Palliative Care in the Trauma Setting

Steven R. Hall Trauma Symposium
October 4, 2018
Kevin Craig, MD, MSPH, FAAHPM
Associate Professor

Objectives

- **Define palliative care and discuss the implications to patient care and how to implement into daily practice.**
- **Discuss the appropriate use of specialty palliative care and be able to implement into clinical practice.**

Palliative Care

- Pain management
- Symptom management
- Serious illness conversations/breaking bad news/goals of care discussions
- You provide palliative care every day to your patients!

World Health Organization

- Palliative Care defined:

  an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Diagnosis

- Palliative care is about the diagnosis
  - Does the patient have a serious injury or illness?
- Concurrent and in parallel with life-sustaining trauma care.
- Cure/recovery is possible

Prognosis

- Hospice
  - Is the prognosis 6 months or less for this patient's condition or injury?
- Surprise question
  - Would you be surprised if the patient died in the next 6 months given the natural history or course of their condition or disease?
- The focus of care; instead of life-sustaining treatment. Cure/recovery not expected/unlikely.

Palliative Care

- Relief of pain and other symptoms
- Affirms life, regards death as normal process
- Neither hastens nor delays death
- Integrated psychosocial & spiritual care
- Extra support to live as well as possible
- Support for family coping/bereavement
  - World Health Organization definition
  - Who.int/cancer/palliative/definition/en/

Palliative Care Screening in Trauma

- Injury Severity
- Disability
- Previous functional status
- Surprise question
  - ACS TQIP Palliative Care Best Practice Guidelines

Potential life-threatening injuries

- Potential disabling injuries
- Frail, older, or previous serious illness
- Wouldn't be surprised if died in next year
- Examples:
  - Spinal cord injury
  - Moderate TBI (or older pt w/mild TBI)
  - Amputation
  - Shock
  - Multiples fractures in elderly patient
    - ACS TQIP Palliative Care Best Practice Guidelines

First 72 hours

- Advance care plan, goals of care discussion
- Discuss appropriate code status
- Time-limited trials
- Consider palliative care consult
  - ACS TQIP Palliative Care Best Practice Guidelines

High Risk of Inpatient Mortality

- Permanent disability or predicted functional outcome inconsistent with patient wishes?
- Frail, older patient, chronic serious illness?
- Wouldn't be surprised if patient died in next 6 months?
- Examples
  - Severe TBI (or elderly with mild TBI)
  - High spinal cord injury
  - Major hemorrhage
  - Multiple amputations
  - Older patient w/multi rib frx, spinal cord injury, surgery
    - ACS TQIP Palliative Care Best Practices Guidelines

High Risk of Inpatient Mortality

- Goals of care discussion, consider DNAR
- Consider cessation of life-sustaining therapy, initiation of comfort care
- There's always something we can do –
  - NOT "There is nothing we can do."
  - "We are going to shift the focus of our care from the injury/disease to a focus on comfort."
- Offer spiritual support, bereavement (or pre-bereavement)
- Hospice, organ donation

Frailty

- Dominant predictor of adverse outcomes in the elderly
- Among older surgical patients, frailty is an independent risk factor for major morbidity, mortality, protracted length of stay and institutional discharge.
  - Joseph B, Pandit V, Zanbar B, et al. Superiority of frailty over age in predicting outcomes among geriatric trauma patients: A prospective analysis. JAMA Surg. 2014;149(8):766-772.

All Trauma Patients

- ID health care proxy & advance directives
- Code status
- Assess/treat symptoms
- Support family
- Continue care consistent with patient wishes
  - ACS TOIP Palliative Care Best Practice Guidelines

DPOA/Proxy vs Surrogate defined

- Durable power of attorney/Proxy
  - Person designated by an individual with decisional capacity to make healthcare decisions on their behalf when they are not able

High Risk of Inpatient Mortality

- Surrogate
  - Next of kin, or person who most appropriately represents decisions that the patient would make

Health care Decisions

- Patients/DPOAs/Surrogates should be presented medical information about which they can make an informed decision
  - "What do you want us to do?" places undue burden on the patient/DPOA/surrogate without medical training or expertise
  - It is our job to present medical options using our medical expertise
  - Ex: Recommend DNAR for a patient for whom CPR would be ineffective and traumatic

Competence vs. Decisional Capacity

- Competence
  - Legal determination (a judge determines)
- Decisional Capacity
  - Determined by a physician
  - Does NOT require evaluation by a psychiatrist
  - Used by a judge to assist in competence eval

Assessing Understanding

- What is your understanding of your condition?
- What are your options in this situation?
- What is your understanding of the benefits and risks of treatment?
- What is your understanding of the risks of no treatment?

- CRAIG BARSTOW, MD; BRIAN SHAHAN, MD; and MELISSA ROBERTS, MD, Womack Army Medical Center, Fort Bragg, North Carolina. *Am Fam Physician.* 2018 Jul 1;98(1):40-46.

