Tough Cases in Palliative Care

Kana Y. McKee, MD
Kara Bischoff, MD
Steve Pantilat, MD
Palliative Care Program
Division of Hospital Medicine
University of California, San Francisco

The Palliative Care Approach to Nausea & Vomiting
Symptoms: General Approach

• Can result from disease or its treatment
• Evaluation based on goals of care
• Base treatment on underlying mechanism if possible or to relief of symptom

Nausea and Vomiting

• Nausea
  – Unpleasant sensation of need to vomit
  – Pallor, sweats, tachycardia, diarrhea
• Common sx in patients with serious illness:
  – 40% of patients at EOL
  – 70% of patients with advanced cancer

One of the most uncomfortable symptoms!
The Triggers of Nausea & Vomiting

• 1st line of defense:  
  Our Senses

• 2nd line of defense:  
  Gut Chemo- and Mechanoreceptors

• 3rd line of defense:  
  Receptors in the brain

• 4th line of defense:  
  Memory, Learned Behavior

Krakauer E. NEJM 2005;352:817-825
Ms. A

- Ms. A is a 43 year-old woman with metastatic breast cancer.
- Her disease has progressed rapidly despite aggressive therapy.
- She recently developed right arm weakness and was found to have brain metastases in addition to bone, liver, and lung metastases.
- Ms. A presents to clinic today complaining of 2 weeks of nausea and vomiting.
Ms. A

• Medications:
  pamidronate, phenytoin, oxycodone prn, ibuprofen, omeprazole, and docusate.
• Exam notable for tachycardia, dry mucosa, normal abdominal exam, and old right arm weakness.
  — Rectal exam: no stool

Questions

• What are the potential causes of Ms. A’s nausea and vomiting?
• Is there any other workup you would like to perform?
• How would you approach a treatment plan?
History

• Onset, frequency, and severity of nausea
• Careful medication review
• Underlying medical illnesses
  – If cancer: type, location, recent treatments (chemo/XRT/surgery?)
• Associated sx(s)
  – Gastritis, reflux, constipation?

History: Look for Patterns

• Early satiety, bloating, relief of nausea w/ small-volume emesis
  ➔ Gastric stasis
• Colicky abdominal pain, large-volume bilious emesis
  ➔ Gastric obstruction
• Nausea with certain smells or the sight of food
  ➔ Activation of chemoreceptor trigger zone
• Motion-induced nausea, vertigo
  ➔ Vestibular
• Early morning nausea, headaches, impaired cognition
  ➔ Increased ICP
• Anxiety or emotionally induced nausea
  ➔ Cortical
Evaluation

- Oral inspection
- Abdominal exam
- Rectal exam (r/o impaction)
- Labs: lytes, BUN, Cr, LFTs, Ca++, drug levels
- Imaging
  - KUB or CT abd/pelvis
  - CT brain
Ms. A: Differential Diagnosis

- Medications
  - pamidronate, oxycodone, ibuprofen, phenytoin
- Metastases
  - brain, liver, peritoneum
- Constipation
- Metabolic
  - hyponatremia, uremia, hypercalcemia, liver failure

Nausea/Vomiting Treatment: 2 Approaches

1. Mechanism-based
   - Determine likely etiology and target first medication to the cause
     - 80-90% effective in the palliative care population
   - Elegant
   - Assesses all causes systematically

2. Empiric
   - Typically multiple etiologies
   - Start with a 5HT3 antagonist (ondansetron) or dopamine antagonist (eg haloperidol) regardless of underlying etiology

Wood et al. JAMA 2007;298:1196-1207
Davis and Hallerberg J Pain Sym Man 2010;39:756-67
Mechanism-Based Approach to Initial Management of N/V

1. Thorough evaluation to narrow DDx
2. Determine underlying pathway and neuroreceptor
3. Choose antiemetic targeted against neuroreceptor
4. Initiate antiemetic around-the-clock
5. Titrate antiemetic to max recommended dose if nausea persists
6. Add additional antiemetic aimed at different neurotransmitter if nausea persists
7. Evaluate for additional reversible mechanisms & treat

Mechanisms of Nausea and Vomiting

- Higher cortical structures
- Chemoreceptor trigger zone (4th ventricle)
  - D2, (SHT3), NK1
- Vestibular system
  - Achm, H1
- Vomiting Center: (Medulla)
  - Achm, H1, (SHT3)
- Mechanical stretch, GI irritation
  - SHT3 in GI tract, mechanoreceptors, vagal, splanchnic and glossopharyngeal nerves
Chemoreceptor Trigger Zone

