End of life care issues in Trauma

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Objectives

• Describe specific end of life care needs
  – Giving bad news
  – Symptom management
• Outline family presence as palliative care
• Describe strategies to improve end of life care
• Review implications of DNR orders in trauma
• Highlight quality issues in end of life care
Palliative care

• …an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial, and spiritual problems.
Palliative Care

Life-threatening illness

Overwhelming symptoms

End of Life Care

Imminent death

Incurable chronic illness
Palliative Care

No Giving up
New cure/care model

Disease Modifying Therapy
Curative, or restorative intent

Diagnosis        Palliative Care          Hospice

Life Closure

Death & Bereavement

NHWG; Adapted from work of the Canadian Palliative Care Association & Frank Ferris, MD
Trajectory of illness

Covinsky et al. JAGS 2003
Lynn & Adamson RAND 2003
“There’s no easy way I can tell you this, so I’m sending you to someone who can.”
## Giving bad news

<table>
<thead>
<tr>
<th>Element</th>
<th>High/medium (%)</th>
<th>Low/not important (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude</td>
<td>91</td>
<td>9</td>
</tr>
<tr>
<td>Clarity</td>
<td>79</td>
<td>21</td>
</tr>
<tr>
<td>Privacy</td>
<td>76</td>
<td>24</td>
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<tr>
<td>Empathy</td>
<td>72</td>
<td>27</td>
</tr>
<tr>
<td>Answer ?s</td>
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<td>29</td>
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<tr>
<td>Time for ?s</td>
<td>63</td>
<td>37</td>
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<tr>
<td>Clergy</td>
<td>52</td>
<td>48</td>
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<tr>
<td>Location</td>
<td>56</td>
<td>44</td>
</tr>
<tr>
<td>Rank/seniority</td>
<td>46</td>
<td>54</td>
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</tbody>
</table>

Jurkovich et al, J Trauma 2000
## Giving bad news

<table>
<thead>
<tr>
<th>Element</th>
<th>Good attention (%)</th>
<th>Poor attention (%)</th>
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</thead>
<tbody>
<tr>
<td>Clarity</td>
<td>52</td>
<td>9</td>
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<tr>
<td>Answer ?s</td>
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<td>41</td>
<td>11</td>
</tr>
<tr>
<td>Time for ?s</td>
<td>39</td>
<td>11</td>
</tr>
<tr>
<td>Privacy</td>
<td>39</td>
<td>17</td>
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<tr>
<td>Location</td>
<td>35</td>
<td>19</td>
</tr>
<tr>
<td>Clergy</td>
<td>15</td>
<td>20</td>
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Jurkovich et al, J Trauma 2000
Pain management

• Percentage-based dose escalation
  – Non-opioid for mild pain
  – 25%-50% moderate pain
  – 50-100% severe pain
  – 100-200% for end-of-life palliation
• Oral breakthrough 10-20% of long-acting dose
• Incorporate as part of palliative care bundle
Pain management

• Tolerance = escalating doses
• Physical dependence = withdrawal reaction
• Psychological dependence
  – RARE
  – Compulsive use
  – Loss of control
  – Use despite harm
Grief response

• “normal” grief
  – Intense emotions
    • Histrionic
    • Stoic
    • Denial
  – Physical symptoms
  – Review relationship
  – 6-10 weeks, up to 1 year
Grief response

- Complicated grief
  - Chronic
  - Delayed
  - Exaggerated
  - Masked
Grief response

- Nature of relationship between mourner and deceased
- Mode of death
- Previous history of loss
- Personality of mourner
- Social factors
- Concurrent stressors

High risk
Grief response

- Preparation, anticipation
- Encourage communication
- Family presence at/near time of death
- Encourage reminiscence
- Normalize grief expression/behavior
Family presence

• 75% desire presence
• 96% believe they deserve option
• 94% would make the same decision
• 100% believe that everything possible done

Patient perspective
  – Comforted
  – Reminder of “person”
  – Enhanced connection with family
  – Positive impact on care
Family presence

<table>
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<tr>
<th>Process</th>
<th>Parkland (anticipatory)</th>
<th>Foote (confirmatory)</th>
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</thead>
<tbody>
<tr>
<td>Aid grieving process</td>
<td>64%</td>
<td>76%</td>
</tr>
<tr>
<td>Aid patient</td>
<td>60%</td>
<td>64%</td>
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</table>

Lower bereavement scores 3 and 9 months after resuscitation event
Family presence
Concerns

- Ability to teach
- Volatility of family
- Not equipped to deal with both patient and family
- Inadequate training of facilitators
- Change care delivered
<table>
<thead>
<tr>
<th></th>
<th>RN</th>
<th>Faculty MD</th>
<th>Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>comfortable</td>
<td>95%</td>
<td>77%</td>
<td>64%</td>
</tr>
<tr>
<td>continue</td>
<td>98%</td>
<td>93%</td>
<td>50%</td>
</tr>
</tbody>
</table>
Family presence
Important considerations

• Designated support staff
• Family assessment
• Provider decision
• Family preparation
• Post-resuscitation involvement
• Bereavement protocol
Palliative Care Bundle

- Adequate pain relief
- Adequate relief of anxiety
- Code status known
- Advance directives known
- Social services, pastoral care involved
- GI symptoms controlled
- Dyspnea relieved
- Family comfort addressed
- Goals of care known
Routine family meetings

- Diagnosis based
- Time based
  - > 3 day ICU stay
  - Initial meeting scheduled
  - 48-72 hour formal briefings
  - More often or comprehensive if needed
DNR

- DNR is a decision to forego the otherwise automatic initiation of cardiopulmonary resuscitation (CPR) in the event of a cardiac and/or respiratory arrest.

- Patient Self-Determination Act (1990) requires hospitals to document whether patients have an executed Advance Directive
Advance Directive

- Healthcare Power of Attorney
  - DNR
- Goals of care
- Living will
Case

• 82 year-old male in MVC
  – Pulse 75, blood pressure 140/70, RR 18, oxygen saturation 94% 4L, GCS 15
  – Multiple rib fractures
  – Grade III splenic injury
  – Left inferior/superior public rami fractures
  – DNR
Case (con’t)

- Rib blocks
- Epidural
- IS, cough
- Increasing respiratory distress
- Retracting, hypoxic
Discussing treatment goals

• What does the patient know?
• Review condition and prognosis
• Invite questions
• Discuss potential goals
• Invite questions, allow time to reflect
• Decide if related issues of treatment withdrawal need to be discussed
Communication phrases

• “What do you understand about your condition?”

• “Although I can’t give you an exact time, in general patients with your condition live X weeks (months) to Y weeks (months)”

• “It seems like you are having a hard time deciding between X and Y”
Statements to Avoid

• What would you like us to do if …..
• The choice is yours—we can keep doing what we are doing or stop everything
• There is nothing left to do

Why?

Shifts total burden of responsibility/guilt from the MD to the patient/family
Quality metrics

- Giving bad news
- Pain control
- Family meetings
- DNR orders
- Goals of care discussions
- Effect on mortality rate
- Bereavement survey
- Avatar, HCAHPS, audit
- Electronic template, number
- Denominator problem
- Denominator problem
- Adjusted mortality rate
Summary

- Palliative care ≠ end of life care
- Benefit to trauma patients
  - Giving bad news
  - Symptom control
- Complicated grief high risk
- Bundle/checklist approach works
- DNR ≠ do not treat (aggressively)
- Quality measures important, difficult