

PALLIATIVE CARE

GOALS of CARE: DNR

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OBJECTIVES

- Understand the scope of palliative care.
- Describe the differences between Hospice and palliative care.
- Examine the success rates and consequences of CPR for different patient populations.
- Look at the consequences of resuscitation.
- Learn frameworks for goals of care, code status, and family meeting discussions.

WHAT IS PALLIATIVE CARE?

A medical specialty focusing on the relief of pain, symptoms and stress of people affected by serious illness – whatever the diagnosis. The goal is to improve quality of life for patients and their families.

Appropriate at any point in illness and can be provided at the same time as “curative” or “aggressive” treatments.

**PALLIATIVE CARE IS NOT
JUST “COMFORT CARE”**

“COMFORT CARE”

- Although palliative care clinicians are experts in keeping patients comfortable at end of life there is much more that can be offered at all stages of illness.
- “Comfort care” does not include medications to sedate patients unless symptoms cannot be otherwise managed.

**PALLIATIVE CARE DOES
NOT MEAN “NO
TREATMENT”**

TREAT OR NOT?

- Palliative care is appropriate at all stages of illness, in conjunction with any other treatment.
- Although many patients may choose to limit some or all treatments our job is to explore options and what those options mean.
- Ideally, palliative care should be consulted before critical treatment decisions are needed.

**PALLIATIVE CARE IS NOT
JUST HOSPICE CARE**

HOSPICE

- Hospice is a separate agency/service.
- Hospice care is a subset of palliative care for terminally ill patients who are stopping/not pursuing aggressive or curative treatment.
- Treatment is symptom driven.
- A referral is appropriate when patients/families want to find out more information or wish to enroll in Hospice.
- Patients will be seen by Hospice RN liaison.

**PATIENTS DON'T HAVE TO
"AGREE TO" OR "BE
READY FOR" PALLIATIVE
CARE**

READY OR NOT

- A palliative care consult does not commit a patient to limitations of treatment, DNR/DNI, or any other specific plan—no single agenda.
- You decide which consultants are needed to help treat and manage your patients.
 - *Would you wait until a patient is “agreeable to cardiology” before asking for a consult for new a fib or NSTEMI? Or tell a pulmonologist his COPD patient’s family “is not ready for a consult yet”?*