- Most common cause of N/V near end of life
- Mediators
  - Dopamine (D2), serotonin (5HT3), NK1
- Etiologies
  - Drugs: opioids, digoxin, antibiotics, NSAIDS
  - Metabolic: hypercalcemia, hyponatremia, uremia, hepatic failure
  - Bacterial toxins

Chemoreceptor Trigger Zone

**Treatment**

- Relieve underlying etiology
  - D/C meds, lower dose, PPI if can’t stop NSAID
  - Correct electrolytes

- Treatment:
  - Ondansetron (5HT3)
  - Haloperidol (potent D2 antagonist at CTZ)
  - Prochlorperazine (D2, H1, Achm, 5HT3)
  - Olanzapine (multiple Ds and 5HTs, Achm)
Ms. A: Differential Diagnosis

• Medications
  – pamidronate, oxycodone, ibuprofen, phenytoin
• Metastases
  – brain, liver, peritoneum
• Constipation
• Metabolic
  – hyponatremia, uremia, hypercalcemia, liver failure

Mechanisms of Nausea and Vomiting

Higher cortical structures

Chemoreceptor trigger zone
(4th ventricle)
D2, (5HT3), NK1

Vomiting Center:
(Medulla)
Achm, H1, (5HT3)

N/V

Vestibular system
Achm, H1

Mechanical stretch, GI irritation
5HT3 in GI tract, mechanoreceptors,
vagal, splanchnic and glossopharyngeal nerves
Mechanical Stretch, GI Irritation

• Mediators
  – 5HT3 in GI tract, GI mechanoreceptors, Vagus nerve (AchM, histamine)

• Etiologies
  – Mucosal irritation (e.g. candidiasis, XRT)
  – External irritation (e.g. peritoneal carcinomatosis)
  – GI stretch (e.g. constipation, obstruction)
  – Viscus enlargement (e.g. liver, kidney)
  – Dysmotility (gastric, bowel infiltration, opioids, anticholinergics)

Mechanical Stretch, GI Irritation: Treatment

• Relieve underlying cause
  – Treat constipation, gastroparesis
  – Antibiotics for candidiasis
  – PPI for gastritis
• Ondansetron (5HT3)
  – Note: avoid if patient constipated
• Promethazine (Anticholinergic/antimuscarinic)
• Metoclopramide (for gastroparesis, partial bowel obstruction)
• Olanzapine (multiple Ds and 5HTs, Achm)
Mechanisms of Nausea and Vomiting

Higher cortical structures

Chemoreceptor trigger zone
(4th ventricle)
D2, 5HT3, NK1

Vomiting Center:
(Medulla)
Achm, H1, 5HT2

Mechanical stretch, GI irritation
5HT3 in GI tract, mechanoreceptors,
vagal, splanchnic and glossopharyngeal nerves

Higher cortical structures

• Direct stimulation of vomiting center
• Etiologies:
  – Tumor, mets, bleed, edema, infection
  – Mind: emotions, memory
• Treatment:
  – Dexamethasone 4-16 mg po/iv per day, divide 1-2 times/day
  – Benzodiazepines for anticipatory nausea, anxiety-induced nausea, and refractory nausea
    • Note: No evidence for BZD as sole agent for tx of nausea.
  – Dietary changes for taste and smell
Mechanisms of Nausea and Vomiting

Chemoreceptor trigger zone
(4th ventricle)
D2, 5HT3, NK1

Vomiting Center:
(Medulla)
Achm, H1, 5HT2

Higher cortical structures

Mechanical stretch, GI irritation
5HT3 in GI tract, mechanoreceptors, vagal, splanchnic and glossopharyngeal nerves

Vestibular System

• Mediators: Histamine and Acetylcholine
• Associated with movement
• Etiology:
  – Tumor, mets at base of skull
  – Middle ear disease
  – Stroke
• Treatment:
  – Diphenhydramine
  – Scopolamine patch 1.5mg q3d
  – Promethazine
  – Meclizine
Mechanism-Based Approach to Initial Management of N/V

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Intractable Nausea and Vomiting

