



Geriatric Palliative Care

Danielle J. Doberman, MD, MPH

Medical Director

Palliative Medicine Program

Greater Baltimore Medical Center

ddoberman@gmbc.org 443-849-6255

Disclosures

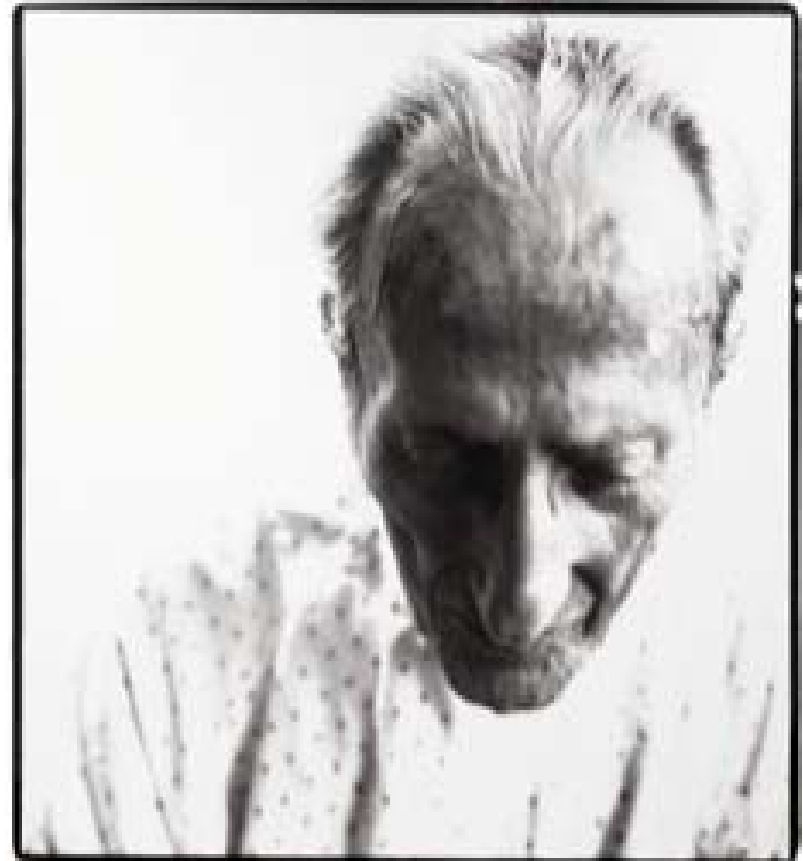
No Relevant Financial Relationships
with Commercial Interests