CONSULT: SYMPTOM MANAGEMENT

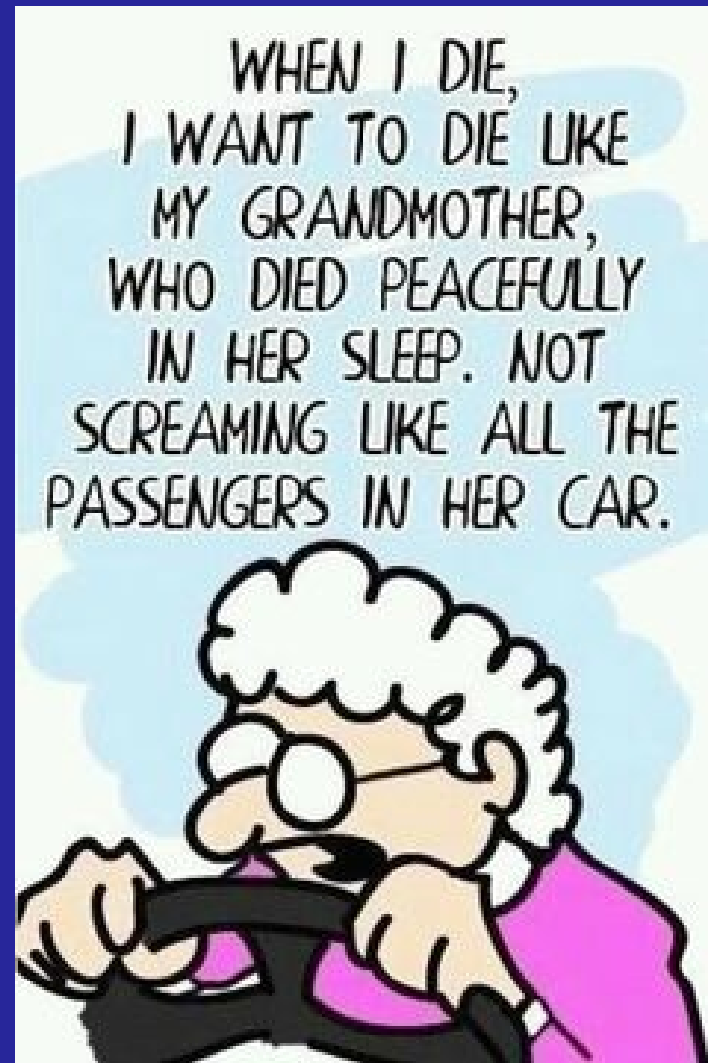


"You say it's a sharp, stabbing pain. Hmmmm ... sharp ... stabbing pain."

- Symptoms common in serious illness:
 - Pain
 - Shortness of breath
 - Nausea
 - Insomnia
 - Delirium/confusion
 - Anxiety
 - Constipation
 - Malignant obstruction
 - Depression

CONSULT: GOALS OF CARE

- Understanding choices:
 - Resuscitation/DNR
 - Intubation/DNI
 - Dialysis
 - Treat or not
 - Health care proxy
 - MOLST
 - Limits to treatment
 - What is “quality of life?”



CONSULT: NEW DIAGNOSIS



Prognosis, natural course, options

CONSULT: BIG PICTURE

Test results, treatments, consults.

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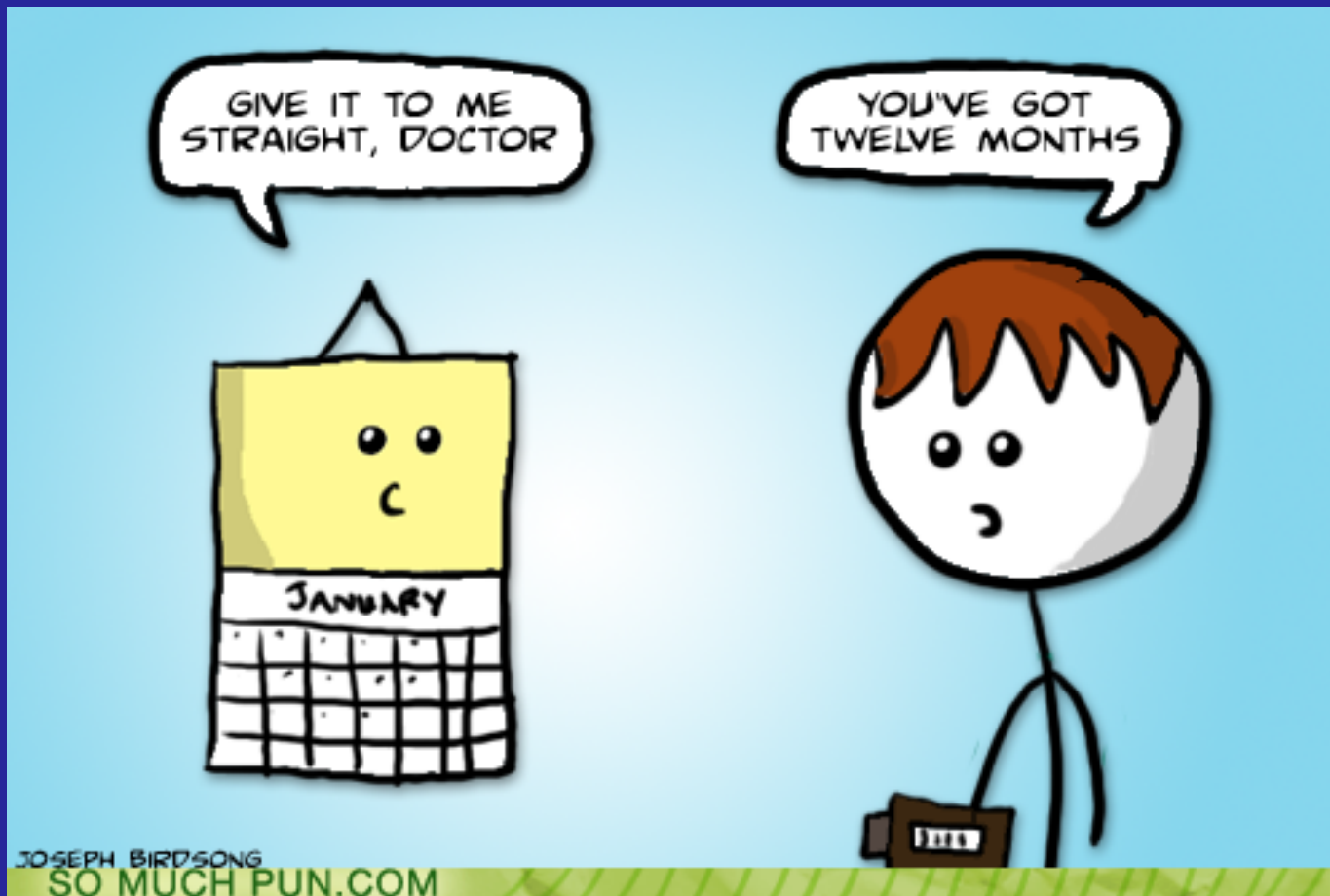
"There's no easy way I can tell you this, so I'm sending you to someone who can."

