The Role of Palliative Care for the ICU Patient

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Critical Care Medicine and Trauma
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Disclosure Statement

Dr. Anderson has no relevant financial relationships to disclose.

Case #1: Yasmine Rezvani

68 year old woman with metastatic colon cancer. Presented to the ER with respiratory failure, intubated. Lymphangitic spread of cancer to lungs, liver failure.

- Patient: Intubated, sedated
- Nurses: Concerned about CPR
- Doctors: Plan to propose DNR, comfort care
- Family: “Need to stay positive”

Case #2: Carlo Salazar

54 year old man ICU Day #70. Diabetes since childhood, s/p renal transplant. Post-op course complicated by rejection and opportunistic infections. Requiring CVVHD. Stage 4 decubitus ulcer.

- Patient: Calling out and moaning
- Nurses: “Torturing him” for dressing changes
- Doctors: “Won’t survive”, “Poor QOL”
- Wife: “When will surgeons do skin graft?”
Objectives

1. Use cases to illustrate the role of palliative care in the ICU.
2. Describe how we can best support families in coming to an understanding of prognosis.
3. Describe methods for alleviating patient, family, and provider distress in the ICU.

Palliative Care: Goal

- Maximize quality of life for patients, families, and providers

Palliative care: Definition

- Specialized medical care for people with serious illnesses.
- Focused on providing relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.
- Goal is to improve quality of life for both the patient and the family.
- Appropriate at any age, stage of illness; provided together with curative or life-prolonging treatments.

ICU Patient, Family, Provider Needs

- High risk of poor outcomes
  - 20% of Americans die after ICU care
- High symptom burden
  - 40-80% of patients report uncontrolled symptoms
- Prevalent conflict, misunderstandings
  - 70% of providers, 40% of family members
- Psychosocial and spiritual distress
  - 1/3 families anxiety, PTSD, complicated grief
- High risk workplace
  - 1/3 of providers report PTSD

References:
- Puntillo et al Crit Care Med 2010
- Myhren et al Crit Care Med 2010
- Azoulay et al Am J Respir Crit Care Med 2009
- Abbott et al Crit Care Med 2011
- Anderson et al J Gen Intern Med 2008
- Merlani Am J Respir Crit Care Med 2011
Benefits of Palliative Care in the ICU

- Reduce ICU LOS
- Decrease duration of mechanical ventilation
- Increase family satisfaction
- Decrease family anxiety/depression
- Improve symptom assessment and patient comfort

Models of Palliative Care in the ICU

- Integrative
- Consultative
- Mixed

Integrative Model

- "Raise all boats"
- Use experience and expertise of ICU staff
- Interventions
  - Palliative order set
  - Proactive family meeting within 72hrs of admission for high-risk patients
  - PC and communication education
  - Guidelines for ventilator withdrawal

Consultative Model

- Interdisciplinary team of PC experts
  - Additional trained clinicians to support patient and family
- Triggers, case finding, or regular rounding
- Participate in, facilitate, or lead family meetings
  - Clarify goals of care
- Recommendations for symptom management
Yasmine Rezvani: First Family Visit

68 year old woman with metastatic colon cancer, lymphangitic spread, liver failure.

Family:
- "We are staying positive. She still has 4 more chemotherapy treatments left. She is a fighter. We are going to take her home."

Patient’s bedside nurse:
- Arranges meeting with physician, himself, family

Yasmine Rezvani: Family Meeting

- Physician explains almost certain death in ICU, recommends comfort focus
- Nurse expresses concern about CPR
- Family: "She's a fighter. Our dad lived 10 years longer than the doctor said he would. She told us she wanted CPR."
- Patient remains full code, providers confused and upset
- Family agrees to palliative care consult

Prognosis: Provider-Family Agreement

- Pts receiving prolonged mechanical ventilation
- MDs + surrogates estimated 1-year outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Family</th>
<th>MD</th>
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</thead>
<tbody>
<tr>
<td>Survival</td>
<td>93%</td>
<td>44%</td>
</tr>
<tr>
<td>Functional independence</td>
<td>71%</td>
<td>6%</td>
</tr>
<tr>
<td>Good QOL</td>
<td>83%</td>
<td>4%</td>
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</tbody>
</table>

- Only 25% of families reported discussing prognosis with physician

Accuracy of Provider Prognostication

- 560 medical ICU patients
- Daily survival estimates: Attendings, fellows, residents, nurses
  - "Do you think this patient will die in the hospital or survive to be discharged?"
- 50% of patients predicted to die survived to discharge
- 15% of patients who all providers predicted would die survived
Accuracy: Long-Term Outcomes