No Conflicts of Interest

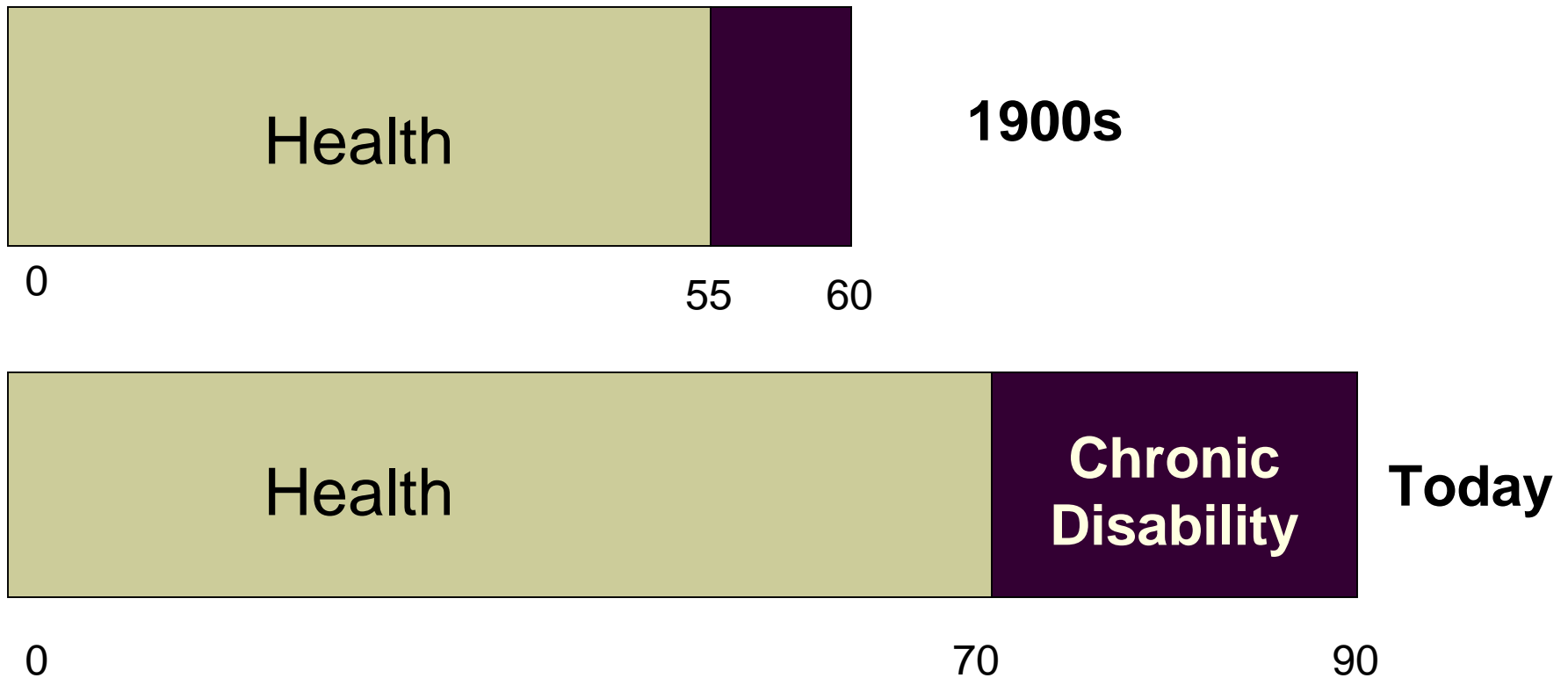
Danielle J. Doberman, MD, MPH

Societal Demographics

- Society is aging
- Life span has increased
- Patients live longer with chronic diseases
- Health care costs are increasing



Effects of Health Improvements: Patients are Older and Sicker



Healthcare Today:

Quality Improvements:

- Hospitalist movement
- Intensivist movement
- Resident work hour restrictions
- Sub-specialization of medicine

Consequence of improvements:

Fractured Patient Care



What is Palliative Care?

- A philosophy of care & a multi-disciplinary system for delivering care.
 - Can be combined with life-prolonging treatment or can be the sole focus of care (Hospice).
- Physical, psychological, spiritual, and practical burdens of illness addressed.
- Goals:
 - Enhance quality of life for pt & family
 - Assist with decision-making
 - Assist patients to achieve their goals

Hospice vs. Palliative Care

Hospice

- Prognosis of < 6 mo
- Focus on comfort care
- Medicare hospice benefit
- Volunteers integral and required aspect of the program

Palliative Care

- Any time during illness
- May be combined with curative care
- Independent of insurer
- Complimentary therapies often included

Palliative Medicine Increases Continuity & Reduces Costs

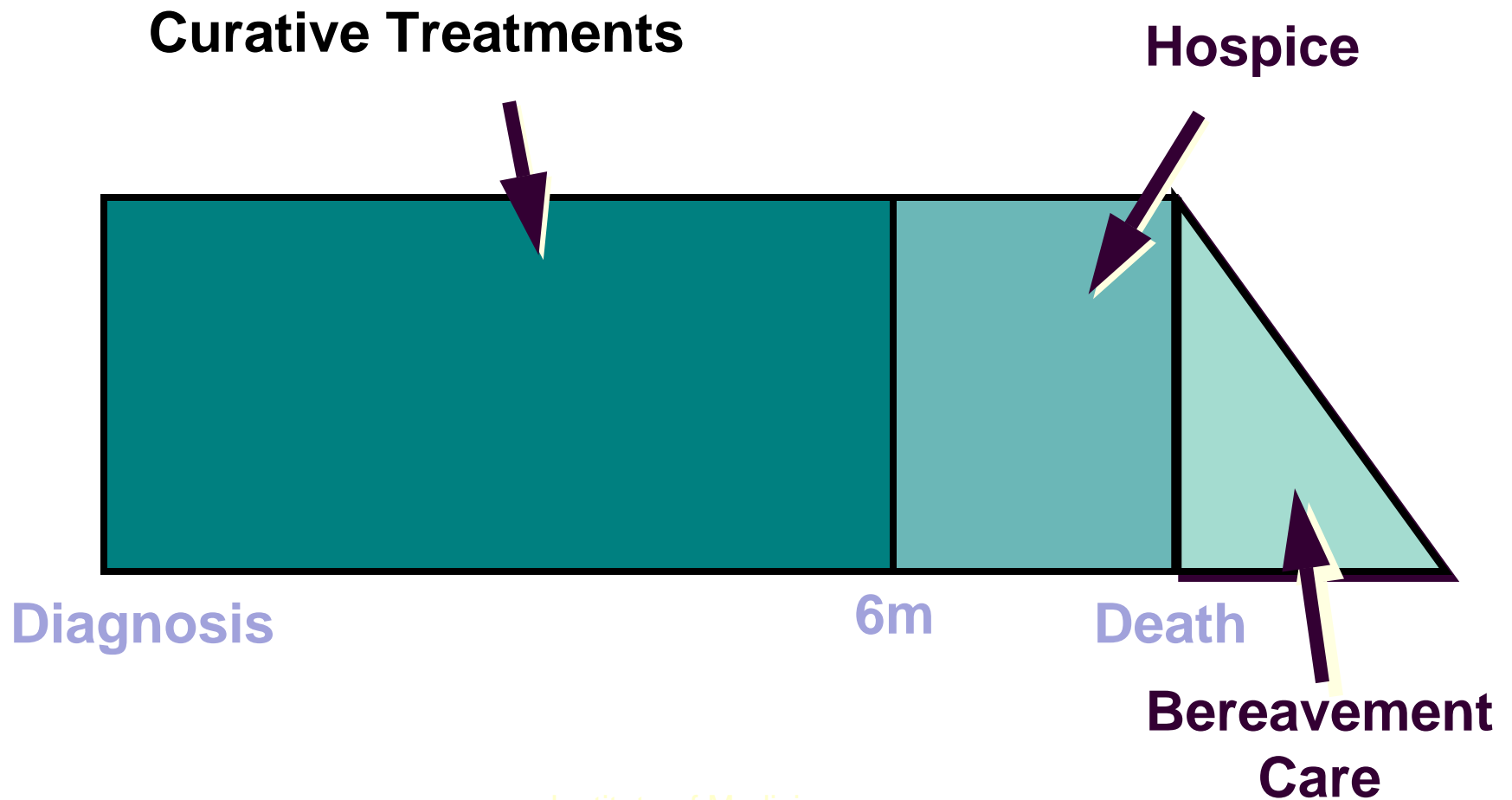
How and when should life-prolonging technology be initiated or stopped?