• Combine antiemetics with different mechanisms of action

• Start with ATC dosing

• Add steroids (dexamethasone)
  – Unclear mechanism of action
  – Less impressive as single agents but quite effective in combination with other agents, such as Ondansetron
  – Good for acute and delayed emesis
Intractable Nausea and Vomiting

• Nontraditional antiemetics:
  – Mirtazapine
    • 5HT3 antagonist. 15-45mg po at bedtime.
    • Can help w/ n/v, insomnia, appetite, mood
  – Olanzapine
    • D2, 5HT3, AchM
    • Can help w/ n/v, delirium, anxiety, insomnia, and cachexia

• Consider bowel obstruction

Nausea and Vomiting

Other Considerations

• Medications
  – Route of administration
  – Frequency of dosing, ATC vs PRN
  – Anticipate nausea triggers and premedicate w/ antiemetic.
  – Cost

• Food
  – Small, frequent, attractive meals
  – Consider odor, fat content
  – Cool carbonated beverages
  – Take medications, except antiemetics, after meals

• Acupuncture, Acupressure
• Imagery
Nausea and Vomiting
Other Considerations

• Tetrahydrocannabinol (THC)
  – The active ingredient of marijuana
  • Marketed as dronabinol
  • More effective than placebo in preventing chemotx-induced n/v
  • Mediated by cannabinoid receptors at Vomiting Center in medulla

– Side effects:
  • Drowsiness, orthostatic hypotension, tachycardia, dry mouth
  • Anxiety, depression, visual hallucinations, and manic psychosis may occurs, especially in older individuals and patients who have never used marijuana.
Malignant Bowel Obstruction

A Case

• A 57-year-old woman with a 1-year history of stage IV ovarian cancer (s/p debulking surgery, carbo + paclitaxel)
  – Was doing generally well, still able to work part-time but with progressive fatigue and gradually increasing abd distention. Eating fairly well.
  – Called her outpt pall care MD with 2 days of nausea and bilious emesis (~5 episodes/day).
  – Unable to tolerate any POs.
  – Last BM was 3 days prior and normal. No hx constipation.
Definition

- Bowel obstruction beyond the ligament of Treitz, in the setting of a diagnosis of intraabdominal cancer with incurable disease, or a diagnosis of non-intraabdominal primary cancer with clear intraperitoneal disease.


The Problem

- Common in ovarian and GI cancers
  - 20-50% of pts with ovarian cancer will develop MBO
  - 10-28% of pts with CRC will develop MBO
- Also occurs when cancers metastasize to the abdomen (i.e. breast, melanoma, lung, bladder)
- Accounts for 15% of admits to pall care units
- Life expectancy is 80 days at presentation

Krouse RS. The international conference on malignant bowel obstruction: a meeting of the minds to advance palliative care Research. JPSM. 2007.
Survival

Fig. 1. Kaplan-Meier curve of overall patient survival.


Predictors of Survival

• Most significant factor affecting survival is **ECOG performance status** preceding obstruction.
  – Median survival:
    • ECOG 0-1: 222 days
    • ECOG 2: 63 days
    • ECOG 3-4: 27 days

• Other predictors of poor prognosis: low albumin, ascites, heavy tumor burden, aggressive disease, extensive previous treatment.

Pathogenesis

• **Mechanical obstruction**
  – *Intra-luminal occlusion*
  – *Extrinsic occlusion* from extra-luminal primary tumor or met, mesenteric and/or omental mets, adhesions, post-radiation fibrosis
  – *Intramural disease* including intestinal linitis plastica

• **Functional obstruction**
  – *Motility disorders* from tumor infiltration of the enteric nervous system, malignant involvement of the celiac plexus, paraneoplastic neuropathy (particularly in lung ca)

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Presentation

- **Nausea**: Mechanoreceptors are triggered by local distention $\rightarrow$ vagus and splanchnic nerves to CTZ
- **Vomiting**: Following nausea or without preceding sx(s)
- **Abd pain**: Periumbilical, colicky. Localized pain worse with movement or palpation suggests peritonitis.
- **Obstipation**: Lack of flatus or stool suggests complete obstruction. Can also have overflow incontinence with liquefaction of stool by intestinal bacteria.
- **Abdominal distension**: From bowel distension +/- ascites.