1-year outcomes of prolonged mechanical ventilation: Actual vs. Predictions

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<tr>
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<th>Family</th>
<th>MD</th>
<th>Actual</th>
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<tbody>
<tr>
<td>Survival</td>
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<td>56%</td>
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<td>4%</td>
<td>33%</td>
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- MD accuracy = 36-74%
- Family accuracy = 41-62%

Medical Prognosis ≠ Prognosis

Use of Prognostic Information from Providers

<table>
<thead>
<tr>
<th>Use of Information</th>
<th>% of Surrogates</th>
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<tbody>
<tr>
<td>Received prognostic information from physician</td>
<td>79%</td>
</tr>
<tr>
<td>Based estimate partially on information from physician</td>
<td>47%</td>
</tr>
<tr>
<td>Based estimate solely on information from physician</td>
<td>2%</td>
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Sources of Prognostic Information

- Patient’s Physical Appearance or Status
  - “He squeezed my hand”
- Optimism, Intuition, and Faith
  - “We need to stay positive”
- Patient’s History of Illness and Survival
  - “He beat cancer”
- Patient’s Intrinsic Qualities, Will to Live
  - “He’s a fighter”
- Power of Support
  - “I have to stay with her.”

Communication Conundrum

Families doubt our ability to prognosticate (88%) But they still want to hear the medical prognosis (97%)
Decisions to Limit LST Take Time

<table>
<thead>
<tr>
<th>Number of Meetings</th>
<th>Decision to Limit LST</th>
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<tbody>
<tr>
<td>1 meeting</td>
<td>63%</td>
</tr>
<tr>
<td>2 meetings</td>
<td>25%</td>
</tr>
<tr>
<td>4+ meetings*</td>
<td>5%</td>
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*Lower APACHE on admission, longer ICU LOS

- Decisions take time, but before that, coming to an understanding of prognosis takes time

Communication Best Practices

- Share prognostic information honestly
- Acknowledge uncertainty and other sources
- Share your hope that the patient does well, what you are doing to save the patient
- Discuss the patient as a person, their goals and values
- Tailor your approach to each family (member)
- Be patient – it’s a process!

Communication Skills

- Value and appreciate what the families say
- Acknowledge families’ emotions
- Listen
- Understand who the patient is as a person
- Elicit questions

- "I’m worried…"
- "I hope…"
- "I wish…"

Empathy: NURSE

Family: “It’s just so hard to see her like this.”

Doctor:
- Name: “You sound sad.”
- Understand: “I can only imagine it is.”
- Respect: “You have been so strong.”
- Support: “We’re here to help her and you.”
- Explore: “What’s the worst part of it?”
Yasmine Rezvani: Palliative Care

- Debriefed, continually supported providers
- Met with each family member
- Daughter requested we not speak in front of the patient, and that we remain positive
- Son asked for information about support for his 7 year old daughter
- After 3 days, family agreed to DNR, patient died comfortably

Take Home Points

- Families use multiple sources of prognostic information – not only that given by providers
- Coming to an understating of prognosis is a process, requires information and emotional support from providers
- Palliative care can serve an important role in supporting providers, relieving moral distress

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54 year old man ICU Day #70. Diabetes since childhood, s/p renal transplant. Post-op course complicated by rejection and opportunistic infections. Requiring CVVHD. Stage 4 decubitus ulcer.

- Patient: Calling out and moaning
- Nurses: “Torturing him” for dressing changes
- Doctors: “Won’t survive”, “Poor QOL”
- Wife: “When will surgeons do skin graft?”

- Primary nurse assessment: Delirium, pain
- Physician:
  - Haldol,
  - Opiate, especially before dressing changes
- Patient:
  - Mental status cleared, able to communicate that wanted to continue current treatment, even after understanding poor prognosis
  - Young kids at home, primary caretaker for mom
**Palliative Care: Levels of Support**

- Providers
- Family
- Patient

**Provider Self Care Best Practices**

- Get involved in improving the system
  - Involvement in quality improvement
  - Improving end of life communication practices
- Self care
  - Awareness
  - Listen to patients, families, colleagues
  - Share experiences

**UCSF ICU-Palliative Care Committee**

- Communication workshop for ICU nurses
  - Leading role in ensuring discussions of prognosis, goals of care, and palliative care
  - Increased discussions with families, physicians, in family meetings
  - Decreased distress, more connected
- Quality improvement metrics
  - Advanced directives, code status
  - Spiritual and psychosocial support
  - Multidisciplinary family meetings

**Take Home Points**

- Palliative care has an important role for many patients in the ICU, those receiving and not receiving life-sustaining therapies
  - Clear communication, decision-making
  - Symptom management
  - Family support
  - Provider support
- ICU providers provide palliative care
- Specialized teams provide additional support
Resource: IPAL-ICU
Improving Palliative care in the ICU
http://www.capc.org/ipal/ipal-icu

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