Who helps family with these decisions?

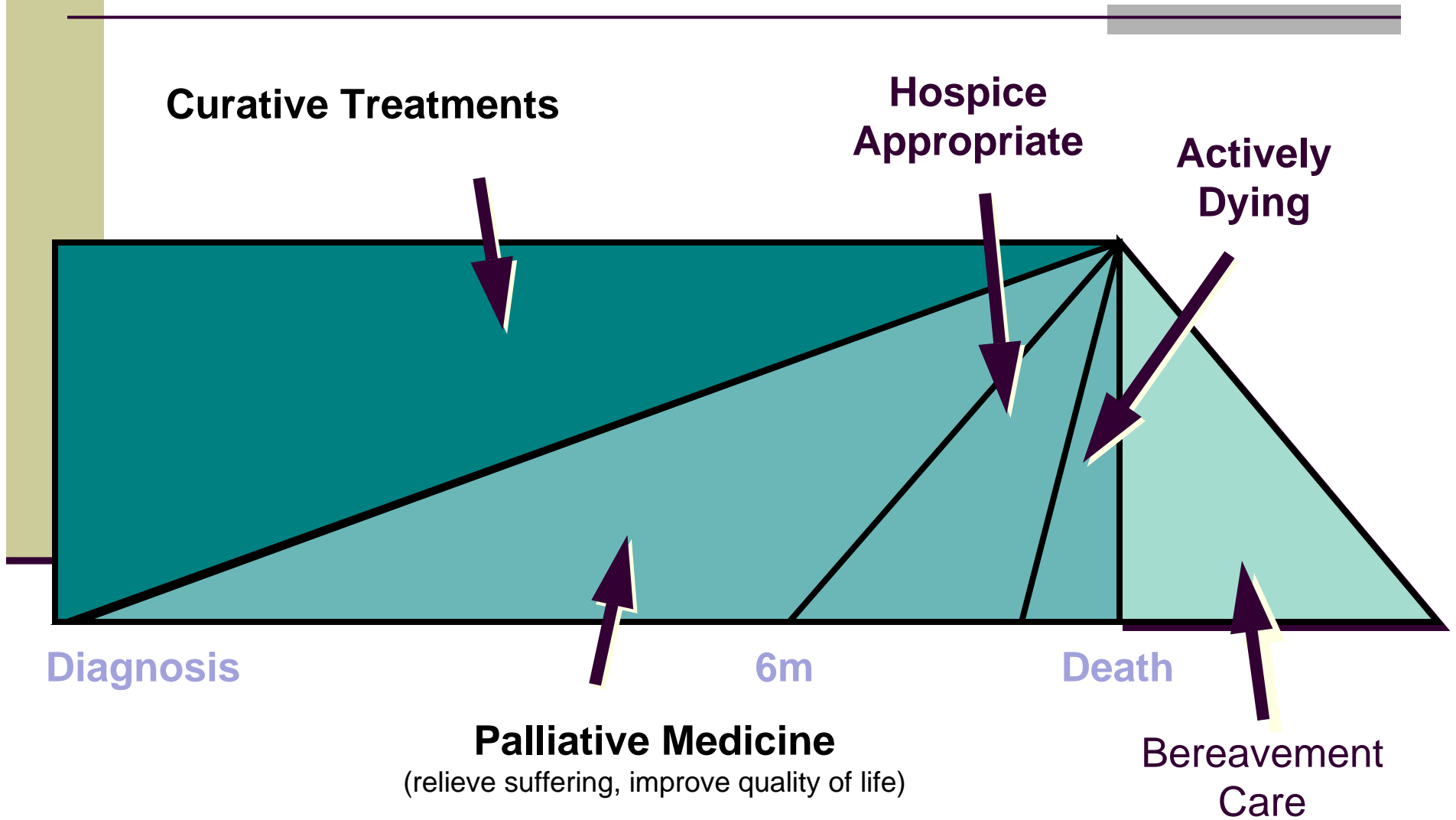
Example:

- Wife considering feeding tube for patient with advanced dementia
- Patient on dialysis considering stopping treatment
- Family considering ventilator withdrawal
- Lung cancer patient considering palliative chemo

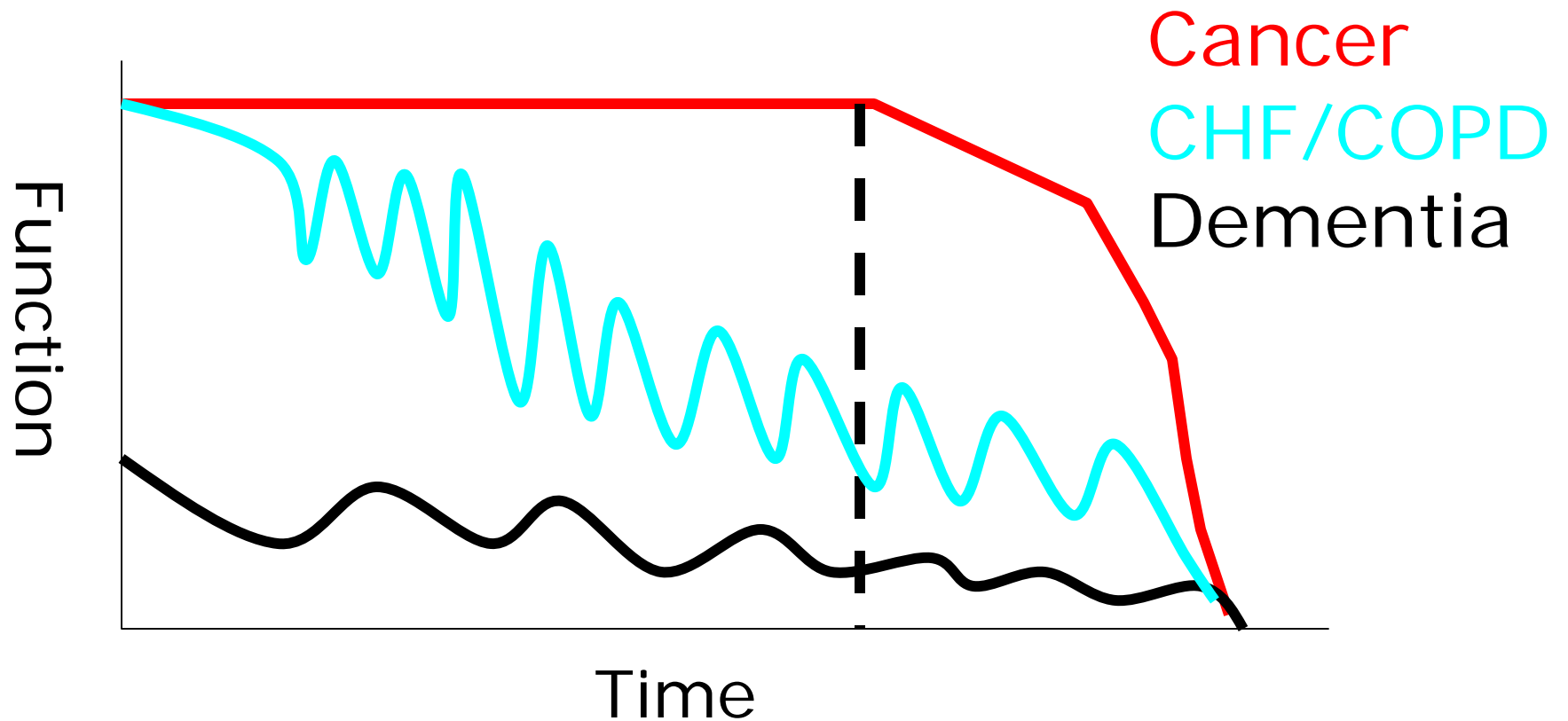
Traditional View of Illness



Trajectory View of Illness



Trajectories of Illness



When does chronic decline become dying?

