Sick Enough to Die
Sick Enough to Die: 
Accommodating the possibility of death as a medical outcome

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Go home

OMG!
ICU consult

Resus

Send to surgeons

Uh-oh...
Monitoring bay; IVT; bloods; radiology

Lie over there and wait; iv access; bloods & obs

Sit over there & wait
Figure 7: Sankey diagram of patient flows in a medium-sized district general hospital
Death: the missing outcome option

• One in three adults admitted via acute take is in the last year of life.

• 80% care home residents are in their last year of life.

• People die despite our efforts to prevent it.
Life expectancy at birth 1911 - 2010, United Kingdom

We have become unfamiliar with death
Recognising dying

Number of deaths in each trajectory, out of the average 20 deaths each year per UK general practice list of 2000 patients:
- Cancer (n=5)
- Organ failure (n=6)
- Physical and cognitive frailty (n=7)
- Other (n=2)

Function:
- High
- Low

Time:
- Death
How do we plan ahead?

• We need to acknowledge disease progression

• We need to discuss diminishing returns of intervention

• We need to offer realistic plans for action when a patient feels less well

• The family needs to know the plan, and to understand it

• The plan needs to written jointly with patient/family

• The plan needs to take local services into account

• The possibility of dying, and how that will probably happen, needs to be discussed.
What’s our role in Advance Care Planning?

• Advocacy: every non-beneficial admission should be fed back to the parent medical team. Why was no plan in place?

• Action: every follow-up patient, or pre-discharge patient, for whom deterioration/acute crises can be anticipated, should be offered an opportunity to begin planning for these.

• Teamwork: GP registers of Palliative Phase Patients can only be populated if GPs are aware. Do hospital letters include a brief ACP status check?
## Advance Care Planning Progress

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>GP aware</th>
</tr>
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<tbody>
<tr>
<td>Patient is eligible for entry in GP Palliative Care Register?</td>
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<tr>
<td>Patient is aware that ACP is appropriate?</td>
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<td>Possible future crises are planned for?</td>
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<td>Emergency Health Care Plan written?</td>
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<td>Patient has ADRT?</td>
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<td>Patient has nominated LPA and registered with OPG?</td>
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<tr>
<td>Patient has agreed their current resuscitation status, which is:</td>
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<tr>
<td>For CPR</td>
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<tr>
<td>DNACPR</td>
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<tr>
<td>If DNACPR, form has been completed &amp; shared with GP &amp; OOH services</td>
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<tr>
<td>ReSPECT discussion has commenced?</td>
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<tr>
<td>ReSPECT form is up to date?</td>
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Dealing with uncertainty in Acute Medicine

- What’s the diagnosis?
- What’s making him/her so sick?
- What’s reversible?
- How reversible?
- Is there an outcome worse than death?

- What does he/she know?
- What are his/her wishes?
- How much disability is s/he prepared to tolerate?
- What’s more important to him/her, quality of life or length of survival?
Useful concepts

• Is death a possible outcome?
• What would ‘dying well’ look like?
• Parallel planning: restorative & EoL care at the same time
• Pre-sedation pause for communication

Helpful phrases

“Sick enough to die…”
“In case we can’t reverse this…”
“If s/he’s sicker by tomorrow, what might we wish we had done today?”
“What do you know about dying?”
The way humans die

• Is a recognisable process...
• ... with clear stages
• ... and predictable progression

The ‘Coma Talk’

‘Midwifing’ dying
Death happens

• We aim to prevent harm and reduce suffering: sometimes, death is our ally in this.

• Achieving a comfortable death requires medical diligence, and deserves our full attention.

• Death is a universal outcome, not a medical failure.

• Dying badly, however, is often down to medical failure.

• Every deathbed is a learning opportunity: for families, for us. Don’t waste it.
Dying.

There’s only one chance to get it right.

Let’s be proud of managing it well.