Advance CPR decision-making in the hospital setting

A facilitator’s guide

Version 1

Pilot to 20/3/2015

Clinical issues – Framework – Communication
Acknowledgements

The Palliative Care Network would like to thank those who provided feedback during the consultation process as well as members of the Working Group for their dedication to the project.

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Disclaimer: The terminology and practice of advanced life support teaching depicted in the videos were current at the time of making this guide. The video drama scenes are not intended as a teaching model for Advanced Cardiovascular Life Support.

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Overview

Background
CPR was originally designed to save ‘hearts too good to die’.\textsuperscript{1,2,3} The clinicians who pioneered CPR never intended for it to be used universally. CPR is usually an appropriate first aid response to cardiac arrest in a community setting but it is not always appropriate in a hospital setting.

Despite the widely held community view that CPR should be provided for all people who experience cardiac arrest, communication about the potential benefits and risks of performing CPR in a hospital setting should usually be discussed with each patient on a case by case basis.

CPR decision-making is one of the most difficult clinical decisions doctors need to make in collaboration with the patient and their family/carer(s). CPR decision-making is a clinical skill that must be systematically taught and practiced in all hospital settings. Despite this, the provision of medical education in CPR decision-making remains an identified gap in the literature.

No legal consent is required to provide emergency medical treatment such as CPR.\textsuperscript{4} However, the decision about whether to initiate CPR in the event of cardiac arrest should be discussed with patients and their families. The way that this is communicated to patients and families must be tailored to individual circumstances. Patients and families may have unrealistic expectations about CPR and other treatments at the end of life. They may over-estimate the effectiveness of CPR and underestimate the potential harms.\textsuperscript{4,5,6} In some cases CPR may be provided inappropriately, despite the likelihood of little or no benefit.\textsuperscript{7,8} Patients at the end of life are particularly at risk of inappropriately receiving CPR as cessation of heartbeat and breathing may be construed as cardiac arrest as opposed to the normal dying process. In this circumstance giving CPR may result in unnecessary harm.

Communication about the outcomes, both potential benefits and potential harms of performing CPR, should be provided to patients and families. Doctors may be concerned that initiating a discussion about end of life care will remove hope or create distress for the patient and their family/carer(s). However, in the absence of a discussion, the patient and family/carer(s) may be unrealistically optimistic about treatment outcomes. Poor communication, like any other medical intervention, can cause harm. Quality communication between doctors and patients is important.

CPR decision-making should be considered as part of best practice for end of life care and is the responsibility of all clinicians who are part of the treating team. Using a systematic approach to quality improvement in this vital aspect of clinical practice responds to the National Safety and Quality Health Service Standards, in particular Standard 9 – Recognising and Responding to Clinical Deterioration.

Studies about CPR outcomes describe a range of survival rates, depending on the circumstances, the cause of the arrest and the patient’s underlying medical condition. Estimates range from 7–26 per cent survival through to discharge\textsuperscript{1,12,13,14} and 6 per cent for patients with metastatic cancer.\textsuperscript{15} For those who survive CPR, between 30 and 50 per cent will have a spectrum of impairment from minimal damage to severe hypoxic brain damage.\textsuperscript{4}

An important clinical skill for every doctor is the ability to identify when a patient is approaching death. This skill is enhanced through comprehensive assessment, critical thinking and reflective practice. Despite this, uncertainty in prognostication may remain. Good communication initiated by the doctor at this time will help the patient to know when death is coming, what to expect, to be comfortable, to have time to say goodbye and to participate in decision-making which limits medically inappropriate life prolonging treatment.\textsuperscript{9,10}
Overview

The facilitator’s role

As a facilitator, your role is to stimulate and encourage discussion about CPR decision-making with your colleagues in a trusted environment with the goal of promoting and improving conversations between medical staff, patients and their family/carer(s)*. An adult learning approach will encourage reflection and critical thinking. It is important to respect individual learning styles and encourage constructive group dynamics.

This guide is designed to help medical staff develop essential knowledge, skills and confidence to initiate and engage in patient-centred conversations, particularly about CPR decision-making. Taking this approach will ensure patients are actively involved in determining the goals of care and preferences for appropriate intervention and treatment, in the event of their deterioration.

The role of the facilitator is to assist participants to learn, to gain from each others’ experience and gather new information. Ideally the facilitator will:

- use a variety of methods to introduce and reinforce information
- provide opportunities to share relevant information and experiences
- encourage active participation through reflective practice.