Palliative Care for the Geriatric Patient

- **Advance Care Planning (ACP) & Anticipatory Guidance are Key**
 - Feeding tubes
- Needs differ from younger pts *
 - Capacity evaluation
 - Withhold/withdraw life-sustaining treatments
 - Greater time
- Jettison guidelines?
- Respect debility
- Give your opinion

* Evers, Meier, Morrison.
JPSM. 23(5) 2002. 424-432.

Prognosis Key to Informed Decisions

- Decisions change based on pts perception of prognosis
- 371 adults age 65+ asked if wanted CPR in case of arrest during an acute illness.
 - Before learning true chance of survival, **41% wanted CPR**
 - After learning true probability of CPR, only **22% wanted it**
- Hypothetically: life expectancy < 1 yr, only 5% wanted CPR.

Physicians and Prognosis

- Prospective study of 343 physicians
- Asked to est. survival of 468 terminal cancer pts.
- Only 20% of predictions were accurate
 - 63% were overly optimistic
 - 17% were overly pessimistic
- Px accuracy decreased with longer and closer Dr-Pt relationships

CPR on TV: Where Pts get their data

- **97 TV** episodes reviewed
- **60 CPR** occurrences
- CPR usually caused by trauma, only 28% caused by cardiac etiology
- 75% of patients survived the immediate arrest
- **67% of patients appeared to survive to hospital discharge**

Which numbers most accurately reflect the outcome of in-hospital CPR?

(all patients, all rhythms)

- a) 40% success, 15% survival to discharge
- b) 20% success, 5% survival to discharge
- c) 10% success, 1% survival to discharge
- d) 5% success, <1% survival to discharge

For elderly, survival is < 5%

CPR and Hospital Discharge:

- Factors predicting survival:
 - Myocardial infarction
 - Coronary heart disease
 - Hypertension
- Factors predicting failure to survive to d/c:
 - Sepsis the day prior to the CPR event
 - Serum creatinine >1.5 mg/dl
 - Metastatic cancer
 - Being African-American (challenged)
 - Dementia
 - Dependent status

CPR and Cancer

- 2006 Meta-analysis
- 6.7% of cancer pts survived CPR to discharge (1 in 14)
 - localized: 9.1%; metastatic: 7.8%
- Survival to discharge for ward patients was better than ICU patients
 - 10.1% vs.2.2%
- Data on neurological outcome not included

Reisfield GM, et al. *Resuscitation*.
2006; 71: 152-160.

CPR and Dialysis

- Survival to discharge: 14% of 137 pts
- Long-term survival:
 - 74 pts with CPR, only 2 survived 6 mo (3%)
 - vs. 9% of non-dialysis controls

Hijazi F, Holley, JL.
Cardiopulmonary resuscitation
and dialysis: outcome and
patients' views. *Seminars in
Dialysis*. 2003; 16(1):51-53.

Advance Care Planning: Communication Pointers



Benefits of ACP:

- Promote patient autonomy and control
- Create trust between clinician and patient
- Avoid future confusion and conflict
- Permit patient peace of mind

Advance Care Planning

- At its core, ACP is about values
- Each one of us has a sense of:
 - who we are
 - what we like to do
 - control we like to have
 - goals for our lives
 - things we hope for
- Goal of ACP is to elicit health care values,
Aka “Goals of Care”

What is meant by Goals of Care?

Goals of Care = Patient Values

- Cure disease
- Avoid premature death
- Maintain or improve function
- Prolong life
- Avoid pain
- Avoid dependence
- Improve life quality
- Stay in control
- Support for families & loved ones support

Goals may change as illness evolves



What is an 'acceptable' quality of life?

Dying in US Hospitals: The SUPPORT Study

- National study of 9000 chronically ill patients
- Resuscitative status rarely addressed until just before death
 - 46% of DNR orders written within 2 days of death
- Few physicians knew their pts wishes regarding resuscitation
 - Of patients wanting DNR at enrollment, <50% of their MDs were aware of their wishes.

ACP for Physicians Themselves

- 765 MD alumni of Hopkins; Avg age 68
- 64% had an advanced directive (AD)
- 46% feel own MD unaware of tx preferences
 - 59% no intention of discussing wishes with their MDs within next year
- 89% thought family probably or definitely aware of preferences

Case Examples

- George is a 71 y/o M with DM2, CAD s/p 4v CABG, TIA one year ago, with OSA and 3x a week dialysis.
- He comes to your office for pre-op clearance for a transmetatarsal amputation of his right foot.



5 Steps for Successful ACP:

1. Introduce the topic
 - Be straightforward, calm, routine, positive
2. Engage in a structured discussion:
 - Determine proxy first
 - Elicit values
 - Describe scenarios and options for care
3. Document patient preferences
4. Review & update at regular intervals
5. Apply directives when need arises

Goals of Care Interview:

Goal: Establish realistic, attainable goals of care

- Help patient and family understand scope of illness and prognosis
- Define “acceptable” and “unacceptable” quality of life
- Define choices to be made and the benefits and burdens each choice
- **OK for PCP/MD to give opinion**

What treatment would you want if:

- You could no longer talk or think clearly?
- You could no longer recognize or interact with your family?
- You couldn't swallow safely and a feeding tube was suggested?
- You couldn't breathe and needed a breathing machine indefinitely to keep you alive?
- You could no longer control your bowel or bladder?
- You lived in a nursing home?
- You had pain most of the time?