A Case

- A 57yo W with stage IV ovarian cancer and suspected MBO
  - What would you advise our patient?
  - What work-up would you suggest?
Work-Up

• Very context dependent

• **CT scan** is the gold standard for diagnosis
  – Can identify presence and degree of obstruction
  – Can determining the pathological process(es)
    • 93% Se, 100% Sp, 94% accuracy in determining cause
    • *Carcinomatosis may be missed.* Accuracy for implants <0.5cm is 20%.


A Case

• A 57yo W with stage IV ovarian cancer and suspected MBO
  – She was instructed to go to the ED.
  – CT scan shows multiple sites of partial narrowing of the intestine, most prominently in the proximal jejunum, with air-fluid levels.
  – Ascites. Peritoneal studding?
STEP 1: Consider Surgical Approaches

1. Intestinal resection or bypass
2. Tumor debulking
3. Diversion (i.e. colostomy)
4. Lysis of adhesions
Surgical Outcomes for Gyn Cancers

- Review of case series of surgery for MBO in gyn ca
  - Sx improvement in 100% of pts w successful procedures; persisted at 90 days in 64% of pts
  - 30-day operative mortality 9-40%
  - Complication rate 9-90%: fistula, dehiscence, infections, bleeding, thrombosis

- Features a/w low likelihood of benefit from surgery
  - Diffuse carcinomatosis
  - Large-volume ascites (perioperative mortality 41%)
  - Palpable intra-abdominal mass(es)

- Neither site of obstruction nor type of operation influenced outcomes


Contraindications to Surgery

A. Patient factors
   - Limited life expectancy (<2 mo)
   - Poor nutritional or performance status (ECOG≥2)
   - Concurrent illness and comorbidities
   - Patient preference

B. Disease factors
   - Diffuse intraabdominal tumors, carcinomatosis, multiple obstruction sites
   - Large volume ascites
   - Previous laparotomy with adhesions

Surgical Outcomes in Carcinomatosis

“MBO from generalized carcinomatosis is a distinct entity that responds poorly, or not at all, to surgical intervention.”

- Blockage of bowel at multiple levels, +/- motility d/o due to bowel wall infiltration or compromise of nerves responsible for peristalsis.
- Usually partial, intermittent, do not strangulate bowel.
- Sxs may resolve temporarily with NG decompression, but will recur.
- When pts go to OR results are generally poor:
  - High 30-day operative mortality
  - Frequent complications
  - Most will re-obstruct


Surgery for Carcinomatosis?

Palliative Surgery for Malignant Bowel Obstruction From Carcinomatosis
A Systematic Review

Temah J. Paul Olson, MD, Carolyn Pinkerton, MD, Karen J. Brasel, MD, MPH, Margaret L. Schwarze, MD, MPP

Supplemental content at jama surgery.com
Surgery for Carcinomatosis?

- Literature review of 17 observational studies (1982-2012), 868 pts, surgery for MBO with carcinomatosis
- Surgery improved sx (32-100%), allowed POs (45-75%), d/c home (34-87%)
- Duration of symptom relief after surgery was short (<60 days)
- 30-d post-op mortality high (6%-32%), complications common (7%-44%)
  - Reobstructions (6%-47%), readmit (38%-74%), reoperations (2%-15%)
- Survival was limited (median 26-273 days), hospitalization for surgery consumed a substantial portion of patients’ remaining life (11%-61%)
- Validated quality-of-life metrics were not reported by any studies

Authors’ conclusions: “Surgeons can inform patients about the probability of real symptomatic relief with surgery for at least a short time. However, these potential benefits should be presented along with the high probability of serious complications, including the high rate of reobstruction and the substantial duration of hospitalization associated with surgery.”


Comparative Studies

- 5 observational studies compared pall surg v. nonsurg tx for MBO w carcinomatosis
- In 4 of 5 studies, surgery resulted in better sx & ability to tolerate POs
- 4 of 5 studies reported improved survival with surgery
  - Median survival after surgery 109-191 days vs 33-78 days for nonoperative tx.
- BUT... Pts with poor prognostic features who underwent surgery had a median survival comparable to that of similar pts who received only PEG-tubes.

Surgical Outcomes in CRC

- Retrospective review of 47 pts with CRC treated surgically for MBO at a single tertiary cancer center.
- Median survival was 3.5 mo. 80% could tolerate POs.
- They found 3 distinct groups:
  - 15% died within 30-days of the operation (2 comps, 5 prog disease)
  - 51% had an intermediate course, survived an average of 2.69 mo
  - 34% received palliative chemo and survived an average of 10.3 mo (range 21 days to 32.8 mo)
- Increasing age and short time between initial resection and presentation with MBO were negative predictive factors.