This Facilitator’s Guide is not prescriptive, rather it is based on a multi-modal learning approach and includes videos and suggested readings. The content may be delivered flexibly, according to the audiences’ experience and needs, and the time available.

At a glance

This guide is organised into three learning parts and includes sample session plans, a suite of video presentations, essential and additional readings and links to other resources. The videos present clinical scenarios and examples of CPR decision-making discussions. Each video may be watched in full or in smaller sections interspersed with audience discussion.

Part A
The clinical issues

Part B
The decision-making framework

Part C
Communication tips and examples

The content is particularly focused on patients with progressive, deteriorating illness.

* For simplicity, this guide will use the term ‘family/carer(s)’ to also include the patient’s legal medical substitute decision-maker because it is important to correctly identify the person who has this role.
Target audience

The primary target group includes:
- consultants, senior and junior medical staff
- medical students
- other clinicians, such as nursing and allied health staff may also find this guide useful.

Ideally this guide should be incorporated into formal hospital in-service education programs and may also be used flexibly to accommodate other training opportunities, for example grand rounds, journal clubs, case reviews and self-directed learning.

How to get the best out of the facilitator’s guide

It is recommended that the facilitator:
- considers how the content relates to your audience and their specialty(s), for example ICU, geriatricians, general medicine
- reads the guide and is well informed about the videos and readings
- starts and finishes on time
- meets the aims of each session
- keeps participants on track and on topic
- is familiar with the topic and audience - pitches the session appropriately and anticipates the questions that might arise
- allows time for group reflection including sharing clinical experiences
- provides evidence to back up claims, e.g. uses the statistics slides
- is open to questions – if you can’t answer the question, ask the group for their thoughts
- respects the range of participants’ experiences and builds their knowledge accordingly
- includes small breakout sessions for larger groups.

Conducting a successful learning session will require you to be aware of what might undermine the group's progress. Planning your session and anticipating what might not work for your group will help ensure a productive session, increase your confidence and achieve the aims of this guide. Consider the following points:
- A participant might say “this is not my responsibility”. Some doctors may have their own personal beliefs that conflict with the contents of this guide. Accept that some participants may not see CPR decision-making as part of their role. If this is the case, explore the following questions:
  - Whose role should it be?
  - Does anyone in the audience see it as their role? Why?
  - Would it be okay if someone other than a senior doctor initiated the conversation? For example, a junior team member, in the presence of the senior doctor, may be better placed within the team to have the discussion.
- Provide an opportunity for all views to be heard, for example “I don't agree with the content!” Ask others if they feel the same?
- Acknowledge that CPR decision-making is everybody’s business. Decisions need to be made on wards every day. Sometimes these decisions are straightforward; at other times they are more complex and may require other opinions, for example input from an Intensive Care Physician.
- Consider how you will support participants who may require follow up/support or the opportunity to debrief with an appropriately qualified professional.
- Acknowledge that you are not teaching but facilitating!
Overview

Resources for each session
Suggested resources and materials include:
- book a venue
- poster/flyer or website to advertise session
- computer
- data projector
- PowerPoint slides
- whiteboard and/or butchers paper and markers
- reading materials and other handouts.

References
Part A: The clinical issues

Pilot to 20/3/2015
Part A: The clinical issues

Aims
A.1 Identify current practices and challenges facing clinicians in CPR decision-making.
A.2 Explore ways in which communication can be improved with patients who have a progressive/deteriorating illness, and their families/carers.
A.3 Investigate strategies for improving CPR decision-making in the hospital setting.

Video summary
The video takes the participants through the hospital journey of a patient who most likely would not survive CPR; yet as a result of poor communication, receives attempts at CPR. It highlights issues around CPR decision-making, identifying problematic areas and potential solutions. It also provides a range of observations and comments from clinicians which the participants can discuss in the context of their own experiences.
### Part A: Sample session plan