Phrases to Avoid:

- “Do you want us to do everything?”
- “Do you want us to start your heart if it stops?”
- “If we do CPR we will break your ribs and you will need to be on a breathing machine – you don’t want us to do that – do you?”
- “Will you agree to discontinuing care?”
- “There is nothing more we can do...”

Statements to Consider:

Elicit values and understand pt's concept of death

- What makes life worth living? What if you could no longer do these things?
- Has anyone close to you ever died? What are your feelings about that experience?
- If you were to die despite our best efforts, would you want us to use heroic measures to try and bring you back?
- If you were called to heaven today, do you have unfinished business in this world, or would you want to go in peace?

Goals of Care Grid:

	CPR	Ventilator	Surgery	Blood Transfusion	Antibiotics	Feeding tube
Current state of health	Yes	Yes	Yes	Yes	Yes	Trial
Chronic illness with physical disability	Yes	Yes	Yes	Yes	Yes	Trial
Mild Dementia	Yes	Trial	Yes	Yes	Yes	No
Severe dementia	No	No	No	Undecided	Undecided	No
Total dependence for care	No	No	No	Yes	Yes	No



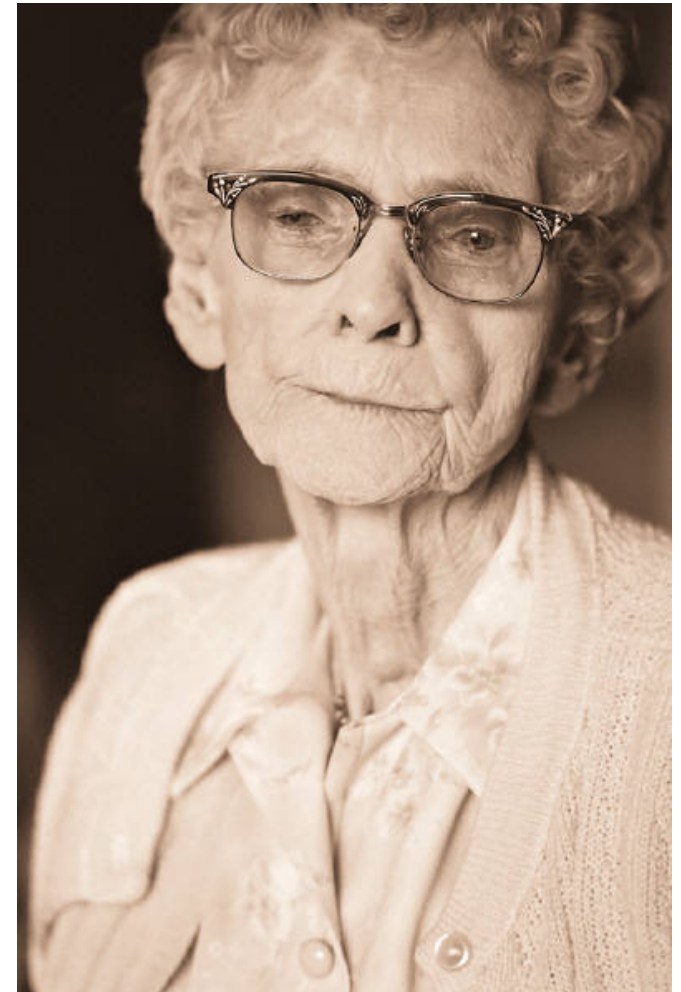
89 y/o Female

- Osteoporosis
- Dysphagia
- Weight loss
- Dyspnea →
- Respiratory Failure →
- Death

