Palliative Care in Trauma

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Objectives

- Understand how palliative care and ethics compliment each other.
- Verbalize strategies in working with patients and families with differing points of view.
- Acknowledge that there are tough cases that have outcomes that are not what “we” want or what “they” want.

Palliative Care Consult Service

- **Interdisciplinary team –**
  - MD, APP, SW, Chaplain, Volunteers
- **Key Elements of palliative medicine**
  - **Pain and symptom assessment and management**
  - **Assessing prognosis and identifying goals of care**
  - **Patient and Family support**
  - **Discharge planning**
  - **End of life care**

Ethics consult service

- **Who**
  - Multidisciplinary
  - Advance training in medical ethics
- **What**
  - Contribute expertise in area of ethics to clinical situation
  - Broaden discussion
  - Clarify options
  - Organize suggested solutions
- **When**
  - Ethical dilemma or conflict
    - Confidentiality
    - Disclosure
    - Decision making
    - End of life issues
    - Informed consent
    - Limited options--

Binh – “peace”

25 year old male admitted after an unwitnessed bicycle crash without a helmet.

- GCS 4 on the scene, intubated
- Initial diagnoses include…
  - **Traumatic brain injury including**
    - **Subdural Hematoma with shift**
    - **Subarachnoid Hemorrhage**
    - **Temporal intraparenchymal hemorrhage**
- Hospitalization complicated by “storming” requiring IV pain medications, ventilatory support and difficulty with secretions.

Binh

- **Length of stay – 119 days**
- In first 60 days = 5 care conferences with family
  - Outcome = Continue full care - “Believe Buddha will save him”, “allow more time for a miracle”, “we get it but his parents aren’t ready to say goodbye”
- Day 62 - 6th care conference scheduled– parents refused to come.
  - Via sister in law “they are afraid of getting bad news and are worried they would be pressured to change the goals of care”
  - Parents present at hospital early in am prior to team rounds
- Day 96 – Palliative Care and Chaplain Consulted
  - Unable to make contact with family via phone or in person prior to discharge.
  - What triggered this? Should it have been sooner?

Binh

- Vietnamese man
- Family
  - Older brother – speaks “ok” English
  - Sister in law – speaks “good” English and is family contact
  - Parents – Vietnamese speaking only
  - Other siblings?
- Occupation? Hobbies? Joys?
- Spiritual practices?
- Healthcare goals/wishes?

Lessons Learned with Binh

- Families “talk with their feet”
- “Time” may move very differently for patients and families.
- Importance of asking/understanding the families cultural views and beliefs.
- Focus on how they make sense of the process and broader goals rather than focusing on clinical options (i.e.. Code status, discharge plan).
- Inform interpreters of the content of family meetings and ask for feedback regarding cultural awareness.

Dwayne

- 43 year old involved in single vehicle MVC riding motorcycle
- Sustained multiple injuries including fractures, ruptured spleen, brain injury
- When EMS arrived agonal breathing, unknown duration, intubated in field

Dwayne

- Married for 19 years
- Business man
- 2 children 17 and 13
- Parents alive
- Has insurance, including disability

Hospitalization—week 1

- ICU
- Moving extremities spontaneously, not following commands,
- Remains vent dependent

- Survival
- Adapting to acute injuries, consenting to recommended interventions
- Family gathering

Hospitalization—Week 2

Health care team	Family
• Survivable injuries • Diffuse axonal injury • Prolonged recovery • Uncertain level of recovery • Proceed with trach and peg • Anticipate will not require vent for long after trach placed	• Quality of life • Clear conversations about not wanting to live with disability dating back to high school and friend involved in MVC • Inquiring about stopping life sustaining treatments

Recovery prognosis

- Survivable
- Prolonged recovery
- Significant deficits—cognitive and physical
- Likely need 24 hour care/supervision
- 3 weeks to 3 months to begin to show level of improvement, better prognosis and 1 year to reach baseline

Plan of care following CC

- Stop life sustaining treatments including artificial food and hydration
- Transfer out of the ICU
- Initiate comfort care order set and allow a ‘natural death’

New Team--disagrees

Source of ethical tension

- Respect for autonomy (respect for person)
- Beneficence (do good)
- Non-maleficence (do no harm)
- Justice (treat the same)

Why surrogate decision making?

- Legally recognized at least since 1976 New Jersey Supreme court ruled that an adult patient's right to make decisions becomes meaningless if that right cannot be exercised by surrogates at the appropriate time. (Quinlan)

Challenges with surrogate decision making

- Stress and anxiety that surrogate is experiencing
- Difficulty in predicting outcome early stages
- Lack of knowledge of patient preferences
- Lack of reliability in predicting patient preferences
- Do not know how patient would adapt to life with major disability

Surrogate decision making

- Surrogates correctly predicted patient choice two-thirds of the time—
  - Not increased when
    - Appointed surrogate
    - Advance directive
    - Previous discussions

However surrogates predicted patient preferences better than physicians

Shalowitz 2006 arch intern med

If not prognosis, what then?

- Knowledge of the internal character and life history of the patient
- Their own observations of the patient
- Belief in the power of the support and presence
- Optimism, intuition and faith

Personal assessment of who the patient is, what the patient's life has entailed, and how their actions and understandings may impact the patient's prognostic outcome .

Limits based on best interest

- Although a decision may not be the ideal choice it has to fall within a range of societally acceptable decisions

When there are disagreements

- Clarify information—do we all have same information?
- What information are we missing?
- Provider care conference?
- What options are available?
- Manage our emotions
- Moral distress
- Conscientious objection

Supporting surrogates

- Attend to the surrogates emotions
- Help surrogate understand their contribution to decision making
- **Understand the patient as a person**
- Explore specific values and value conflicts
- Summarize the patient's values relevant to the decision
- Bridge from the patient's values to specific treatment pathways
- Give permission to follow the patient's values

Take Away

- Futility- Should we even use this word?
  - Medical treatment is ineffective or unlikely to achieve an effect that the patient could appreciate as a benefit, it has been termed futile
  - Case 1
  - Case 2
- Moving beyond medical options and understanding the patient and/or families goals and wishes
- Use your resources!
- Acknowledge your own feelings and wishes
- Self Care!!!

Questions?