**Duration:** 45 minutes.  
The session plan is provided as a guide. All activities can be used flexibly.

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<th>Time</th>
<th>Video</th>
<th>Activity</th>
<th>Considerations</th>
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| 20 mins | **Part A: The clinical issues**  
**A.1 The current situation** (2 mins 47 secs):  
- CPR was designed for a selected population and has now been applied to a broader hospital group.  
- A patient with advanced progressive illness or frailty may not survive or benefit from CPR.  
- Identify how poor communication and lack of training contributes to poor end of life decision-making | **A.1.1** Introduce the session and background briefing.  
**A.1.2** Ask participants if CPR decision-making is an important issue for them?  
**A.1.3** Invite participants to discuss past experiences – good and bad.  
**A.1.4** Give an overview of the video content.  
**A.1.5** Invite group discussion by asking if the video reflects their own clinical experience? | The participants will have had a variety of clinical experiences in CPR decision-making.  
It is important to create an environment where they will want to share their stories. It is important to note that past experiences may continue to impact upon them and affect their decision making.  
Acknowledge participants’ engagement and emotions expressed. |
## Part A: The clinical issues

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<tr>
<td>10 mins</td>
<td>A.2 Why has this situation arisen? (5 mins 9 secs):</td>
<td><strong>A.2.1</strong> Ask the participants why we sometimes fail to make proactive decisions including escalation and limitations to treatment, e.g. making decisions to withhold CPR.</td>
<td>This will enable the facilitator to better understand the participants, their specialty and prior learning on CPR decision-making.</td>
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<td>10 mins</td>
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<td><strong>A.2.2</strong> Consider stopping the video after Dr Nick’s discussion and asking: Has anyone in the group been formally taught CPR decision-making?</td>
<td>It is likely that they have not been taught CPR decision-making specifically, but have received some teaching in the area of communication skills.</td>
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<td>10 mins</td>
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<td><strong>A.2.3</strong> Do you feel that poor communication can lead to poor treatment outcomes?</td>
<td>Participants are more likely to engage in CPR decision-making conversations with patients and their families if they know that they are supported by:</td>
</tr>
<tr>
<td>10 mins</td>
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<td><strong>A.2.4</strong> Ask the group to share their reflections on the video. What further help would you need to undertake these decisions/discussions/actions in the context of your specialty?</td>
<td>- local clinical governance, policy and quality improvement</td>
</tr>
<tr>
<td>10 mins</td>
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<td><strong>A.2.5</strong> How does this activity fit within the quality improvement agenda of your health service?</td>
<td>- endorsement by the hospital executive and the Department of Health and current legislation.</td>
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<td>10 mins</td>
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<td><strong>A.2.6</strong> Is the depiction of CPR in the video realistic? Can the participants describe any flaws (acknowledging that clinical practice is often imperfect)?</td>
<td>Clinical uncertainty is part of decision-making, and the illness process is changeable and dynamic. There is no single solution to this complex problem.</td>
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Consider the implications of:

- Poor engagement with end of life discussions and decision-making.
- Providing treatment that is not likely to benefit the patient, is excessively burdensome, or may cause unnecessary suffering.
- Not seeking input from patients, in a timely manner, about their preferences. For example wanting or not wanting treatment, providing treatment that the patient would refuse if they were fully informed about their illness trajectory, and about CPR or other life prolonging treatment.
- The Clinical team providing inconsistent or ambiguous advice.
- Avoiding difficult conversations which lead to default treatment.
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| 10 mins | A.3 How can we improve clinical care? (3 mins 29 secs): Include opportunities for improvement in CPR decision-making through systems based approaches including:  
• Use of training to improve clinician communication practices.  
• Recognition of the importance of discussions about goals of care and resuscitation especially for patients with progressive deteriorating illness.  
• Shared responsibility by all medical staff. | Invite group discussion by asking:  
A.3.1 Is the depiction of CPR in the video realistic?  
A.3.2 Support the participants to reflect and critique the content of the video.  
A.3.3 Do you feel that the two questions posed would be useful in clinical practice?  
• Who do you want to speak for you?  
• Have you spoken to that person?  
A.3.4 Can they be applied in current practice?  
A.3.5 Discuss the characteristics of effective communication for CPR decision-making discussions. | Collaboration between patient, family/carer(s) and clinician is essential for good clinical care.  
Shared decision-making means that:  
• clinicians bring the necessary medical expertise  
• patient/family/carer(s) bring necessary expertise about the patient’s values/priorities  
• collaborative decision-making occurs within the context of available medical options  
• ethical processes will be upheld.  
Exploring a range of accepted communication techniques will enable:  
• the adoption of specific change strategies for individuals, supported by the specialty and hospital  
• improvements in clinical decision-making and performance outcomes. |
| 5 mins | Conclusion  
• Recap session aims consider what has been learnt by the group.  
• Where to from here? | Remind participants of the availability of further training especially Parts B and C within the guide. |  
Pilot to 20/3/2015  
Pilot to 20/3/2015 |
Part A: The clinical issues

Essential reading

(*essential reading for facilitator, recommended reading for participants*)


Facilitator’s tips

- *Futility* is a term that is likely to arise in discussion and best avoided as:
  - it is a highly subjective and ambiguous term open to misinterpretation
  - is influenced by the clinicians’ own values
  - may imply that the person rather than the condition is not worthwhile treating.

