Goals of care and treatment: missed opportunities

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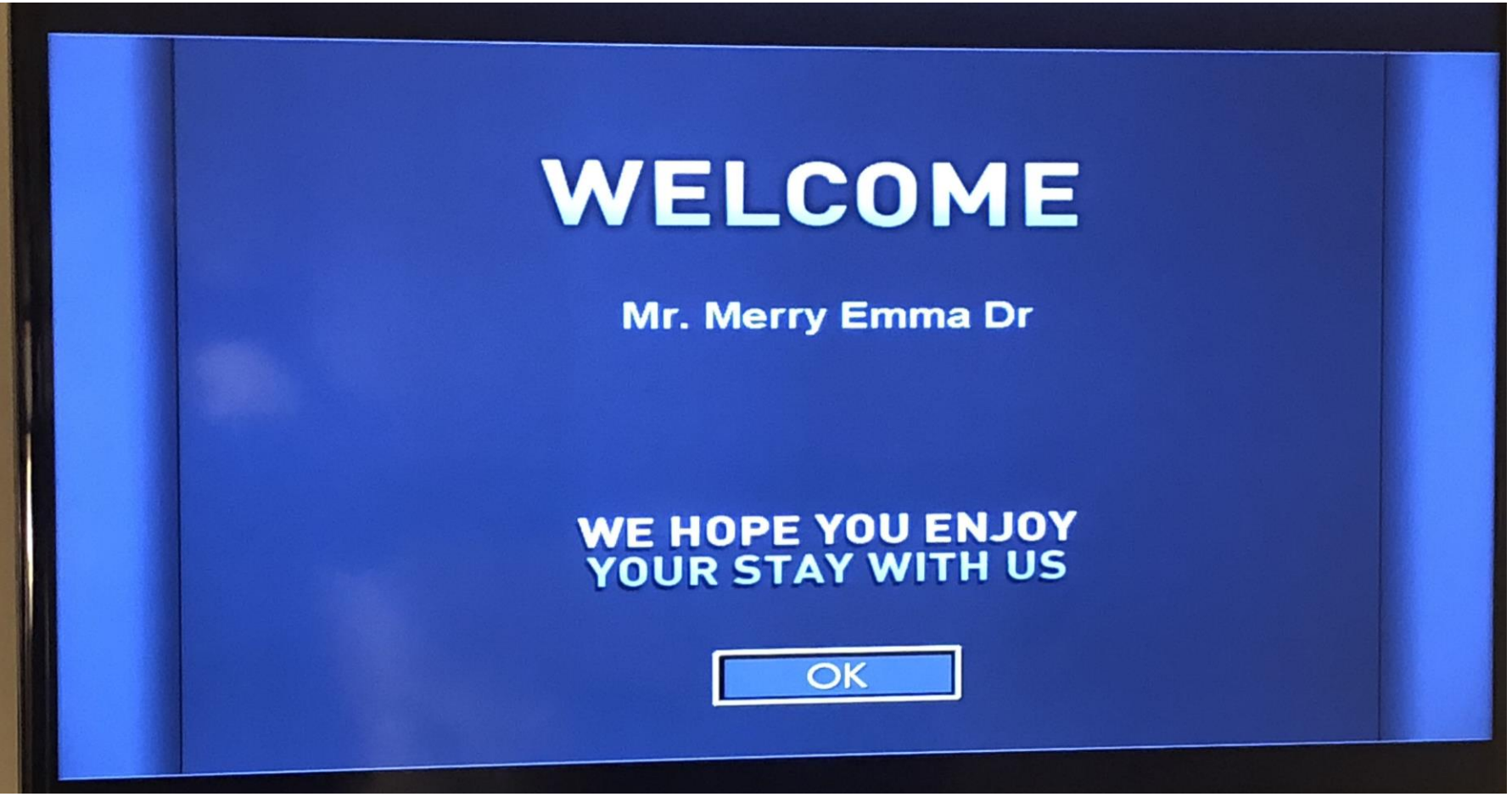

WELCOME
Mr. Merry Emma Dr
WE HOPE YOU ENJOY
YOUR STAY WITH US
OK

Two weeks of intensive care can save an hour of difficult conversation

(Psirides ™)

(Cairns)

You may ask yourself…

Why is it important?

What are goals of care and treatment?

How do we make sense of non-medical goals?

What if the goals are unrealistic?

Who should think about them?

How are they recorded?

Some challenges for Goals of Care

- Acknowledging a condition is life limiting
- Diagnosing dying is harder than diagnosing death
- Treatment is offered and given which is not wanted/warranted
- Conversations are deferred/avoided

What do we know for sure?

- Admission to hospital takes a toll (frailty, deconditioning)
- ICU stay has an impact on patient and family
- 1 in 5 inpatients has a PC need, often not recognised/acted on
- EOL can be unrecognised until RRT call

Consequences of inadequate communication

Worse QOL, anxiety, family distress, prolonged dying, treatment incongruent with wishes and goals, mistrust, resource/patient mismatch, physician burnout

Healthcare context

- Complexity of disease/psychosocial issues
- Frailty, acuity increasing
- Harder to diagnose dying in older patients
- More non-malignant disease with different illness trajectories
- Changing practice: treatment, life expectancy, less fatalistic

Why do important conversations not occur?

