Palliative Medicine in Critical Care—Not Just Hospice

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Palliative Medicine

Robin
- 45 year old female married, husband in Afghanistan. 4 children ages 17-24. Mother has been providing care. Loves to have her hair done, manicures, pedicures.
- History of severe achalasia s/p multiple GI surgeries, PEG tube with chronic tube feeds, ILD 2/2 chronic aspiration. 4 intubations in past 6 months.
- Admit 9/13/14-9/25/14 resp failure
- Palliative consulted on 9/24: Discussed fears, previous bad experience with PM, aggressive care

Truth or Myth
- Palliative Medicine is appropriate when “there is nothing more to offer”
- Palliative Medicine patients by definition are at the end of life
- Palliative Medicine = Hospice
Palliative Medicine: Definition

- Palliative care: “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.”

http://www.who.int/cancer/palliative/definition/en/

What is hospice?

- Patient, family, and many healthcare provider perception:
  - A place where people go to die

- Reality:
  - Not a place, a philosophy of care: Live as well as we can for the time that we have
  - Goal is to neither not prolong nor hasten the end of life
  - Can be provided in different settings and different levels of care

Palliative Medicine

- Symptom Management
- Define goals of care
- Hospice referrals
  - * * Excels in communication and facilitation of transitions and continuity across care settings
  - * * Most effective when initiated early in course of illness and continued throughout disease process, can be utilized at any stage of an illness
What are the differences?

Palliative Medicine | Hospice
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- Consult only | - Ongoing comprehensive care
- Do not meet hospice criteria or do not embrace hospice philosophy of care | - Terminal illness with life expectancy of < 6 months and embrace philosophy
- Can be utilized in conjunction with curative treatments and skilled care | - Typically not utilized in conjunction with Medicare skilled level of care or with disease-modifying therapies
- Business hours | - 24 hour availability
- Does not cover DME, supplies, meds, or treatments | - Covers all meds, DME, supplies, and treatments that are related to terminal prognosis

Palliative Medicine and Critical Care

Concordance of Values and Goals

Improving palliative care in intensive care units: Identifying strategies and interventions that work
Byock, MD
C/ Crit Care Med 2006 Vol. 34, No. 11

Robin

- Admit 1/3/15-1/13/15
- Intubated for acute on chronic respiratory failure
- Discussed goals, likely future complications
- Husband still out of the country
- Discussed worries about her children “blaming her for being sick”
- Aggressive care
When to Refer to Palliative Medicine:

Palliative Medicine Consultation

- Symptom Management
- Goals of Care
- Hospice Information

Palliative Medicine Referral Triggers

- Uncontrolled pain or symptom
- Poly-pharmacy
- Decline or weight loss
- Prior to PEG, dialysis, other aggressive measures in frail, elderly
- Frequent falls
- Multiple hospitalizations
- Uncertainty about prognosis
Palliative Medicine Referral Triggers, continued....

• Communication:
  – Questions regarding aggressive versus comfort care
  – Unrealistic expectations
  – Confusion among family members regarding expected clinical course and prognosis
  – Discussion of advance directives (Living wills, POST forms, Surrogates)

Common Symptoms

• Pain
• Dyspnea
• Anxiety
• Nausea
• Constipation
• Agitation
• Fatigue

Robin

• Admit 2/20/15 for acute on chronic respiratory failure, mother asked for Palliative Medicine consultation

• Palliative Medicine consulted on 2/23

• Spent time with mom, husband, children further discussing qualities of life, recovery since last hospitalization

• Remained intubated
Symptom Management

- Always looking for lowest dose to achieve symptom management to limit side effects
- Sometimes need to choose between comfort and alertness

Pain

- Depending on location, quality, severity, etc
- Neuropathic versus nociceptive?
- Mild?
- Moderate-severe
- Myths about narcotics
- Equivalent doses, conversions, side effects, huge therapeutic window
- Other adjuvant therapies: Steroids, radiation, NSAIDS, etc

Dyspnea

- Fan
- Cooler temp
- O2, nebs, inhalers, etc
- Narcotics
- Treat anxiety if present...
Anxiety

• Chronic: SSRI's
• Acute, episodic: Benzos
• Underlying symptom causing distress (pain, etc)

Nausea

• Serotonin antagonists: Zofran, Kytril, Anzemet (1st line for chemo/radiation)
• Dopamine antagonists: Haldol, compazine, reglan, benadryl
• Steroids
• Antihistamines: Benadryl, dramamine, meclazine, phenergan
• Anticholinergics: Scopolamine
• Cannabinoids: Merinol
• Anxiolytics: Benzos
• BAD-R pump

Constipation

• When using narcotics, never forget to think about a bowel regimen
  – Easier to prevent than fix
• Senna-s, titrate
• Miralax
• Lactulose, mag citrate, MOM
• Suppositories
• Enemas
Agitation

- What is causing it—think about pain in dementia patients

- Anti-psychotics, schedule if needed

Fatigue

- Think about underlying condition and treat if possible (sedating meds, infection, electrolyte imbalance, sleep disturbance, etc)

- Energy Banking, Exercise

- Drug Therapy
  - Stimulants
    - Methylphenidate
    - Modafanil
  - Steroids

Nutrition

- Artificial nutrition

- Pleasure feeding

- Agents to stimulate appetite
Goals of Care

- There is no “one right answer”
- Palliative care tries to assess:
  - What the patient/family understands medically
  - How the patient was at baseline and what are acceptable qualities of life for that particular person
  - Is it medically possible to achieve that quality of life and what we need to do to try
  - If not, what are the realistic options
- The goal we are trying to reach is more important than the procedures needed to reach it

Robin

- Withdrawal of support 2/24 and expired on 2/25 with family at her bedside

So What is Hospice?
Hospice Criteria for Admission

- Prognosis of 6 months or less if disease runs usual course (statement by attending physician and hospice physician)
- The patient chooses the philosophy of care (comfort as opposed to curative measures) and sign a statement choosing the benefit over other routine Medicare covered benefits
- Medicare Part A coverage, most private insurance plans also cover, many charity cases accepted for care by hospice organizations

So what are the barriers?

- My patient is not sick enough, I am not ready
- My patient is “not ready”, I don’t want to take away hope
- There are more things we can still do
Is my patient sick enough? How can I be sure?

• Are we accurate in our prognosticating?

• Can we tell when our patients are sick enough?


Christakis NA, Lamont EB
Department of Medicine, University of Chicago Medical Center, Chicago, IL 60637, USA.

• Only 20% (92/468) of predictions were accurate (within 33% of actual survival)

• 63% (295/468) were overly optimistic and 17% (81/468) were over pessimistic

• Doctors overestimated survival by a factor of 5.3

Implications

• Most all physicians regardless of specialty overestimate life expectancy

• The better a physician knows his patient, the more likely he will err in determining prognosis

• Experienced physicians are more likely to make accurate predictions
What do patients want from us?

- Receiving adequate pain and symptom management
- Avoiding inappropriate prolongation of dying
- Achieving a sense of control
- Relieving burden on loved ones
- Strengthening relationships with loved ones

- Research has failed to demonstrate that these patient goals are being met
Barriers continued:

• Won’t it just make my patient die quicker?
  – “Every time I send a patient to hospice, they die within days”
  – “Maybe you are waiting too long to refer them?”

Hospice Facts

• In 2010 ~42% of deaths in US under hospice care
• Median length of service 19.7 days

Palliative Medicine Consultation

• Just like any other consult (cardiology, ID, etc)
• Currently inpatient consultation service only
• Make recommendations to team
• Follow-up visits as needed