- Show the following Powerpoint slides:
  - Dr Barbara Hayes’ decision-making framework slides (Appendix 1)
  - Survival rates (Appendix 2)
  - Two questions (Appendix 3)
  - slides that support your local initiative/quality improvement initiatives.

Additional reading


*NB: ACCESS BY PURCHASE ONLY*
Part B: The decision-making framework

Pilot to 20/3/2015
Part B: The decision-making framework

Aims

B.1 Consider the importance of quality CPR discussions and the risks of inadequate discussion, for example inappropriate use of CPR.

B.2 Explore clinical situations where it is not appropriate to offer CPR.

B.3 Describe how discussions should be framed in the following circumstances, considering:
   – that the patient might die or live following CPR
   – the potential benefits and harms of CPR/no CPR
   – why CPR might not be provided
   – planning care for a comfortable death.

Video summary

The video presents information and guidance for CPR decision-making and communication using a structured decision-making framework (Appendix 1) and aims to provide clinical insight into this decision-making process.
Part B: Sample session plan

Duration: 45 minutes.
The session plan is provided as a guide. All activities can be used flexibly.

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| 10 mins | **Part B: The decision-making framework**  
**B.1 Is CPR decision-making different?**  
*(3 mins 9 secs).* | **B.1.1**  
Open the session – give an overview of the session and the video content.  
**B.1.2**  
Invite past personal experiences and the sharing of clinical approaches.  
**B.1.3**  
Invite group discussion by asking:  
• Is CPR decision-making different or the same as other treatment decisions?  
• How do we decide whether someone is likely to survive CPR?  
**B.1.4**  
Suggest use of the Decision-making Framework (Appendix 1). Also include discussion about local forms and documentation. The session should align with hospital policy and quality improvement initiatives. | There is no one tool which adequately captures each patient/situation. Clinicians should use:  
• a structured approach to CPR decision-making  
• a combination of tools, for example SPICT and ‘The Surprise Question’* to cover all scenarios to help identify patients for whom CPR may not be of benefit.  
(*Would I be surprised if this patient was to die in the next 6-12 months?)  
• Tools as an aid to memory.  
• A considered approach, exploring the patient's medical condition, their wishes and values. |

It is different because:  
• CPR is first aid treatment in the community for ALL cardiac arrests  
• expectations and perceptions vary between the community and clinicians  
• it is a high stakes (life and death) decision  
• unless there is an order to not provide CPR, it is provided.  
The CPR decision is embedded in an individual's life, values, illness, expectations and part of an ongoing discussion.
Part B: The decision-making framework

