A Primer in Palliative Care for the Stroke Team

Mohana Karlekar, MD, FACP
Medical Director Palliative
Vanderbilt University
May 15th 2013
Disclosure

- I have a disclosure
- I am on advisory board for Hospice Compassus
Ron...

- 71 year old male
- Hx of ILD, CAD, DM, HTN
- Admitted for elective cath...
Nancy...

- Ron’s mother
- Currently 96
- Has had multiple previous strokes
- Graduated from hospice
- Currently requires total care, eats some with assistance, lives at home
Ron has been working on a living will
Never had a discussion about his EOL wishes
Objectives

O Differentiate hospice and palliative care
O List, understand and apply basic advance care directives available in Tennessee
O List steps in initiating a conversation on advance care directives
Old Model of Palliative Care aka...Hospice
Hospice Certification

- 2 MDs certify life expectancy < 6 months
  - If disease runs its natural course
- Treatments are for palliation
- Do not have to be DNR
- Can revoke at any time
Services Provided

- Nursing Care
- MDT Team
  - Chaplain, SW, volunteers...
- Covers cost of medications related to terminal illness
- DME
- Bereavement Care
- Respite
Hospice Locations

- Home
  - Assisted living
  - Nursing home
- Inpatient Hospice
  - General Inpatient Status
Hospice...Levels of Care

- Residential
- Home
- Respite
- General Inpatient Care
Current Model of Palliative Care
Palliative Care

- Multidisciplinary care
- Appropriate for all patients facing serious illness
- Not just for end of life
- Appropriate to offer while hoping for cure/prolongation of life
- Available inpatient and outpatient settings
Palliative Care

- VUMC
  - Outpatient clinics at 100 Oaks
  - Inpatient Palliative Care Unit
  - Consultation Service
- Community
  - Hospices often offer palliative care services at home or at nursing homes/skilled facilities/rehabilitation centers
## Hospice Vs. Palliative Care

<table>
<thead>
<tr>
<th>Hospice</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined life expectancy</td>
<td>No defined life expectancy</td>
</tr>
<tr>
<td>Pt must forego life prolonging therapies/curative intent</td>
<td>Can continue curative/life prolonging measures</td>
</tr>
<tr>
<td>More support in the home setting (equipment, MDT)</td>
<td>Little to no support in the home</td>
</tr>
</tbody>
</table>
When should I call Palliative Care?
How do I explain this to my patient and family?
Will they think I am giving up?
Have we called them too early?
Will patients opt out of treatments that may potentially help them?
Advance Care Directives

How Do I Decide Which is Appropriate???

Living Will...
Health Care Agent...
Advance Care Plan...
POST...
“My advance directive was for you not to show up.”
Advance Care Directives

- Physician Orders
  - DNR orders
  - POST forms
- Advance Care Directives
  - Living will
  - Health Care Agent
- Court Appointed Documents
  - Conservator
Completing Advance Care Directives

- Do not need an attorney
- Do not need notary
- Must be witnessed by 2 individuals not named in the document
What If...
One has no advance care directive??

- Tennessee Surrogate Decision Maker Act
- Physician may act as surrogate decision maker
  - If no surrogate available or willing to serve
ADVANCE CARE PLAN

(Tennessee)

I ________________, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: __________________________ Phone #: __________________ Relation: __________________________

Address: __________________________________________________________

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: __________________________ Phone #: __________________ Relation: __________________________

Address: __________________________________________________________

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): □ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. □ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking “yes” below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking “no” below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life).

☐ □ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

Yes No

☐ □ Permanent Confusion: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

Yes No

☐ □ Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.

Yes No

☐ □ End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Yes No

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked “no” above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking “yes” below, I have indicated treatment I want. By marking “no” below, I have indicated treatment I do not want.

☐ □ CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

Yes No

☐ □ Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.

Yes No

☐ □ Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

Yes No

☐ □ Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient’s stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Yes No

PLEASE SIGN ON PAGE 2

Page 1 of 2
Physician Orders
for Life-Sustaining Treatment (POLST)

**A Cardiopulmonary Resuscitation (CPR):** Person has no pulse and is not breathing.
- [ ] CPR/Attempt Resuscitation
- [x] DNR/Do Not Attempt Resuscitation (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B, C and D.