STEP 2: Consider Stenting

- Self-expanding metallic stents (SEMS) for localized esophageal, gastric outlet, duodenal and large-bowel obstructions
  - Alternative or bridge to surgery
- 2007 systematic review of stenting for LBO:
  - Technical success 96%, clinical success 92%, mortality <1%
  - Early comps: Perf 4.5%, stent migration 11%, reobstruction 12%
  - Late comps: Migration, obstruction, perf, tenesmus in up to 50%
- More distal obstructions and shorter length of obstruction have better long-term outcomes
- Greater success with stenting primary CRC; less success for obstruction caused by extrinsic compression

Comparative Studies:
Stenting v. Surgery for Colorectal Obstruction

• *Data is observational!*
• Both surgery and stenting leads to relief of sx, but pts with stents experienced greater QoL.
• Decreased cost and length of hospital stay.
• As a bridge to surgery, the successful placement of SEMS for MBO has been shown to allow for more 1-stage procedures.


This Decision Need Not be Rushed

When the Sun Can Set on an Unoperated Bowel Obstruction: Management of Malignant Bowel Obstruction

Robert S Krouse, MD, Laurence E McCahill, MD, FACS, Alexandra M Eason, MD,
Geoffrey P Dunn, MD, FACS

“Malignant bowel obstruction is rarely an emergency and strangulation is uncommon. Therefore, there is time to monitor the clinical situation, undertake appropriate radiological investigations, provide symptom control, and make a decision jointly with the patient and family.”

STEP 3: Medical Management

A. Partial obstruction:
   – Goal is to normalize gut function

B. Complete or refractory obstruction:
   – Goal is to rest the bowel

Medical Management

A. Partial obstruction:
   – NPO with judicious fluids +/- NG tube to suction
   – Analgesia
   – Antiemetics
     • Prokinetics (i.e. metoclopramide, dulcolax PR, senna)
     • Serotoninergic antagonists (i.e. ondansetron)
       – Elevated serotonin metabolites in pts with MBO
     • Dopaminergic antagonists (i.e. haloperidol)
     • Combination of scheduled meds may be needed

Medical Management

A. Partial obstruction:
   – NPO with judicious fluids +/- NG tube to suction
   – Analgesia
   – Antiemetics

   • Anticholinergics
     • i.e. Scopolamine, glycopyrolate
     • Reduce secretions, decrease motility
     • Scopolamine is inferior to octreotide but cheaper, not SC/IV, and can be used in conjunction

Medical Management

A. Partial obstruction:
   - NPO with judicious fluids +/- NG tube to suction
   - Analgesia
   - Antiemetics
   - Anticholinergics
   - **Steroids**
     - Antiemetic and antiinflammatory effect → can decrease tumor swelling to relieve obstruction
     - Cochrane review: Trend towards resolution (NNT 6)
     - Due to SEs, more appropriate for short term use?


Medical Management

A. Partial obstruction:
   - NPO with judicious fluids +/- NG tube to suction
   - Analgesia
   - Antiemetics
   - Anticholinergics
   - Steroids
   - **Goal is to get the NG tube out!**
     - May gradually advance diet once sx improve

Question for Steve and others: Would you do all of this for a partial obstruction? Or hold octreotide, steroids, other stuff for complete obstruction? All the literature seems to suggest throwing the kitchen sink at obstructions up front, but in my experience we’ve more often added things sequentially.

Office 2004 Test Drive User, 3/12/2014
Medical Management

B. Complete obstruction:
- NPO with judicious fluids +/- NG tube to suction
- Analgesia
- Antiemetics \(\rightarrow\) *Stop prokinetics*
- Anticholinergics
- Steroids
- *Goal is still to get the NG out!*

\(\rightarrow\) *Consider venting*


Venting Procedures

- **Initial guidelines:** Contraindicated if ascites, carcinomatosis, portal HTN, tumor infiltration of the stomach.
- Retrospect review of 53 pts, PEG for MBO a/w ovarian cancer
  - 74.5% had ascites, 80.3% had carcinomatosis.
  - All pts had successful tube placement. No mortality a/w placement.
  - 28% had complications (obstruction, leakage, infections, replacement)
  - 93% had relief of sx; 91% tolerated POs.
  - 71.7% d/c’d home. 47% readmitted (60% for tube complications).
  - Median survival 46 days (33 days if no chemo, 169 days w chemo).
- Patients are then able to drink!