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<td>10 mins</td>
<td><strong>B.2 The medical assessment</strong> <em>(3 mins 28 secs)</em>. CPR decision-making is a two stage process: 1. A technical assessment and decision about the patient’s potential to survive CPR; and 2. A discussion. Identifying patients who are likely to survive CPR is challenging. There is little discrete clinical research on the topic. Considerations include: • What is wrong with them now? • Do they have chronic progressive illness? • What are their co-morbidities, lifestyle, function, frailty and physiological reserve? • Less experienced doctors may need advice from more senior doctors to help them answer this question about likely survival. CPR discussions should be considered, rather than just providing default CPR without discussion. Clinical tools such as the Supportive and Palliative Care Indicators Tools (SPICT) and ‘The Surprise Question’ are useful in assessing the patient.</td>
<td><strong>B.2.1</strong> It is important for clinicians to ask: &gt; What are the likely consequences if the patient survives CPR? &gt; How they will be afterwards? <strong>B.2.2</strong> Have the slide available on the illness trajectories and the link for further reading: <strong>B.2.3</strong> Have the clinicians seen the trajectories and do they use them to assist in decision-making? <strong>B.2.4</strong> Do you find it difficult to establish when someone is dying?</td>
<td>The decision to use CPR is likely to have other implications for the patient, for example ventilation, prolonged hospitalisation, or disability. ICU admission is a second decision made at the time of cardiac arrest by the intensivists. It may be very helpful to obtain an ICU opinion prior to initiating any CPR discussion. These factors are important inclusions in the discussion about goals of care. There are no easy answers. Clinical experience will assist and for that reason consultants should be involved in these decisions. Junior staff will benefit from support as they are more likely to over estimate the patient’s outcomes and ability to recover.</td>
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<td>10 mins</td>
<td><strong>B.3 Four clinical categories of patients being considered for an order to withhold CPR – each with its own discussion aim (4 mins 38 secs).</strong>&lt;br&gt;Describes a framework which can be used to guide decision making.&lt;br&gt;Each category contains discussion aims.&lt;br&gt;1. Dying patient&lt;br&gt;2. Medically unwell-not imminently dying&lt;br&gt;3. Very poor outcome likely from CPR&lt;br&gt;4. Uncertain outcome from CPR.&lt;br&gt;There will be another group of patients for whom default CPR without specific discussion is entirely appropriate (in the absence of any advance care planning refusing CPR)</td>
<td><strong>B.3.1</strong> Invite discussion about the decision-making framework handout (Appendix 1) and ask the participants to consider:&lt;br&gt;<strong>B.3.2</strong> Are “unilateral decisions” commonly made in clinical practice?&lt;br&gt;<strong>B.3.3</strong> Facilitate a discussion about why this may not be appropriate.&lt;br&gt;<strong>B.3.4</strong> Would you currently discuss CPR if you believed the patient would not survive?&lt;br&gt;<strong>B.3.5</strong> Discuss category 3 and 4.&lt;br&gt;<strong>B.3.6</strong> How do these categories fit with patients currently in your care?&lt;br&gt;<strong>B.3.7</strong> Can you see how these principles might apply to other medical treatment decisions?</td>
<td>A conversation about CPR fits into a broader conversation and decision-making about:&lt;br&gt;• where the patient is on their illness trajectory and overall goals of care&lt;br&gt;• what the patient’s expectations are regarding ongoing treatment including CPR.&lt;br&gt;Asking about prior Advance Care Planning is a way to also identify those patients, who might be considered medically appropriate to receive default CPR, but where the patient has their own CPR preferences.&lt;br&gt;Unlike CPR, other treatments may have palliative benefit, independent of any life-prolonging intent. For example, surgery to fix an unstable fracture or antibiotics for a symptomatic urine infection.</td>
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## Part B: The decision-making framework

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| 10 mins | The video alludes to, but does not describe, strategies for dealing with disagreement.  
B. Hayes (2013) article, *Clinical model for ethical cardiopulmonary resuscitation decision-making* describes strategies for disagreement in each of the four CPR discussion categories. | **A strategy to deal with disagreement**  
CPR decision-making requires clear verbal/written communication, including clinical handover.  
**B.4.1** Invite participants to discuss examples of disagreement/conflict regarding CPR (or other end of life) decisions.  
**B.4.2** What happened and how did you address it as an individual/team and with the patient and family/carer(s)?  
**B.4.3** Discuss the Framework and its specific applications in practice which include:  
  - to build quality practice  
  - as a teaching tool  
  - to aid decision-making in difficult cases.  
**B.4.4** Explore common questions as they arise. Ensure that the participants understand that the Framework is a tool which should be used together with the participant’s professional judgment. | Every effort should be made to maintain working clinical and therapeutic relationships. Conflict should be avoided wherever possible during CPR decision-making; good communication will assist. For example, from an ethical standpoint, it may be better to provide CPR when it is not expected to be clinically beneficial to the patient rather than fall into a dispute with the patient and family/carer(s).  
The Framework will be specifically useful for clinicians who are inexperienced.  
As doctors gain experience in a systematic approach to CPR decision-making they will apply the principles of the Framework but will be less likely to rely on the document. |
| 5 mins | **Conclusion**  
Where to from here? | Remind the participants of the availability of Part C within the guide. |                                                                 |
Essential reading

(essential reading for facilitator, recommended reading for participants)


Facilitator’s tips

- Provide copies of the decision-making framework to the participants (Appendix 1).
- Show slides that support your local initiative/quality improvement initiatives.
- Show survival rates slide. Figures used for a poor outcome/uncertain outcome are a theoretical guide, based on estimated survival along the 0-18% survival continuum.
  - Poor outcome is approximately < 6% but not zero
  - Uncertain outcome is approximately 6-12%.
- Note: Figures used in this guide are based on an overall in-hospital cardiac arrest survival for unselected patients of 18%. These statistics may vary between settings and may change over time.
- Note: Corrections for Video B:
  - Video time (9 mins 55 secs): 2% survival to same level of function should be 3-4%.
  - Video time (10 mins 22 secs): 4-5% survival, technically should be 6-7%.

