical Strategies

- Diversity and Equity 21 Day Challenge - San Francisco Department of Public Health
- Daring Discussions Toolkit - National Association for the Education of Young Children
- Video: 3 Ways to be a Better Ally in the Workplace - TED.com / Melinda Epler
- Guide to Allyship – project by Amelie Lamont
- What Works - Evidence Based Ideas to Increase DEI in the Workplace - University of Massachusetts Amherst
- Diversity in Fellowship Selection Materials - University of California, San Francisco
  - Video: UCSF Fellow Selection Orientation
Other References


Action Plan
Thank You
churd@uw.edu