A Role for Ranitidine?

- Given that reduction of GI secretions is a goal of med mgmt of MBO, rationale for H2 blockers
- Meta-analysis of effects of ranitidine and PPIs on volume of gastric secretions prior to surgery:
  - Volume of gastric fluid in placebo arm: 0.54 ml/kg.
  - Volume of gastric fluid in pts on PPI: 0.410 ml/kg
  - Volume of gastric fluid in pts on ranitidine: 0.16 ml/kg.
- No studies yet to show clinical effectiveness of H2 blockers or PPI in MBO


TPN

- TPN should be considered carefully; routine use should be avoided.
- Risks, inconvenience, cost. Sx exacerbation?
- Survival benefit in carefully selected patients
  - Suggested that TPN should be considered only if KPS >~50 and life expectancy >2 mo so that death from malnutrition is more likely than death due to other processes.
  - May be the same pts who are candidates for chemo.

Further Research

- Randomized controlled trials

- Endpoints that value patients’ and families’ perspectives
  - Condition-related outcomes: Survival, sx control, ability to eat, hospital days, readmissions.
  - Patient-related outcomes: Ability to return home, QoL.
  - Family-related outcomes: Caregiver burden, emotional distress, and family’s perception of QoL.


Working with the Family that Wants “Everything Done”
“Do Everything” Cases

• Think about patients you have cared for where the family asked you to “do everything”
  – What was the clinical situation?
  – What was the setting?
  – What about the case was difficult or challenging?

Mrs. M

• Mrs. M is a 73 year old woman s/p renal transplant 12 weeks ago admitted 6 weeks ago with MRSA pneumonia. She developed multisystem organ failure despite antibiotics and supportive care. She is intubated on high FiO2, hypotensive on 2 pressors with necrosis and gangrene of her toes and fingers, on CVVH for renal failure, has a large, deep sacral decubitus ulcer. She is confused and visibly in pain. Opioids make her comfortable and less responsive.
Mrs. M

Mrs. M’s family is very devoted and someone is always at her bedside. They insist that she responds to them and says she wants to live. Mrs. M’s family speaks English but Mrs. M speaks only Arabic. In-person interpreters say that Mrs. M cannot answer questions coherently. Mrs. M’s children understand that she is very sick and that all the doctors and nurses think she will die. They repeatedly state they want “everything done” with a goal of taking their mother home.

Challenges: Provider Perspective

- Prognostic uncertainty
- Information from many providers
- Patient suffering
- Distress of staff- nurses, RT
- Time consuming
- Poor utilization of resources
- Feeling of lack of efficacy
Prognostic Uncertainty

• The only certainty
• Many mortality prediction models exist
  – APACHE
  – Mortality probability model: MRM
  – Simplified Acute Physiology Score: SAPS3
  – eprognosis.org
  – Karnofsky Performance Status: KPS
  – Palliative Performance Scale: PPS

Vincent and Moreno Critical Care 2010;14:207

Prognostic Uncertainty

• What level of certainty is needed for decision making?
  – 0%
  – 100%
  – 99.9%
  – 1 in a million
• What about functional outcomes?
• Can people understand prognostic information?
Prognosis by Age

Challenges: Family Perspective

- Unrealistic expectations
- Lack of knowledge of patient wishes
- Multiple decision makers
- “She wants to live”
- Cultural issues
- Awaiting miracles
Understanding “Miracles”

- By definition, miracles are:
  - Rare
  - Not brought about by medical professionals
- Meaning of miracles:
  - Divine intervention bringing about recovery
  - “Don’t give up on him”
  - “I’m not giving up on my loved one”
  - “I’m not ready for her to die”
  - “I’m not giving up on God”
  - “I don’t believe what you say about prognosis”

Responding to Hope for a Miracle

- Probe the meaning of miracle
  - “What do you mean by miracle?”
  - “What would that look like?”
- Explain
  - “I, too, hope for that miracle”
  - “As a physician I have to practice medicine as we understand it”
- Avoid religious debates

Sulmasy JAMA 2006;296:1385-1392
DeLisser Chest 2009;135;1643-1647
Widera et al. JPSM 2011;42:119-25
“Do Everything”