Additional reading


   Note – readers will need to: 1) Right click on the PDF link, then 2) select Open (or Open in New Tab or Open in New Window) then 3) Select Open (or Save) to get the free copy from this link.


   NB: ACCESS BY PURCHASE ONLY


Part C:
Communication tips and examples

Pilot to 20/3/2015
Part C: Communication tips and examples

Aims

C.1 Discuss the importance of communication in the provision of medical care including CPR decision-making.

C.2 Explore how communication for quality patient care can be improved with training and practice.

C.3 Consider communication strategies and clinical tools that can be used by doctors to enhance CPR decision-making discussions.

Video summary

The video presents a broad overview of communication and provides clinicians with tools and tips to aid communication. It illustrates the application of the tools through the use of clinical scenarios.
Sample session plan
Duration: 45 minutes.
The session plan is provided as a guide. All activities can be used flexibly.

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<tr>
<td>15 mins</td>
<td><strong>Part C: Communication tips and examples</strong></td>
<td><strong>C.1.1</strong> Open the session – give an overview of the session and the video content and invite past personal experiences.</td>
<td>The doctor patient relationship is the cornerstone of good medical care. Good communication improves accuracy and efficiency of clinical practice as well as patient satisfaction. Good communication skills can be taught and learnt. Successful communication is prefaced on spending more time listening than talking. CPR decisions are contingent on the decision-making discussion; different conversations can lead to very different patient outcomes. Advance Care Planning will inform doctors of the patient’s preferences in the event of deterioration even for those who may be considered medically appropriate to receive default CPR.</td>
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<td></td>
<td>C.1 Improving communication (5 mins 13 secs.)</td>
<td><strong>C.1.2</strong> Do you use any communication tools in your clinical practice?</td>
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<td><strong>C.1.3</strong> Emphasise the group’s suggestions and recommendations about what can and will be done to improve CPR decision-making.</td>
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<td><strong>C.1.4</strong> Are there suggestions for improving communication?</td>
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<td><strong>C.1.5</strong> What have you found particularly useful in your own practice?</td>
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<td>Time</td>
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<td>25 mins</td>
<td><strong>C.2 Patient/Doctor scenarios</strong></td>
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<td></td>
<td><strong>Scenario 1</strong></td>
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<td></td>
<td>Dot and Dr Nick (2 mins 52 secs)</td>
<td><strong>C.2.1 Play scenario 1:</strong></td>
<td>The better our communication skills, the better we will care for patients.</td>
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<td></td>
<td></td>
<td>Remind the group of the acronyms for the tools</td>
<td>Dying itself is not a failure; the failure is in managing the dying process poorly.</td>
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<td></td>
<td></td>
<td>and what they stand for:</td>
<td>Discussions are dynamic and at times challenging. Like all human experiences they are imperfect and as such will at times be flawed. Relationships are established with trust and a shared understanding.</td>
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<td></td>
<td><strong>Scenario 2</strong></td>
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<td></td>
<td>Dot and Dr Eng (5 mins 29 secs)</td>
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<td></td>
<td><strong>Scenario 3</strong></td>
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<td></td>
<td>Jo and Dr Eng (4 mins 43 secs)</td>
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<td></td>
<td>Provides advice and tips for good communication and identifies tools that can aide communication including:</td>
<td><strong>C.2.2</strong></td>
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<td></td>
<td>How might the two tools be usefully applied?</td>
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<td></td>
<td><strong>C.2.3</strong></td>
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<td></td>
<td>What was done well and how could it be improved?</td>
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<td><strong>C.2.4</strong></td>
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<td></td>
<td>Do you think that Dot had a good or bad death?</td>
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<td></td>
<td><strong>C.2.5 Play scenario 2:</strong></td>
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<td></td>
<td>Do you think that this was a good death or bad death? List the reasons why:</td>
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<td></td>
<td><strong>C.2.6</strong></td>
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<td></td>
<td>What is done differently in this scenario?</td>
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<td></td>
<td><strong>C.2.7</strong></td>
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<td>What ways, other than being a fighter, might patients use to describe how they cope with their illness? Be cautious about imposing on the patient a perception about how they should cope with illness. For example, ‘fighting’ or ‘giving up’.</td>
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<td><strong>C.2.8</strong></td>
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<td><strong>C.2.9 Play scenario 3:</strong></td>
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<td>Discuss the scenario with the participants:</td>
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<td><strong>C.2.10</strong></td>
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<td>What was done well?</td>
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<td><strong>C.2.11</strong></td>
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<td>Were there aspects of the communication that you would do differently? And why?</td>
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<td><strong>Scenarios which give examples of communication practice including:</strong></td>
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<td><strong>What is done well?</strong></td>
<td>C.2.2.1 Play scenario 1:</td>
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<td>Remind the group of the acronyms for the tools</td>
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<td>and what they stand for:</td>
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<td>Discuss the scenario with the participants:</td>
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<td><strong>C.2.11</strong></td>
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<td>Were there aspects of the communication that you would do differently? And why?</td>
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<tr>
<td>Time</td>
<td>Content</td>
<td>Activity</td>
<td>Considerations</td>
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<td><strong>C.2.12</strong> How did the doctor’s communication fit with the CPR Framework?</td>
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<td><strong>C.2.13</strong> Consider how the patient’s condition might change over time – moving between discussion categories in the CPR Framework.</td>
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<td><strong>C.2.14</strong> How do you approach this and open a CPR discussion with a patient and family/carer(s)?</td>
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<tr>
<td>5 mins</td>
<td>Conclusion</td>
<td><strong>Conclusion</strong> Where to from here?</td>
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</tbody>
</table>
Essential reading

