Palliative Care: Assessment & Communication in the Outpatient Setting

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Objectives

• Review elements of palliative care assessment
• Discuss spectrum of communication topics appropriate for outpatient setting
• Present goals-based approach to advance care planning
• Review mechanisms for translating goals communication into care decisions
• Observe and practice goals of care communication

Palliative Care Patient Population

• Life-limiting medical condition
  » Cancer
  » Organ failure: dementia, CHF, COPD
  » Diabetes
• Recent functional decline, hospitalization(s)
• Symptom needs
• Suffering
• Palliative is not just for dying patients (as if we know who’s dying!)

Start with Symptoms

• Distress complicates or prevents ability to communicate
• Demonstrate commitment first to patient’s comfort
• Safer to discuss than care goals, treatment decisions

Symptom Assessment (Review of Symptoms)

• Pain
• Dyspnea
• Nausea
• Constipation
• Appetite
• Depression
• Anxiety
• Fatigue
• Psychosocial distress
• Spiritual distress

Communication Premise

• Skill rather than based solely on innate ability
  » Can be improved upon with practice, over time
• Procedure that should be taught, evaluated
• Critical to care quality, patient and family experience
Outpatient Communication Topics

- Advance care planning
  - Health care proxy (power of attorney)
  - Advance directives
    - Living will
    - 5 wishes
- Treatment decisions
- Prognosis
- Code status
- Hospice

Advance Care Planning

- Treatment preference communication and documentation
- Historically document-driven
- Process, not an event
- Requires effective communication
  - Health care professional – patient
  - Patient – family

Putting the Cart Before the Horse…

- Living will, Health care proxy completion without:
  - Health care professional – patient discussion of patient’s motivations, values
  - Patient understanding that living wills do not substitute for Do Not Resuscitate form
  - Patient – proxy discussion

Goals of Care

- Promote patient/family discussion of
  - Patient’s values
  - Quality of life perceptions
  - Primary care goal
- Patients understand their goals and values more than specific treatment decisions
- Translate care goal into advance directives, treatment plan

Goals of Care

- Longevity
- Maintain/Promote Function
- Comfort
- Patients/families may have other goals (safety)
- Multiple goals apply simultaneously
- Goals may be contradictory
- Goals may shift during the illness course

EPEC-O, Self-Study Module 9, Negotiating Goals of Care

Longevity
7 Step Protocol to Negotiate Goals of Care & Treatment Priorities

1. Create an appropriate setting
2. Assess what the patient knows
3. Explore what the patient expects, hopes for
4. Address achievability of goals
5. Respond empathically
6. Make a plan and follow through
7. Review and revise periodically

Adapted from SPIKES protocol for communicating bad news

2. What does the patient understand?
- What have the doctors shared with you about your condition, what to expect?
- What’s your sense of how you’re doing?
- Tell me more…
  - Experience with hospitalization, treatments
  - Interactions with physicians

3. Goals
- What’s most important to you?
- What gives you pleasure?
- What does quality of life mean to you?
- What are your hopes when thinking about the future?
- Communicate commitment to aligning treatment with patient’s values

4. Are the goals achievable?
- May be difficult to assess, particularly during an initial visit
- May require input from specialists
- May need understanding of social support, community resources
- Communicate concerns if goal difficult to achieve
- Recognize that patients may pursue unachievable goal
5. Empathic Responses

- Name the emotion(s)
  - You really seem angry about this
  - I can appreciate that you’re feeling sad
- The attempt to name an emotion is empathic even if the patient disagrees with your naming attempt
- Wish statements

“Wish” Statements

- Instead of stating “I’m sorry”
  - Confused with pity or an apology
  - Shortcuts deeper understanding
- Empathic statement
  - Wish for different circumstance
  - Acknowledge emotional impact of loss
  - Aligns physician with patient and family
- Desired outcome unlikely to occur
- Doesn’t specify what can be done
  - May initiate deeper level of conversation
  - I wish we had treatments that could turn things around
  - I wish I had better news to give you


6. Make a plan with follow through

- Translate goals into treatment recommendations
- Allow patients to disagree with recommendation
- Document communication content
  - Advance care planning note in Webcis
- Consider completion of MOST for appropriate patients

Medical Order for Scope of Treatment (MOST)

1. Promote patient autonomy by documenting treatment preferences and converting them into physician orders
2. Clarify treatment intentions and minimize confusion regarding a person’s treatment preferences
3. Facilitate appropriate treatment by emergency medical services personnel
4. Enhance the transfer of patient records between healthcare professionals and healthcare settings.

MOST: 5 Sections

A. CPR
B. Medical Interventions
  - Full scope of treatment
  - Limited additional interventions
  - Comfort measures (Akin to goals)
A. Antibiotics
B. Medically Administered Fluids & Nutrition
C. Discussed with and agreed to by...
MOST Characteristics
- Optional
- Comprehensive
- Portable
- Reviewed regularly (at least annually)
- Most appropriate for patients in long-term care settings and/or patients with advanced chronic progressive illness

MOST Resources
- Frequently asked questions: http://www.ncmedsoc.org/pages/public_health_info/most_faq.html

Medical Student Role in the Clinic?
- #1 setting
- #2 patient's understanding
- #3 goal(s)
- #5 empathic responses
- Collaborate with preceptor re: considering achievability of goals, developing plan (eg, refer to specialist, make treatment recommendations)

Workshop Format Options
- I will interview a student “SP” after creation of patient characteristics and decision re: care goal
- Students’ role play
- Wrap-up discussion

References
- http://vitaltalk.blogspot.com/
- http://depts.washington.edu/oncotalk/