

Palliative care

Author: Leigh Vaughn

Palliative care: While many hospitals have palliative care experts available for consultation, few residents understand the value and meaning of palliative care. Palliative care is a collaborative, comprehensive, interdisciplinary approach to preventing and treating “total pain” (includes physical, psychosocial, and spiritual needs) of patients *and* families. Palliative care should be seen as extra layer of support for patients and families with serious diseases. Consults are often called to assist with symptom management, establishing goals of care (preferences for chemo, dialysis, or artificial feeds), discussing advance directives.

Hospice ≠ palliative care: Hospice = Medicare/ Medicaid benefit, available to recipients in last 6 months of lifeⁱ. It requires 2 physicians to certify a terminal diagnosis; clear criteria exists for patient eligibility. Offers patients additional support at home (more aggressive pain control), without requiring hospitalization, but hospice will not cover the cost of 24 hour home care.

Palliative care → appropriate at **any stage** of illness; **simultaneously** with all other medical treatments, including curative intent.

Goals: 1) Improve quality of life of patients living with debilitating, chronic or terminal illness 2) Prevention and relief of suffering by early identification, assessment, and treatment of distressing symptoms 3) Care delivery through combined efforts of an interdisciplinary team (MD, RN, social work, volunteers)

Patients to consider for Palliative care consultationⁱⁱ:

- Yes to "surprise question": *You (primary team considering the consult) would not be surprised if the patient died within 12 months?*
- Patients with frequent admissions, difficult-to-control physical or psychological symptoms, or with complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings)
- Chronically ill patients: decline in function, unintended decline in weight (e.g., failure to thrive)
- Patients with poor prognosis: metastatic or locally advanced incurable cancer, those who have an out-of-hospital cardiac arrest
- Patients with limited social support (e.g., family stress, chronic mental illness)
- No history of completing an advance care planning discussion/document

Symptom management: Under curative model, symptoms are clues to a diagnosis; under Palliative care model, symptoms entities in of themselves.

- **Pain:** stepwise approach using WHO ladder with appropriate and frequent titration (25-50% increase in total daily dose for mild-moderate pain and 50-100% for moderate to severe pain). Long acting pain medications, need to be scheduled, never PRN. Avoid Morphine in renal insufficiency.
- **Dyspnea:** mainstay is opioid therapy; O₂ of no palliative benefit in non-hypoxemic patientⁱⁱⁱ
- **Others:** fatigue, poor function status, sedation, nausea, vomiting, constipation, mouth discomfort, dysphagia, delirium, terminal secretions- each symptom has multiple evidence-based treatment options
- **Depression:** not part of dying; it should be actively diagnosed and treated. Choice of treatment is dictated by life expectancy. SSRI or SNRI for longer life expectancy; methylphenidate for shorter life expectancy
- **Anorexia/weight loss:** Anorexia/weight loss is not a symptom to treat, rather a manifestation of the disease. “Fixing” the loss of appetite will not improve the patients’ condition, make the patient feel better, or add to the quality of life. Medications are expensive, little benefit, weight gain is fat > muscle. PEG-limited scenarios with proven benefit; increases use of chemical or physical restrains without prolonging life. Educating families to manage their expectations helps to counteract fear of “starving” their loved one.

Leading a family meeting^{iv}: Prepare by being fully knowledgeable about the patient and his/her disease → Establish proper patient-centered setting (enough seating), free from distractions (silenced pagers, phones), with proper

introductions of all family members (including relationship to patient) → Obtain patient's & family's understanding of condition → Review medical facts, summarize, including prognosis (all without use of medical jargon) → Allow for silence → Present options; set goals of care including discussions on DNR/DNI, palliative care, and hospice → Invitation to family for second meeting → Document conversation; discuss with team or other consultants

Comfort care: If patients and families have decided to move in the direction of comfort, consider adopting "comfort care or palliative order set." Decisions must be individualized to align with goals of patient.

D/c all meds, tests that do not directly add to comfort, including antibiotics and insulin

Stop DVT prophylaxis.

Allow for liberalized diet, including salt and sugar in those previously been restricted, including those who failed a swallow study and full liquids. Encourage meals brought in by family.

Minimize vitals, alarms. Avoid Foley (unless families prefer for comfort), nasogastric tubes, IVs.

Ensure adequate treatment of pain, anxiety, and delirium.

Treat constipation actively.

Treat terminal secretions with anticholinergic (transdermal scopolamine takes 24 hrs to work; glycopyrrolate or atropine quicker onset)

Legal terms: Advanced directives - AND (allow natural death) or DNR (do not resuscitate) or DNAR (do not attempt resuscitation): states patient's wishes that resuscitative efforts will not be initiated in the event of cardiac and/or respiratory arrest. This alone is NOT synonymous with comfort care or de-escalation of current care.

Health care power of attorney: designated surrogate to make decisions only in event patient cannot for him/herself

Living will: document that specifies patient's preferences for artificial feeds, wish for dialysis, organ donation and resuscitation

Competency vs. capacity: Competency is legal terminology. Capacity is a time-specific decision; patient's ability to make a decision for him/herself can fluctuate day to day with patient's ability to make a decisions.

Clinical pearls: Palliative care seeks to prevent and relieve suffering. Palliative care is not synonymous with hospice; rather, it can be offered along with curative therapy and is beneficial early in disease to aggressively manage a wide variety of symptoms, establish goals of care, and provide an additional layer of support for patients and families by an interdisciplinary approach.

References

ⁱ Gazelle G. Understanding hospice – an underutilized option for life's final chapter. NEJM. 2007; 357: 321-324.

ⁱⁱ Weissman DE, Meier DE. Identifying patients in need of a palliative care assessment in the hospital setting: a consensus report from the Center to Advance Palliative Care. J Palliat Med. Jan 2011;14(1):17-23.

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