(essential reading for facilitator, recommended reading for participants)


   Note – readers will need to: 1) Right click on the PDF link, then 2) select Open (or Open in New Tab or Open in New Window) then 3) Select Open (or Save) to get the free copy from this link.


Facilitator’s tips

Provide relevant handouts to the participants:

- recommended language for communicating end-of-life concepts (Appendix 4).

Show the following Powerpoint slides:

- Dr Barbara Hayes’ Decision-Making Framework slides (Appendix 1)
- slides that support your local initiative/quality improvement initiatives.

Additional reading


   Note: To access this article, you will need to click on the Download PDF link at the top right hand side of the list of Article – Contents. It takes time to download the 22 pages and large graphic.

Appendix 1: Decision-making framework slides
CPR decisions are both technical and moral

Q1 Would the patient survive CPR?

- Technical assessment and judgement
  - NO
  - Possibly YES

Q2 What are the ethical implications of CPR/no CPR?

- Would the patient survive CPR?
  - NO
  - Possibly YES

Deliberative discussion
- Dying patient
- Medically unwell - not imminently dying

© B Hayes PhD 2011

Emanuel & Emanuel, JAMA, 2012
Discuss good dying

Medically unwell - not imminently dying

Dying patient

Discuss why CPR not being offered

Discuss why CPR may be inappropriate but accept opposite view

Uncertain outcome from CPR

Discuss to obtain informed decision

Would the patient survive CPR?

NO

Possibly YES

Very poor outcome likely from CPR

Uncertain outcome from CPR

Interpretative discussion

© B Hayes PhD 2011

Emanuel & Emanuel, JAMA, 2012
Notes:
Appendix 2: Treated cardiac arrest survival rates
Treated cardiac arrest survival rates

Treated cardiac arrest survival

~100% with coronary angiography (elective)
~60% for VF in CCU after myocardial infarct

~18% for general hospital patients*
< 5% for advanced illness - cancer, dementia etc*

*~30-50% of these survivors will have further impairment
Appendix 3: Two questions
Two questions

If you were so unwell that you could not talk about your treatment with your doctor, is there someone you would want to speak for you?

Have you discussed this with that person?
Appendix 4:
Recommended language for communicating end-of-life concepts
## Recommended language for communicating end-of-life concepts

<table>
<thead>
<tr>
<th>Poor statement</th>
<th>Possible interpretation by family</th>
<th>Better statement</th>
</tr>
</thead>
</table>
| *Do you want us to do everything?* | Do you care whether they live or die?  
Do you want us to try? | We want to work out what is the right thing to do. |
| *What do you want us to do?*                         | It is the family’s responsibility to decide medical treatment – not the patient or doctor. | What would he or she want?  
OR  
What do you think he would want us to do? |
| *We need your permission or consent to stop.*             | The family have total control of decision-making. | *I would like to discuss with you whether it is appropriate to keep on...* |
| *There is nothing more we can do.*        
**We are withdrawing treatment.** | Abandonment. | *We will do everything we can to ensure his or her last days are as comfortable and dignified as possible.* |
| *We are going to withdraw care.*       | The medical staff do not care. | *We are recommending making comfort a priority and to stop doing unpleasant things that are not helping.*  
OR  
*We are recommending continuing good care while stopping treatments that are distressing and not helpful.* |
| *Futile treatment*                  | Your relative’s life is futile/worthless. | *Overly burdensome or ineffective treatment.*  
OR  
*Treatment that is ineffective and distressing.*  
OR  
*Treatment that is worse than the disease itself.* |

