The Cascade Effects: Engaging in Early Conversations to Avoid Unwanted Treatment and Over-Treatment in Life-Sustaining Treatment at or Near the End of Life

Courtenay R. Bruce, JD, MA
Assistant Professor of Medicine & Medical Ethics, Baylor College of Medicine
Director, Houston Methodist Bioethics Program

Objectives

• Define and describe cascade effects using case examples

• Describe the implications of cascade effects in primary care medicine

• Discuss three different communication and decision making techniques to help "break" cascade momentum

What is the current landscape of primary care medicine?

Shared Decision Making

Paternalism

Independent choice
What is the problem?

Cascade Effects

- **Goal of Professional Initiatives**: Curb overtreatment and unwanted treatment
- **Problem**: These initiatives fail to account for a strong motivating force behind the costs from unwanted treatment and overtreatment.\(^1\)\(^2\)

**Cascade Effects: What is it?**

**Definition**: A term in decision psychology that refers to a process that, once initiated, continues to lead to a chain of events that snowball and cannot easily be stopped until the case concludes. Participants are often unaware that it has been triggered.\(^1\)

Why should we care?

**Ethical Bases**

- **Physicians have an ethical obligation to recognize and mitigate cascade effects**:
  - **Justifications**
    - Beneficence-based obligations to protect patients from unwanted treatment or overtreatment
    - Autonomy-based obligation to empower patients to make choices aligned with their values.\(^1\)\(^2\)
Where do we see this in primary care medicine?

Missed Opportunities

Surrogate: "They’ve had to intubate her several times over the last couple of years...There were no discussions about taking care of her other than the way we were doing it now. Last time one of her doctors, a pulmonologist, told me there was no cure for pulmonary fibrosis and that it would just get progressively worse and worse and, at some point, she was going to die from it...I was hesitant about taking the tube out and saying, ‘That’s it.’ I wanted to see if she could make it without the tube. But the doctors wanted me to tell them not to put the tube back in if she failed...When we signed the durable power of attorney, [the patient] said ‘I can’t make this decision (withdrawal of life support) right here. I trust that you will make the right decision for me.’ I wasn’t comfortable then, and I am not comfortable with it now."

Missed Opportunities

"I was hesitant about taking the tube out and saying, ‘That’s it.’ I wanted to see if she could make it without the tube."

A CHANCE OF RECOVERY

"You’re...you want to give her a chance. And that’s it, that’s all. And that’s why even now you...they talk about the trach and dialysis and things and you think, well, I’m not sure if she’d want that trach thing going on, but...why not give her a shot at it, a chance...I don’t know. That’s what I struggle with, that’s the struggle."

RESPONSIBILITY FOR A LOVED ONE’S DEATH

Implications: "It’s your decision. What do you want us to do?"
So, how can we prevent these missed opportunities for early conversations?

Missed Opportunities

<table>
<thead>
<tr>
<th>UPSTREAM STRATEGIES</th>
<th>DOWNSTREAM STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning</td>
<td>Carving Out Decision Points As Case Progresses</td>
</tr>
<tr>
<td>Changing Defaults</td>
<td>End-Of-Life Conversations</td>
</tr>
<tr>
<td>Outlining Trajectories</td>
<td></td>
</tr>
</tbody>
</table>

Advance Care Planning

- Elicit preferences early and revisit often
- Document preferences
- Patient should discuss preferences with families
- Capture patient’s “narrative”3,6

Advance Care Planning

A 53-year-old woman is admitted to the hospital because of lower-extremity swelling and pain. She has a history of breast cancer, metastatic to bone and liver. She has been treated with several different courses of combination chemotherapy. There is no record of existing advance directives or evidence of any discussion about advance care planning in the medical record. The diagnostic work-up reveals an extensive deep vein thrombosis.7

Advance Care Planning

Scenario One: A resident physician, looking preoccupied, enters the room.

MD: Mrs. B, according to hospital rules, I need to discuss your code status with you. Do you wish to be a full code or a no code?

Mrs. B: (looking pensive). Oooh, I don’t know… I’ve never thought about this before… I don’t want to die. I still have relatively young children.

MD: So you want to be a full code.

Mrs. B: Yes, I guess so.