- Training, support absent
- Time and timing
- Team has incomplete understanding of success/impact of treatments offered
- No structure exists
- Asking the wrong question

Barriers to effective communication

- Asking the wrong question: “do you want everything done?”
- Not knowing what a “good outcome” looks like for this person
- Individual preferences very variable

What might “do everything” mean to patients?

- Fear of abandonment: don’t give up on me
- Anxiety: I am afraid of dying
- Incomplete understanding: I don’t really understand how sick I am
- Valuing life above all else: I want all possible treatments, even if the chance of success is small

What does “do everything” mean to the team?

- Everything technically possible, even if not going to succeed
- In most centres, referral for multi-organ support in ICU/HDU

When considering life sustaining treatment

Risks

Complex

Immediate and delayed

Invisible and visible

Unknown

Hard to predict

Benefits

Aim to return to quality of life and function acceptable to patient, consistent with their goals

The RUB

- Highly individual
- Chocolate ice cream vs running marathons

Gillett; Gawande

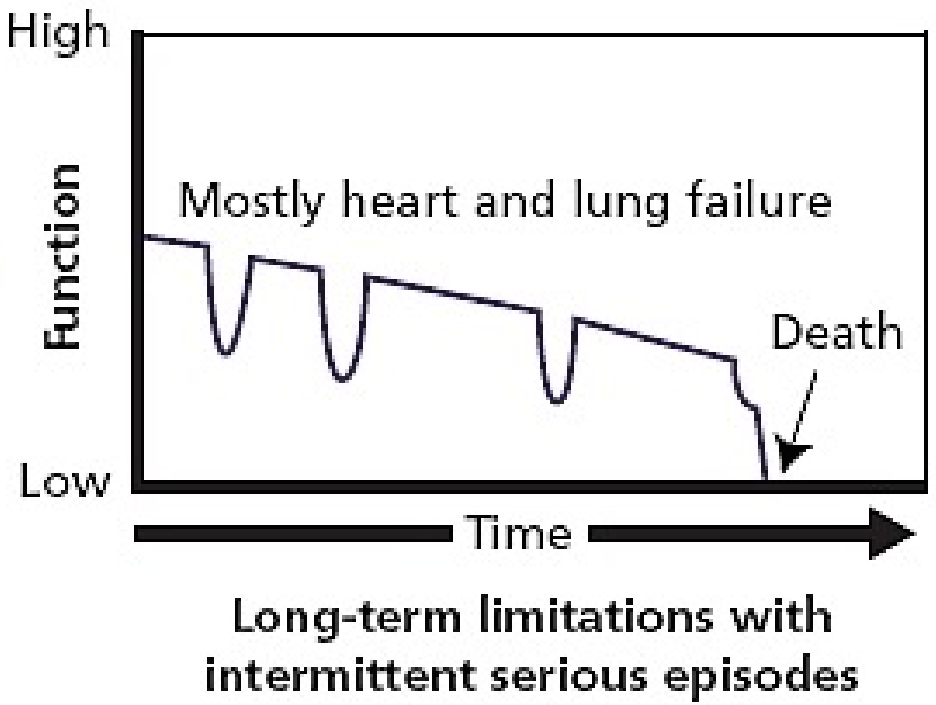
Examples

John

- Dilated cardiomyopathy
- Chronic renal failure, single functioning kidney with nephrostomy
- COPD
- Recurrent urosepsis
- Bowel cancer 2009
- Multiple admissions (149d over 40m)

Final admission

- Attended ED with SOB
- VF arrest, resuscitated
- Died in ICU on full support



Issues

- No long term plan/ overall view
- Documentation: EDS not true reflection
- Community/hospital interface
- Multiple teams but no unified approach

What did this patient need?

- A frank discussion of illness and goals
- Prognosis: what to expect
- Documented plan agreed with primary care
- Opportunities identified and not missed

Brenda

- Severe COPD
- Admitted for elective incisional hernia repair
- Referred HDU postop with respiratory failure
- Long ICU stay, eventually weaned from support at day 91

Issues

- Waiting list delay: functional status worsened pre-op
- Patient selection
- No discussion with ICU during planning phase
- Not an elective admission
- Informed decision making by patient?

What did this patient need?

- A frank discussion of illness and goals
- Prognosis: what to expect
- Documented plan agreed with primary care
- Opportunities identified and not missed

Eileen

- Dementia progressing in residential care
- DM, AF, HT
- Warfarin

Events

- Deterioration: attended ED
- Decreased level of consciousness
- Discussion with EPOA
- Consensus for supportive care
- Transferred back to care home
- Died 4 days later

Why was this possible?

- EPOA aware of wishes
- Capacity for conversation and resource for transfer
- Person-centred care
- Health professional in the family

What did this patient have?

- A frank discussion of illness and goals
- Prognosis: what to expect
- Documented plan (agreed with primary care)
- Opportunities identified and not missed

Other questions to consider

- What is reversible?
- What is reasonable?
- Who should be involved?
- When should it happen?
- Is there time now?

Questions?