Assessment of understanding of situation

- Tell me what you understand about your medical condition.
- Why do you think this treatment has been recommended for you?
- Do you think this treatment is best for you? Why or why not?
- What do you think will happen if you accept this treatment, or don't accept it?
  - CRAIG BARSTOW, MD; BRIAN SHAHAN, MD; and MELISSA ROBERTS, MD, Womack Army Medical Center, Fort Bragg, North Carolina. *Am Fam Physician.* 2018 Jul 1;98(1):40-46

Determine Ability to Reason

- What factors are most important to you in deciding your treatment?
- How are you balancing the pluses and minuses of treatment?
- Do you trust your doctor? Why/why not?
- What do you think will happen to you now?

  - CRAIG BARSTOW, MD; BRIAN SHAHAN, MD; and MELISSA ROBERTS, MD, Womack Army Medical Center, Fort Bragg, North Carolina. *Am Fam Physician.* 2018 Jul 1;98(1):40-46

Palliative Care Consult

- Varies by facility/hospital
- Nurses – triage patient/family needs, explain role of palliative care
- Social workers – counseling, bereavement, discharge planning
- Chaplains – spiritual support
- Physicians – may be board certified in hospice & palliative medicine or may simply have an interest

Palliative Care Consult

- Assist with complex pain and symptom management
- Support families in difficult situations, facilitate resolution of family conflict
- Assist with identification of DPOA and completion of advance directive and DPOA documentation
- Assist with determination of decisional capacity
- Assist with disposition

Broaching Palliative Care Consult

- To best meet some of the goals we've been discussing, I'd like to have some consultants from the Palliative Care Team visit with you. They can help us in treating the symptoms you are experiencing, and they can help your family deal with all the changes brought on by this injury.
-
- Do NOT say "that there is nothing more to do" or "I have nothing more to offer."
-
- "The palliative care team will work together with us in your care," to relieve fears of abandonment.
- www.mypcnow.org/blank-to9nv FAST FACTS AND CONCEPTS #42, BROACHING THE TOPIC OF A PALLIATIVE CARE CONSULTATION WITH PATIENTS AND FAMILIES, Robert Arnold MD and David E Weissman MD Accessed 9/30/18

Comfort Care

- Death expected during inpatient stay
- Order set or protocol for symptom management
  - Opioid for pain/air hunger
    - Morphine, hydromorphone, fentanyl, oxycodone
    - Fan on the face helps with air hunger also
  - Benzodiazepine for agitation/anxiety/air hunger
    - Lorazepam, alprazolam most commonly use
  - Glycopyrrolate or hyoscyamine for secretions
    - Best management is prevention – hold IV fluids hours before planned extubation to comfort care

Comfort Care

- Discontinuation of lab, radiology, and other tests/procedures that do not contribute to comfort
- Unlimited visiting hours
- Compassionate Companions for those alone
- Pet policy

Comfort Feeding

- Assistance with oral feeding is an evidence-based approach to provide nutrition for patients with advanced dementia and feeding problems
- In the final phase of this disease, assisted feeding may focus on comfort and human interaction more than nutritional goals.

• Hanson LC, Ersek M, Gilliam R, Carey TS. Oral feeding options for people with dementia: A systematic review. J Am Geriatr Soc. 2011;59(3):463-472.

Hospice

- Prognosis < 6 months (would you be surprised?
  - benefit for which a patient qualifies with a prognosis of <6 months, in opinion of 2 physicians.
  - Interdisciplinary agency w/RN, SW, home health aides, volunteers, hospice attending MD and hospice medical director

General Inpatient Hospice

- For patients with symptoms that a hospice agency could not reasonably manage outside the hospital setting, they may be evaluated by a hospice agency for GIP.

High Risk of Inpatient Mortality

- The agency would need to be contracted with the facility to provide such services.
- The patient/family have chosen a hospice plan of care and would enroll in hospice.

Resources

- Fast Facts in Palliative Care
  - Free, online one-page evidence-based guides for everything palliative
- CAPC – Center to Advance Palliative Care
  - Modules on ICU care
- Vital Talk
  - Online resource and onsite workshops
- Serious Illness Conversation Guide
  - Free online patient-tested guide from Dana Farber

It's not easy

- The difficulty for physicians/health care providers:

  acknowledging and supporting the patient's hopes while

  recognizing the severity of the patient's disease, thus

  offering an opportunity to discuss end-of-life concerns.

Hope for the Best, and Prepare for the Worst, Ann Intern Med. Anthony L. Back, MD; Robert M. Arnold, MD; and Timothy E. Quill, MD, **4 March 2003 | Volume 138 Issue 5 | Pages 439-443**

Hope

- When … focusing exclusively on hope, [you] may miss important opportunities
  - to improve pain and symptom management
  - respond to underlying fears and concerns
  - explore life closure
  - deepen the patient–physician relationship.

Hope for the Best, and Prepare for the Worst, Ann Intern Med. Anthony L. Back, MD; Robert M. Arnold, MD; and Timothy E. Quill, MD, **4 March 2003 | Volume 138 Issue 5 | Pages 439-443**

When physicians and other healthcare professionals provide their patients with the honesty, expertise, advocacy, compassion, and commitment they would want for themselves and their families, they provide the highest quality of medical care possible.

Initiating End-of-Life Discussions With Seriously Ill Patients Addressing the "Elephant in the Room"
Timothy E. Quill, MD *JAMA.* 2000;284:2502-2507

Thank you for all you do!

- Questions?