MD: OK (leaves the room).
Advance Care Planning

Scenario Two: A resident physician, looking uneasy, enters the room.
MD: Mrs. B, umm, uhhh, if anything were to happen, do you want us to do everything?
Mrs. B: I don’t understand.
MD: Well, if your heart were to stop, would you want us to use shocks to start your heart and put you on a breathing machine?
Mrs. B: Yes, I guess so....
MD: You mean you want us to jump up and down and break your ribs and put a big plastic tube down your throat and o a lot of aggressive and invasive measures only to have you die in the intensive care unit?
Mrs. B: Oh, I guess not.
MD: OK, so you want DNR status.  

<table>
<thead>
<tr>
<th>Stage</th>
<th>Goal</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish the setting</td>
<td>Ensure comfort &amp; privacy;</td>
<td>“I’d like to talk with you about possible decisions for your future.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I’d like to discuss something I discuss with all patients.”</td>
</tr>
<tr>
<td>Assess understanding</td>
<td>Ask open-ended questions</td>
<td>“Tell me about how you see your health.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“What have the doctors told you...?”</td>
</tr>
<tr>
<td>Assess expectations</td>
<td>Ask patients to consider their future</td>
<td>“Have you ever thought about how you want things to be if you were much more ill?”</td>
</tr>
<tr>
<td>Discus treatment options &amp; trajectories</td>
<td>Give information in small pieces</td>
<td>“If you were to die unexpectedly, would you want us to try to bring you back? [Discuss likelihood; what the patient will return to]”</td>
</tr>
</tbody>
</table>

Advance Care Planning

- Fails to place conversation in context of a larger discussion of goals of care.
- No education on full code, no code, and relative health condition.
- Presumes that because the patient does not want to die, she wants to be resuscitated.
- Starts the conversation by asking if she wants everything.
- Describes advanced cardiac life support in the worst way possible.

Advance Care Planning

- Change defaults in modest ways to align expectations
  - Intervention can be the non-default
- When discussing any critical care therapy, various trajectories should be outlined at the outset.
- Focus on subset of populations & trigger points, likely therapies, and likely misconceptions
  - Dementia -- feeding tube placement
  - Respiratory issues – ventilator and tracheostomy
  - Talk about time-limited trials

Triggers in Primary Care Medicine

1. Missed opportunities for advance conversations about life-sustaining treat preferences

2. Frequent Admissions
   A. Lack of support system
   B. Chronic non-cancer pain

Frequent Admissions: Lack of Support

- Many evidence-based transitions of care models developed to improve patient outcomes
- Calling on patients that are frequently admitted
- Nurse follow-ups
- Encouraging presence of someone else to be present @ meetings
Frequent Admissions: Chronic Non-cancer Pain

- Hospice Community
  - Dying in pain ethically unacceptable

- World Health Organization & JCAHO
  - Ethical mandate for pain relief as basic care has been extended from end of life to all cancer pain

- Institute of Medicine
  - Ethical mandate for pain treatment has recently been extended to chronic non-cancer pain

Recommendations

- Do not “risk shift”
- Use second opinions from addictionologist or psychologist
- Engage in frequent functional assessments
- Become familiar with risk predictors
  - Medicaid and disabled patients
  - Patients with a previous history of substance abuse
  - Patients with a history of psychiatric illness (e.g., bipolar, borderline)
- Look for problematic behaviors (e.g., focusing on opioids, escalation in use, multiple phone calls, lack of improvement)

So, what can we do to break cascades for frequent admissions?

Recommendations

- What Can You Do About It?
  - Don’t get drawn into the conflict
  - Be aware of your own emotions
  - Attempt to understand their expectations
  - Avoid cycle of diagnostic testing and referrals
  - Regard the patient as a new patient; conduct information gathering again
  - Use behavior contracts
  - Educate them on importance of therapeutic alliance

Take Home Points

- Cascade effects happen
- Triggers can be found in primary care medicine
- Cascade effects contribute to healthcare costs by not arresting overtreatment and unwanted treatment.
- Sources:
  - Missed opportunities for advance conversations about life-sustaining treatment
  - Not arresting problems associated with frequent admissions
- Theory: You can “break” cascade effects by implementing techniques upstream and downstream.
  - Evidence: Advance care planning initiatives


