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How to respond to an ICU patient asking if she/he is going to die

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“Doctor, am I going to die?”

This question has been fielded by many clinicians working in the intensive care unit (ICU). Discussing poor prognosis and impending death with families and surrogate decision-makers is done frequently by ICU clinicians. However, it is less common to have these conversations directly with critically ill patients. A question like this can be deeply uncomfortable for clinicians. It obliges us to deliver potentially devastating news about prognosis directly to an ill patient. In the process, we must face our own apprehensions about navigating difficult conversations and perhaps even contemplate our own mortality. Talking about prognosis with patients can feel far more daunting than discussing with a family member or surrogate decision-maker. In addition to delivering serious news, clinicians often struggle with the balance between hope and truth-telling in the face of uncertainty.

Core principles of patient-centered communication can guide clinicians in their responses to these types of questions – skills such as eliciting a patient’s perspective on illness, inquiring about additional concerns, and acknowledging and exploring emotions [1]. Table 1 summarizes one possible approach.

Exploring the Patient’s Perspective and Experience

The question “Am I going to die?” may be a reflection of other unspoken hopes and fears. It can be an expression of fear of pain and physical suffering, anticipatory grief over the loss of loved ones, and existential and spiritual distress in facing both the unknown and the totality of one’s life [2]. Patients may also experience grief and regret around broken relationships and unrealized life goals. Exploring the patient’s perspective is critical to ensure that clinicians are adequately addressing these specific concerns. Questions such as “Tell me more about what you think is going on right now.” or “What fears do you have right now?” can be particularly helpful in this setting. Physicians may feel comfortable and well-

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equipped to address physical symptoms and psychological suffering, though existential and spiritual distress may be an even greater burden for patients at the end of life [3]. These types of concerns can be even more complex and challenging to address, falling outside of what many physicians consider to be their scope of practice [4]. Identifying this type of suffering should invite further exploration by clinicians and cue them to involve other potential sources of support including hospital chaplains, community clergy, and family members.

Personal experiences with loved ones at the end of life can also shape patient's expectations around prognosis and disease course. Asking questions such as "Have you known anyone who has dealt with a life-threatening illness? What was that like?" can be helpful in understanding the broader context of hopes and fears.

Other tools that can be helpful include the "Ask-Tell-Ask" framework for patient-centered communication[5] – initially asking questions to elicit a patient's understanding, but also requesting permission to share frank prognostic information before continuing the conversation. Not all patients want explicit prognostic information [6]. Asking a physician "Am I going to die?" might suggest that a patient is opening the door to a frank conversation about prognosis, but obtaining explicit permission to discuss this further can help support a sense of control for patients in a frightening and disempowering situation and can help them prepare for the information that will follow.

Discussing Prognosis

When discussing prognosis, best practices including framing prognosis in quantitative, numeric terms rather than using nonspecific language, avoiding vague language such as "uncommon" or "bad outcomes". Framing prognosis in the positive and the negative and using consistent denominators can also enhance understanding [7] (e.g. "for every 100 patients with your condition, we would expect 99 of them to die in the hospital, and only one of them to survive to be discharged").

Acknowledging and validating patient's emotions when prognosis is delivered is a critical and often neglected step [8] – making statements like "I can see that this is not what you were expecting", or "I wish that things were different."

Reassurance and Non-Abandonment

It is important to communicate to patients overt expressions of reassurance and non-abandonment, which could include explicit statements that every effort will be made to ensure comfort throughout the course of the patient's illness and assurances that the clinician will remain involved and accessible [9]. Care should be taken to not promise outcomes that may not be achievable – phrases such as "We will do everything possible to ensure your pain is well controlled" are preferable to "We will make sure you are not in pain." In the current healthcare landscape of shift work and frequent transitions in care, guaranteeing one's involvement and care until the time of death may be disingenuous, but articulating a plan for the way forward and a way to navigate transitions in care can guard against a sense of abandonment even as the care team and location may shift. Some patients are likely to

survive the ICU, but are still at high risk of death in the hospital. Involving a specialty palliative care service can help ensure continuity as patients transition out of the ICU, especially when ICU clinicians do not follow patients out of the critical care setting.

Robert Frost wrote that “Hope is not found in a way out but a way through.” Reframing hope in the face of life-limiting illness is one way that clinicians can help their patients to maximize their quality of life when time is short and partner with them in achieving a “good death”. Hope evolves over the course of life-limiting illness: a man who once hoped for cure may now hope to live two more months to see a grandchild born; a woman who once hoped to have another year of life may now hope to have a peaceful death with her loved ones at her side. As clinicians treating patients at the end of life, we seek to understand those for whom we care and in that understanding, we find our opportunity to heal when we cannot cure.

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Table 1

The 5 Ps of Discussing a Poor Prognosis

The 5 Ps	Description	Sample Questions
P erspective	Explore patient's and families' perspective on life-limiting illness	"Tell me more about what you think is going on right now." "You asked if I thought you were dying. Is that how it feels to you?" "Tell me more about that."
P rior experiences/context	Prior experiences with life-limiting illness (personal, family member, friend)	"Have you had anyone close to you go through something like this before? What do you remember about that experience?"
P ermission	Permission to share information about prognosis	"Is it all right with you if we talk more specifically about your prognosis?" "I'm afraid I have some bad news – is it ok if I share it with you now?"
P rognosis	Utilize best practices for expressing prognosis; balance truth-telling and hope	"What we know now is that your cancer is something we can't fix. And – as you've had more and more complications, it's become clearer to me that your body probably won't be able to recover from this." "If we had 100 people in your situation, I think about 1 in 100 might recover enough to leave the hospital and go to a nursing facility, which means that 99 in 100 would die from their illness."
P rovision of support	Support emotion; explicitly communicate statements of non-abandonment; discuss next steps; reframe hope	"I wish that things were different." "I can see that you're sad." "I want you to know that, no matter what happens, we are committed to caring for you." "Even though we may not have medicine to fix your kidney disease, we have so many things that we can do to care for you – to help with your nausea, your pain, and the anxiety you're feeling."