CONSULT: UNDERSTANDING ILLNESS



Typical symptoms, treatments, natural course

CONSULT: PROGNOSIS





SIPRESS

"Don't freak out—it's just a save-the-date."

CONSULT: REPEAT ADMISSIONS



Most impact via goals of care, symptom management

CONSULT

- Palliative care: Dr. Luczkiewicz or Supportive Medical Partners.
- Helpful if reasons for the consult are included:
 - Symptom management
 - Goals of care
 - Understanding illness
 - Treatment options
 - Discharge options
- Can call us to discuss case.

GOALS OF CARE: CPR



“As a close friend of mine once said, ‘One of the scariest things in the world is to look someone in the eye and tell them they are dying.’

But in my practice I do try to tell patients they are dying because I believe in my heart that it is worse when clinicians don’t.”

Pauline Chen MD, Talking Frankly at the End of Life. *NY Times*, May 28, 2009.

GOALS OF CARE: RESUSCITATION

- CPR is the only medical intervention provided in the U.S. without consent.
- Serves only to prolong the dying process in patients in the terminal phase of illness.
- Return of circulation: mean success 31%.
- Survival to discharge: mean success 15%.

CPR in patients with cancer. *American Journal of Hospice and Palliative Medicine*. Vol 24, No 3, June/July 2007, 224-229.

RESUSCITATION

- Most successful for:
 - V fib and ischemic heart disease
 - Hypothermia
 - Drug overdose
 - Acute airway obstruction
 - Primary respiratory arrest

CPR in patients with cancer. *American Journal of Hospice and Palliative Medicine*. Vol 24, No 3, June/July 2007, 224-229.

SURVIVAL TO DISCHARGE: ELDERLY ADULTS WITH CHRONIC ILLNESS

- Review of Medicare data 1994-2005 on 358,682 resuscitated patients > 66 years old.
- Survival to discharge after CPR lower for patients with chronic disease.
- Majority who survived discharged to SNF or another hospital rather than home.
- Median survival post CPR after discharge if severe chronic disease: < 6 months.

Long-term outcomes after in-hospital CPR in older adults with chronic illness. *Chest*. Nov.2014, 1214-1225. journal.publications.chest.org.

SURVIVAL TO DISCHARGE AFTER CPR: ELDERLY ADULTS WITH CHRONIC ILLNESS

	Severe	Mild/mod
CKD	18.3%	14.7%
Diabetes	17.8%	16.5%
CHF	16.7%	18.4%
COPD	14.8%	16.7%
Malignancy	11.3%	13.6%
Cirrhosis	10.1%	13.5%
None of above		17.3%

Long-term outcomes after in-hospital CPR in older adults with chronic illness. *Chest*. Nov.2014, 1214-1225. journal.publications.chest.org.

SURVIVAL TO DISCHARGE: ELDERLY ADULTS WITH CHRONIC ILLNESS

- 30-50% of in-hospital CPR recipients who survive refuse further CPR and wish they had been resuscitated.
- Lower likelihood of discharge home.
- Increased incidence of repeat hospitalizations.
- Significantly shortened lifespan after discharge.

