on the pods

End of life care

With Professor Imogen Mitchell, Intensive Care Specialist, Canberra Hospital, and Dean of the Medical School of Australian National University, Canberra, Australia

Introduction
End of life management in the hospital setting presents a number of clinical and communication challenges, especially for junior doctors who may be unfamiliar with the process of dying. These challenges will become more prevalent as an increasing number of patients with multiple comorbidities die within hospitals.

Case – A 77 year old male who was bought in by his family to the Emergency Department (ED) for drainage of ascites on a background of pancreatic cancer with extensive liver metastases. On presentation, he is jaundiced with Glasgow Coma Scale (GCS) 15 and a heart rate of 70. His respiratory rate is 17 and SpO2 is 97%. His blood pressure is 105/60. The patient is admitted under Gastroenterology for drainage of his ascites and for assessment for further services.

1. **If a junior doctor was reviewing this patient and noticed that they had no Advanced Care Directive, when would it be appropriate to address this with the patient?**
   - As soon as they are seen or admitted into the hospital, there should be a very clear plan around end of life care and more generally, around diagnosis and care plan in hospital
   - This patient has a poor prognosis, so it is concerning that they do not have a clear direction for care
     - End of life care or a resuscitation plan at least should be filled out in the ED, especially if after hours and treating team are not available

2. **When a patient such as this one deteriorates, would that be an appropriate juncture for a junior doctor to organise an end of life plan?**
   - In an ideal situation this patient should have an early palliative care review especially because of the complexity and terminal nature of disease with acute deterioration
   - Make the treating consultant aware of the deterioration and that you think they should be palliated
   - Palliative care referrals can be difficult due to the low number and availability of palliative care specialists in Australia – so early referral is key

3. **How do you bridge the divide between the desire for all care and resuscitation to be given and knowing that it may not be in the patients' best interests?**
   - It is quite common for the treating team to feel one way and the family to feel differently
   - It is difficult for junior doctors to have the time to sit with the family so that they can have a full understanding of the patient's condition and timeline
   - The family need to have a real understanding of where the journey is headed
   - Junior doctors may need to correct their perceived ideas about the disease process, associated symptoms and prognosis
   - Once you take the conversation slowly and repeat the conversation if needed, the families start to understand that the disease process is worsening and not reversible

4. **What are the sort of things that need to be described or discussed with the family about certain types of care?**
   - The conversations are best had after discussion with the consultant to make sure they are on the same page
   - You may also consider talking to someone from intensive care for their expert opinion
   - You can then talk to the family to have an informed discussion and be fully prepared prior to this conversation

5. **Sometimes the role as a junior medical doctor can be managing the expectations of the medical and nursing team. What is a good way to have the discussion and set up expectations of care when often the teams are primed for patient deterioration and response?**
   - One of the first team members you need to talk with is the nursing team leader
     - Make sure they are on the same page
     - Ensure everyone is on board including nursing and allied health staff and that they have appropriate expectations of what the goals of care are
   - If nursing staff raise a concern to you about being too aggressive with a patient's care, it is important to address these concerns and discuss them with your consultant
   - Everyone has to be moving in the same direction as a team

6. **Sometimes the family can be very passionate about taking the patient home when reaching a palliative state. Is this appropriate?**
   - You have to honour a patient's wishes if they have expressed a desire to finish the rest of their life at home
   - It is important to be realistic about whether this is possible
   - A lot of families do not understand how much effort is required to care for someone that is passing away, however it is not impossible to do

7. **The patient is becoming more and more hypotensive throughout the night and is in pain; the nursing staff are asking you to chart more morphine. What should you do given that this morphine will likely worsen hypotension and decrease respiratory drive?**
   - If there is a very clear palliative approach, then the most important thing is that symptoms are relieved
   - If the patient is in pain, then give analgesia
     - No patient should pass away in pain
     - Hypotension is an unfortunate side effect of analgesia sometimes – however, symptom relief should always take priority

8. **The junior doctor comes onto their morning shift and one of their patients has passed away overnight. The nursing staff request the certification of death. What is the best way to manage this?**
   - If the patient's family wants to stay, then allow them to stay and certify the death with the family present
   - You need to acknowledge the death and the grief the family are feeling

9. **Take home messages**
   - We are all afraid to talk about death, however if there are patients that fill certain criteria, then these patients need a goals of care conversation
   - Don't be afraid to talk about it at any time of night
   - Most hospitals will have goals of care plan that can be filled out according to the patient's wishes
   - The treating team and consultant also should agree with the goals of care plan
   - Junior doctors should debrief after anxious situations

References

Most hospitals have internal resources for palliative care and advanced care planning

Flinder's University – End of Life Essentials. Available from: https://www.caresearch.com.au/caresearch/tabid/3866/Default.aspx

Australian commission of safety and quality of health care has a toolkit that separate hospitals can use. Available from: https://www.safetyandquality.gov.au/our-work/end-of-life-care-in-acute-hospitals/tools-and-resources-for-health-services/