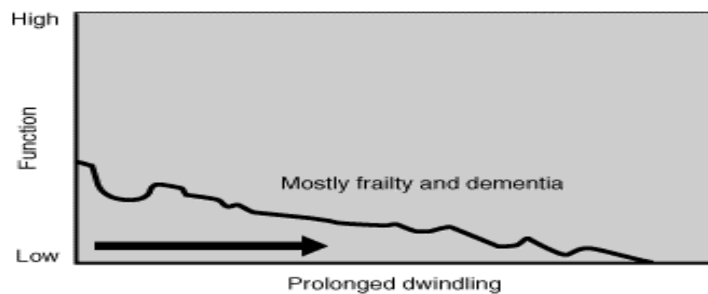
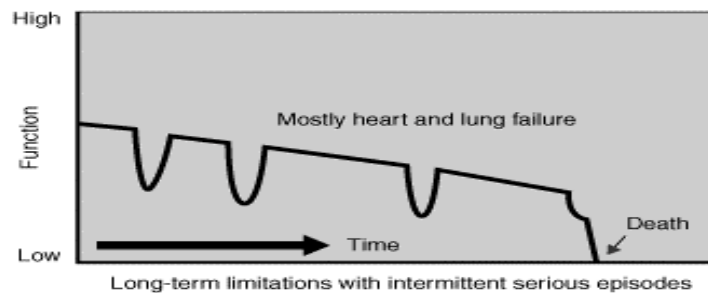
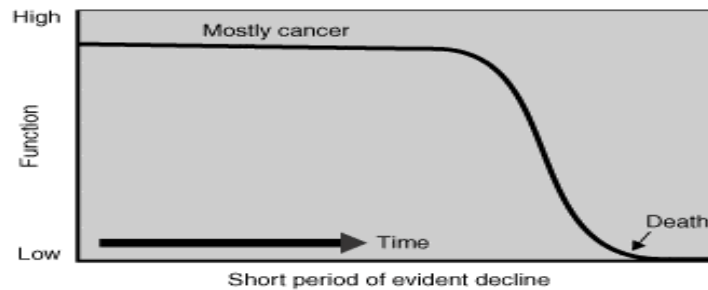
Blechacz B, Gajic O.
NEJM. 2008 Jun
12;358(24):e28.

Case Examples

- Millie is a 94 y/o NH pt with dementia, CHF, CRI and recurrent infections.
- She is spoon fed, and minimally verbal, yet she still wanders about the NH.
- She has had 4 admissions in 6 months, all for aspiration pneumonia.
- She now presents to the ED in respiratory distress.



Is Mom Going to Die?



- What does pt think?
- What does family think?
- Respect Debility
- Consider multi-morbidity

Is Mom Going to Die?

COPD:

- FEV1 < 30
- Dyspnea at rest
- Pulmonary HTN
- Tachycardia
- pO₂ < 55%
- Wt loss in last 6 mo

CHF:

- EF < 20%
- Arrhythmias resistant to treatment
- Dyspnea at rest despite maximal medications

Is Mom Going to Die?

Dementia:

- Recurrent infections
- Functional decline and dependence
- Dysphagia
- Wt loss
- Minimally verbal

Stroke

- Dysphagia
- Functional decline
- Post-stroke dementia
- Alteration in mental status

Is Mom Going to Die?

Liver Disease

- Albumin <2.5
- Ascites despite maximum Rx
- Hepatorenal syndrome
- Encephalopathy
- Elevated INR
- Recurrent variceal bleeding

Kidney Disease

- Creatinine clear < 15 cc/min
- Potassium >7
- Signs of renal failure:
 - Confusion
 - Nausea
 - Itching
- Fluid overload

Resources

Example of a living will that explores a patient's values & goals

5 Wishes is valid in many states; does not require a lawyer. Easy to read 1888-5-WISHES

www.agingwithdignity.org

The image shows the cover of the 'Five Wishes' living will form. The title 'FIVE WISHES' is prominently displayed at the top in a large, serif font. Below the title, the text 'MY WISH FOR:' is centered. The five wishes are listed in a numbered format: 1. The Person I Want to Make Care Decisions for Me When I Can't; 2. The Kind of Medical Treatment I Want or Don't Want; 3. How Comfortable I Want to Be; 4. How I Want People to Treat Me; 5. What I Want My Loved Ones to Know. At the bottom of the form, there are two horizontal lines for input, labeled 'print your name' and 'birthdate'.

FIVE WISHES®

MY WISH FOR:

1 The Person I Want to Make Care Decisions for Me When I Can't

2 The Kind of Medical Treatment I Want or Don't Want

3 How Comfortable I Want to Be

4 How I Want People to Treat Me

5 What I Want My Loved Ones to Know

print your name

birthdate

Resources



Consumer's Tool Kit for Health Care Advance Planning

Second Edition



American Bar Association's Commission on Law & Aging,
Consumer's Tool Kit for Health Care Advance Planning:
<http://www.abanet.org/aging/toolkit/>



Tool #1

How to Select Your Health Care Agent or Proxy

Name & Date _____

When you decide to pick someone to speak for you in a medical crisis, in case you are not able to speak for yourself, there are several things to think about. This tool will help you decide who the best person is. Usually it is best to name one person or agent to serve at a time, with at least one successor, or back-up person, in case the first person is not available when needed.

Compare up to 3 people with this tool. The persons best suited to be your Health Care Agents or Proxies rate well on these qualifications...