Reproduced with permission from the Australian & New Zealand Intensive Care Society, 2014  
(extract from Table 5.1: Recommended language for communicating end-of-life concepts).
<table>
<thead>
<tr>
<th>Poor statement</th>
<th>Possible interpretation by family</th>
<th>Better statement</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>We can’t be certain...</em></td>
<td>Things are too uncertain for important decision-making.</td>
<td><em>We are as certain as we can be.</em>&lt;br&gt;OR&lt;br&gt;There are some things that we can’t be sure about but other things that are very clear. (i.e. focus on the most certain facts rather than on the least certain).*</td>
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<tr>
<td><em>The medical team have decided...</em></td>
<td>The family and their views do not matter at all.</td>
<td><em>We are becoming concerned that the burden of continuing this sort of treatment outweighs the benefit. I am afraid the treatment is not working.</em></td>
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<tr>
<td><em>We could do this or this or that... (the ‘shopping list’).</em></td>
<td>The family have the power and responsibility to decide. Continued treatment is being offered and advocated by the doctor.</td>
<td><em>There are lots of treatments that we could do but it is important for us to discuss what we should do.</em>&lt;br&gt;OR&lt;br&gt;<em>We could theoretically do a number of things but I should like to discuss what we should actually do.</em></td>
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<tr>
<td><em>Terminal care.</em>&lt;br&gt;OR&lt;br&gt;<em>Comfort care.</em></td>
<td>Clichés that obscure meaning.</td>
<td><em>Reset our focus to ensure his or her end is as comfortable and dignified as we can make it.</em>&lt;br&gt;OR&lt;br&gt;<em>Reconsider our goals to make comfort the priority.</em></td>
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<tr>
<td><em>There is a lot of misinformation on the internet.</em></td>
<td>Family efforts to get information are being derided.</td>
<td><em>Can you show me what you have found so we can discuss it?</em></td>
</tr>
<tr>
<td><em>This is not euthanasia.</em></td>
<td>He is talking about euthanasia and using a controversial, highly emotional, weighted word.</td>
<td><em>Permitting to die (with a specific explanation of what is proposed).</em></td>
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</tbody>
</table>

Reproduced with permission from the Australian & New Zealand Intensive Care Society, 2014 (extract from Table 5.1: Recommended language for communicating end-of-life concepts).
Recommended language for communicating end-of-life concepts

Notes:
Appendix 5: Supplementary resources
Supplementary resources

The supplementary resources listed below are provided for your interest:


Arnold R. [Internet]. [Video], Ask, tell, ask (physicians). Pittsburgh: University of Pittsburgh Medical Centre; 2013 Nov 19 [cited 2014 Nov 7]; [4 min., 03 sec]. Available from: https://www.youtube.com/watch?v=Bwq0qAFRct8


Arnold R. [Internet]. [Video], Naming emotions (physicians). Pittsburgh: University of Pittsburgh Medical Centre; 2013 Nov 19 [cited 2014 Nov 7]; [2 min., 31 sec]. Available from: https://www.youtube.com/watch?v=-PYmEaVme1Q

Arnold R. [Internet]. [Video], Surrogate decision makers (physicians). Pittsburgh: University of Pittsburgh Medical Centre; 2013 Nov 19 [cited 2014 Nov 7]; [1 min., 54 sec]. Available from: https://www.youtube.com/watch?v=lwjtpONoo3c


Video example of a good discussion based on the paper published by Stephen Workman in International Journal of Clinical Practice “Never say die? – as treatments fail doctors’ words must not”]


Video example of a bad discussion based on the paper published by Stephen Workman in International Journal of Clinical Practice “Never say die? – as treatments fail doctors’ words must not”]


Jointly published by the Tasmania Dementia Training Study Centre (TAS DTSC).

Note: Includes a link to video developed by Prof Joe Ibrahim.