**B Medical Interventions:** Person has pulse and/or is breathing.
- [ ] Comfort Measures Only
  - Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer:** EMS contact medical control to determine if transport indicated.
- [ ] Limited Additional Interventions
  - Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated. Avoid intensive care if possible.**
- [ ] Full Treatment
  - Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated. Includes intensive care.**

*Additional Orders: (e.g. diazepam, etc.)*

**C Antibiotics:**
- [ ] No antibiotics. Use other measures to relieve symptoms.
- [ ] Determine use or limitation of antibiotics when infection occurs, with comfort as goal.
- [ ] Use antibiotics if life can be prolonged.

*Additional Orders:*

**D Artificially Administered Nutrition:** Always offer food and liquids by mouth if feasible.
- [ ] No artificial nutrition by tube.
- [ ] Trial period of artificial nutrition by tube. **Goal:**
- [ ] Long-term artificial nutrition by tube.

*Additional Orders:*

**E Summary of Goals and Signatures**

<table>
<thead>
<tr>
<th>Discussed with:</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Representative</td>
<td></td>
</tr>
<tr>
<td>Durable Power of Attorney for Health Care</td>
<td></td>
</tr>
<tr>
<td>Court-Appointed Guardian</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Print Physician/ARNP/PA-C Name</th>
<th>Phone Number</th>
<th>Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)</th>
<th>Date</th>
</tr>
</thead>
</table>

Physician/ARNP/PA-C Signature (mandatory) | Date |

**SEND FORM WITH PERSON WHenever TRANSFERRED OR DISCHARGED**

Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
Initiating Conversations on Advance Care Planning
“Mind if I go in first?”
Consider...

- Assess patient family readiness
- Assess clinical relevancy
- Determine who is best able to have such a conversation

- Initiate conversations early!
- Revisit conversations over time
Decline Varies...

Source: Murray, S.A. et al

- Cancer (n=5)
- Organ failure (n=6)
- Physical and cognitive frailty (n=7)
- Other (n=2)
We do not accurately prognosticate
Physicians’ accuracy in estimating prognosis???

U. Chicago Medical Center Study: extent and determinants of error in prognostication.
Study participants:

- 343 physicians
- 468 terminally ill patients

Conclusions

- Median survival for patients 24 days
- 20% predictions were accurate (within 33% estimated survival time)
- 63% predictions were over optimistic

We may not feel comfortable disclosing true prognosis even if we know what it is...
“I’m right there in the room, and no one even acknowledges me.”

The New Yorker, 9/18/06
Steps to take...
Assess Patient’s Readiness
Discuss what "Better" means
Language that can be helpful...

- “I hope that you will recover from this stroke, but it is important that we discuss all of the possibilities....”
- “I worry that this stroke may leave you with some disabilities...”
- “I want to be sure that I know what your goals are, what you are hoping for...”
Message should...

- Focus on quality of life
- Life goals

- Language is less effective if
  - Focused on individual interventions
    - Lose the trees within the forest
How Doctors Die...It's not like the rest of us but it should be

By Ken Murray

http://zocalopublicsquare.org/thepublicsquare/2011/11/30/how-doctors-die/read/nexus/
It’s not a frequent topic of discussion, but doctors die, too. And they don’t die like the rest of us. What’s unusual about them is not how much treatment they get compared to most Americans, but how little. For all the time they spend fending off the deaths of others, they tend to be fairly serene when faced with death themselves. They know exactly what is going to happen, they know the choices, and they generally have access to any sort of medical care they could want. But they go gently.
Of course, doctors don’t want to die; they want to live. But they know enough about modern medicine to know its limits. And they know enough about death to know what all people fear most: dying in pain, and dying alone. They’ve talked about this with their families. They want to be sure, when the time comes, that no heroic measures will happen—that they will never experience, during their last moments on earth, someone breaking their ribs in an attempt to resuscitate them with CPR (that’s what happens if CPR is done right).
Back to Ron...
Questions???