Long-term outcomes after in-hospital CPR in older adults with chronic illness. *Chest*. Nov.2014, 1214-1225. journal.publications.chest.org.

PATIENTS WITH CANCER

- Patients and physicians overestimate survival likelihood.
- 2006 meta-analysis of 42 studies of adult patients with cancer and in-hospital cardiac arrest:
 - Survival to discharge 6.2%
 - If localized disease: 9.5%
 - If metastatic disease: 5.6%
 - If on the medical floor: 10.1%
 - If in the ICU: 2.2%

CPR in patients with cancer. *American Journal of Hospice and Palliative Medicine*. Vol 24, No 3, June/July 2007, 224-229.

CONSEQUENCES OF CPR

- 222 patients at autopsy after unsuccessful out of hospital CPR.
- 83 received manual CPR/139 automated.
 - 75.9/91.4% had injuries from CPR
 - 54.2/58.3% had sternal fractures
 - 64.6/78.8% had rib fractures
 - Median number of rib fractures 7/6

CPR-related injuries after manual or mechanical chest compressions with the LUCAS™ device: a multicentre study of victims after unsuccessful resuscitation. *Resuscitation*. Vol 85, No 12, Dec. 2014, 1708-12.

RESIDENTS AND DNR

- 18 question survey mailed to internal medicine residents in Illinois.
- 22% (n=175) response rate.
- Asked about comfort level with conversations:
 - 37% very comfortable
 - 53% somewhat comfortable
 - 10% not comfortable

Resident's practices and perceptions about do not resuscitate orders and pronouncing death:
An opportunity for clinical training. *American Journal of Hospice and Palliative Medicine*. Vol
28, No 2, 2011, 94-97.

RESIDENTS AND DNR

- Barriers identified:
 - 47%: Lack of patient/family understanding
 - 30%: Lack of time
 - 16%: Inadequate training
 - 1%: “not my job”

Resident's practices and perceptions about do not resuscitate orders and pronouncing death:
An opportunity for clinical training. *American Journal of Hospice and Palliative Medicine*. Vol
28, No 2, 2011, 94-97.

CASE

87 year old female, advanced COPD, admitted with CAP. History includes DM, PVD, CHF with EF 45%. Has had 3 admissions in last 4 months and is now back on your service again.

Has been on solu-medrol, multiple antibiotics, nebulizers, etc., x 5 days, requiring 6L O2, not improving, and having some non-sustained VT on telemetry.

CASE

You are seeing her for goals of care.

She has no advance directives on file and so is a full code, by default.

What are you concerned about?

Where do you begin?

(GOOD) OPENING QUESTIONS

- What have you been told about (your tests/ how you are doing/your illness)?
- What are you hoping we can do for you?
- What do you think is happening with your (cancer/heart/COPD/kidneys)?
- If (your mother/father/wife) could see herself now, what would (she/he) tell us to do?

(NOT SO GOOD) OPENING QUESTIONS

- Do you want to be a DNR/DNI?
- If your heart stops do you want us to push on your chest, break your ribs, and shock you?
- Do you want us to do everything?
- Do you want to try to live or do you want comfort care?

CONSENSUS STATEMENT

- 1) Timing the discussion
- 2) Framing the discussion
- 3) Distinguish between choices
- 4) Describe terms
- 5) What happens after cardiac arrest?
- 6) Modify/tailor approach
- 7) Offering a prognosis
- 8) Making a recommendation
- 9) Aim for trust and rapport

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

1) TIMING: WHEN TO DISCUSS CPR

- Hospital admission.
- High risk surgical procedure.
- Diagnosis of serious, incurable, or end-stage illness.
- Clinical deterioration with change in prognosis.
- Critical care admission.
- When limiting or stopping treatment.
- Patient feels quality of life unacceptable.
- Physician feels that aggressive treatment would be futile.

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

2) FRAMING THE DISCUSSION

- Discussion of goals, not “code status”.
- Active exploration of values.
- Current perception of illness.
- Hopes for the future.