• Request can have many meanings
  – “Do everything you possibly can to keep our loved one alive at all costs”
  – “Don’t abandon her/us”
  – “She is scared to die”
  – “I can’t bear the thought of him dying”
  – “I don’t believe that she’s really dying”


Responding to “Do Everything”

• “Everything” has different meanings to families and medical staff
• Ask a better question
  – “How were you hoping we could help?”
• Try to establish a philosophy of treatment
  – Everything that will prolong life, but not if it increases suffering
  – Everything that will prolong life, even if it increases suffering

Pantilat *JAMA* 2009;301:1279-81
When Families Want “Everything Done”

- Ensure good information from all clinicians
  - Provide consistent, clear information
- Focus on the patient
  - Avoid detailed discussions of medical management
- Demonstrate caring, concern, and understanding
  - Listen
  - Stay engaged and collaborative

Expressing Dismal Prognosis

- Be direct, but only as direct as you can
  - “Your mother is dying and unfortunately nothing we can do will change that.”
  - “The question is not whether your mother will die, but how, when, and where.”
  - “I am worried that even with everything we can do, it will only prolong her suffering.”
  - “As amazing as modern medicine is, unfortunately it still has its limitations.”
### Invoking Futility

- Futility is rare and of little use at the bedside
- Alienates the family
- Seek constructive solutions
  - Focus on what you can do
  - Most conflicts resolve within days
  - Write Unilateral DNR order only if absolutely necessary


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### When Families Still Want “Everything Done” Despite Your Best Efforts

- Focus on harm reduction and collaboration
  - Stop regularly discussing limiting treatment
  - Acknowledge and adhere to the patient’s treatment philosophy
  - Address the medical team’s discomfort
  - Use clinical judgment to limit treatments that do not support the patient’s goals
- Ensure the best possible communication
  - Improves outcomes for patients and families

The VALUE of Good Communication

- 22 ICUs in France
- 108 family members randomly assigned
- VALUE communication and brochure about bereavement vs usual care
- All patients had life-sustaining interventions withdrawn
  - 90% had mechanical ventilation
  - 72% had vasopressors
  - 76% sedated

Lautrette A et al. NEJM 2007;356:469-78

VALUE Intervention

- Value and appreciate what the family members said
- Acknowledge the family members’ emotions
- Listen
- Ask questions that would allow the caregiver to understand who the patient was as a person
- Elicit questions from the family members
VALUE Intervention Results

• Longer family conferences
  – 30 min vs 20 min
• Family talked more: 14 min vs 5 min
  – Physician talked the same
• Lower prevalence of PTSD-like symptoms, anxiety, and depression in family members 3 months later

Family Meeting: Set up

• Arrange for a quiet, private place to meet
• Invite all invested parties
  – Patient, family, especially surrogate decision maker
  – Care team members: MDs, RNs, SWs, RTs, Chaplain
• Determine beforehand:
  – Goals of the meeting
  – Who will lead
Family Meeting: The Basics

- “Thank you for coming to talk with us”
- Introductions
- Elicit family’s understanding
  - “I was wondering if you could tell me what you understand about your father’s condition”
- Provide a summary of the patient’s condition
  - Begin from where the family is
  - Avoid jargon
  - Check for understanding

Curtis and White Chest 2008;134:835-43

Family Meeting: Patient Preference

- Determine what the patient would want in this situation
  - Substituted judgment
  - The key role for the family
- Keep the focus on the patient
  - “If she could sit up in bed…”
  - “What would she think of this?”
  - “Not what you want for her, or what you’d want for yourself, but what she would want for herself”
Family Meeting: Summarize and Follow Up

- Assume responsibility for the decision
  - “Based on what I know about your mother and the medical situation… I recommend”
  - Don’t force the family to decide
  - Check for agreement and leave room for disagreement
- Summarize
- Arrange follow up contact
- Document the meeting

Maintain Perspective

- Really difficult cases are stressful, but rare
  - All cases will resolve
  - Occasionally the patient will surprise you
  - Resist badgering
- The family is suffering
  - Having a sick loved one is very stressful
  - Conflicting and contradictory information from providers can be very distressing
Conclusion

- “Do everything” can have many meanings
- Elicit and establish overall goals and treatment plan
- Provide the best possible communication
- Practice harm reduction
- Provide support to patient, family, staff, and yourself