Name #1:		
Name #2:		
Name #3:		
		1. Meets the legal criteria in your state for acting as agent or proxy or representative? (This is a must! See next page.)
		2. Would be willing to speak on your behalf.
		3. Would be able to act on your wishes and separate his/her own feelings from yours.
		4. Lives close by or could travel to be at your side if needed.
		5. Knows you well and understands what's important to you.
		6. Is someone you trust with your life.
		7. Will talk with you now about sensitive issues and will listen to your wishes.
		8. Will likely be available long into the future.
		9. Would be able to handle conflicting opinions between family members, friends, and medical personnel.
		10. Can be a strong advocate in the face of an unresponsive doctor or institution.

Tool #1:
Choosing a proxy



Tool #2

Are Some Conditions Worse Than Death?

Name & Date _____

This worksheet helps you to think about situations in which you would *not* want medical treatments intended to keep you alive. These days, many treatments can keep people alive even if there is *no* chance that the treatment will reverse or improve their condition. Ask yourself what you would want in the situations described below if the treatment would not reverse or improve your condition.

Directions: Circle the number from 1 to 5 that best indicates the strength and direction of your desire. If you wish, you can add additional thoughts on the Comment lines.

- 1 -- Definitely want treatments that might keep you alive.
- 2 -- Probably would want treatments that might keep you alive.
- 3 -- Unsure of what you want.
- 4 -- Probably would NOT want treatments that might keep you alive.
- 5 -- Definitely do NOT want treatments that might keep you alive.

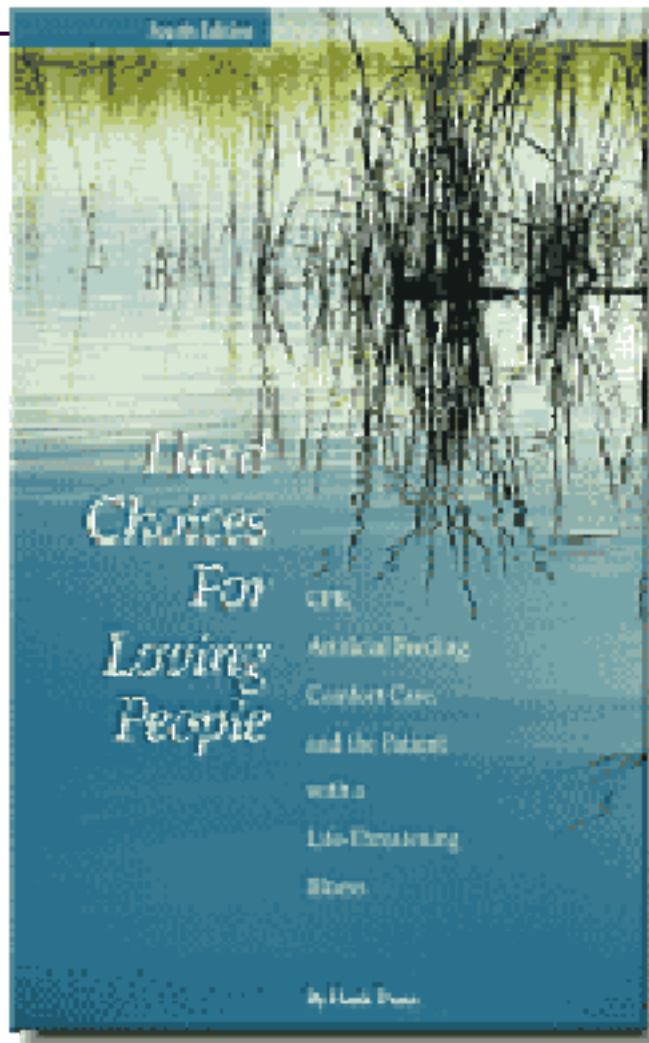
What If You . . .

	Definitely Want Treatment	←————→	Definitely Do Not Want Treatment		
a. No longer can recognize or interact with family or friends.	1	2	3	4	5
Comment _____					
b. No longer can think or talk clearly.	1	2	3	4	5
Comment _____					
c. No longer can respond to commands or requests.	1	2	3	4	5
Comment _____					
d. No longer can walk but get around in a wheel chair.	1	2	3	4	5
Comment _____					
e. No longer can get outside and must spend all day at home.	1	2	3	4	5
Comment _____					
f. Are in severe untreatable pain most of the time.	1	2	3	4	5
Comment _____					

Tool #2

Are Some Conditions Worse Than Death?

Resources for Family



<http://www.hardchoices.com/>



http://www.alz.org/alzheimers_disease_publications.asp

Summary

- Hospice is one form of palliative medicine, designed for the predictably dying.
- Palliative medicine is guided by patients' goals.
 - It is “Patient-centered” and “Patient-driven”
- Palliative medicine should be introduced early in the course of chronic illnesses and is compatible with curative care.
- Advance care planning and anticipatory guidance are the cornerstones of geriatric palliative medicine.



*How people die
remains in the
memories of those
who live on.*

Dame Cicely Saunders