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

3) DISTINGUISH BETWEEN CHOICES

- CPR vs. Life Sustaining Treatments (LST)
 - Mechanical ventilation
 - Pressors
 - Dialysis
 - Artificial nutrition
 - Antibiotics
 - Future hospitalizations

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

4) DESCRIBE TERMS

- Depending on knowledge and goals, describe:
 - Cardiac arrest
 - CPR
 - LST
 - Palliative care
- Start by asking about what is known.
- Not a choice between “everything” and “nothing”.

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

4) DESCRIBE: CARDIAC ARREST

“ . . . a situation in which the heart stops beating and the patient dies. This is often because the underlying disease . . . has become severe or irreversible.”

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

4) DESCRIBE: CPR

“CPR is when a team of health professionals attempts to restore the heartbeat using chest compressions, a tube down the throat to help push oxygen into the lungs, and possibly intravenous medications or an electric shock.”

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

4) DESCRIBE: PALLIATIVE CARE

- Should be described as a valid treatment plan.
- Not “doing nothing”.
- Not “keeping you comfortable”.
- Active treatment plan focusing on symptom management and quality life.

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

5) WHAT HAPPENS AFTER CPR?

- ICU transfer.
- Usually unconscious or sedated and unable to communicate.
- Very sick.
- Still likely to die.
- Underlying disease still present and often worse after resuscitation.

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

6) MODIFY/TAILORED APPROACH

- Sensitive to cultural beliefs.
- Appropriate to clinical status.
- May be affected by discrete goals.
- Tailored to education, knowledge, level of understanding.

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

7) OFFERING PROGNOSIS

Discuss likelihood of success:

“A cardiac arrest is usually a sign of severe illness, so very few people are able to survive it long enough to leave the hospital.”

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

TV AND CPR

- Correct misconceptions regarding success portrayed on TV.
- 3 TV shows 1994-95 (*Chicago Hope, Rescue 911, ER*):
 - 75% success rate
 - 67% discharge rate

Cardiopulmonary resuscitation on television – miracles and misinformation. *NEJM*. Vol 334, No. 24, 1996. 1578-1582.

8) MAKING A RECOMMENDATION

- May offer guidance and relieve some of the burden of decision making.
- If unsure regarding LST, a trial may be appropriate.

What should be say when discussing “code status” and life support with a patient? A Delphi analysis. *Journal of Palliative Medicine*. Vol 13, 2010, 185-190.

9) AIM FOR TRUST AND RAPPORT

- Avoid medical jargon.
- Check frequently for understanding.
- Allow time to process and ask questions.
- Primary goal to establish trust and initiate dialogue.
- May require time, collaboration with family members, multiple conversations.

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CPR ATTEMPTS

- CPR was originally intended for patients who were *not* in the terminal phase of illness.
- At best, resuscitation at the end stages of a terminal illness returns patients to a dying state.

Multiple cardiopulmonary resuscitation attempts in a community hospital: Evaluation of the futility assessment. *American Journal of Hospice and Palliative Medicine*, epub Feb 2014.

WHY DO WE CODE SOMEONE UNLIKELY TO BENEFIT?

- Poor estimates of likelihood of survival.
- Avoidance of discussion of prognosis.
- Desire to “offer hope” to patients.
- Fear of litigation.
- Poor communication regarding goals of care.

A population-level analysis of 5620 recipients of multiple in-hospital cardiopulmonary resuscitation attempts. *Journal of Hospital Medicine*, Vol 9, No 1, Jan 2014, 29-34.

ADDRESSING CONFLICT: “STADA”

- **SIT:** *Indicate willingness to listen.*
- **TELL:** *“Tell me about your mother?”*
- **ADMIRE:** *Thank family for coming, for caring, for sharing information.*
- **DESCRIBE:** *What’s been going on medically.*
- **ASK:** *What should happen next?
What are goals/expectations?*

When families and hospital docs disagree. *Medscape*, May 7, 2015.

http://www.medscape.com/viewarticle/844140?nlid=80988_426&src=wnl_edit_medp_fmed&uac=17983DJ&spon=34

“To be cliché, death is a part of life and it’s going to happen to all of us. I have the blessing of getting a little bit of advance notice and I am able to optimize my use of time down the home stretch.”

Randy Pausch, *The Last Lecture*, 2008.

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QUESTIONS?



"We managed to resuscitate him, but he's still very critical."