COMMUNICATION AND CONSIDERATIONS AT THE END OF LIFE

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DISCLOSURE OF INTEREST

Nil to disclose!

OBJECTIVES

- 2 clinical cases
- Considerations at the end of life
- How to facilitate good communication

2 CASES

CASE 1: 37Y MALE

- Epithelioid angiosarcoma rising from the left sternoclavicular joint (Apr 2015)
- Concomitant weekly paclitaxel (partial response) and consolidation radiotherapy (pleural effusion, loss of appetite and increasing fatigue)
- Partner and young child
- Admitted with:
  - Complex left sided chest pain
  - Recurrent fevers
  - Deteriorating PS

CASE 1: WHAT HAPPENED

- IV Abx
- Complex pain management:
  - Increasing drowsiness with analgesic regime
  - Increasing psychological distress
- Decision made to discontinue anticancer treatment
  - Poor PS
  - Intolerable side effects
  - Unlikely to offer further benefit
- Married on ward
- Management of terminal agitation
- Died in hospital

CASE 2: 64Y FEMALE

- Recurrent carcinoma cervix with R-V and V-V fistulae and bilateral nephrostomies
- Main carer for husband (post CVA) and Warden
- Planned de-functioning colostomy and ileal conduit formation but admitted with:
  - Significant functional decline
  - Weight loss
  - Increasing frailty

CASE 2: 64Y FEMALE

- Issues during admission (CCU):
  - Bowel obstruction (receiving PN)
  - Incontinent of faeces PV on standing (syringe pump)
  - Recurrent sepsis (iv Abx)
  - Blocked nephrostomy with AKI and ARDS post re-insertion (Oxygen support)
  - Poor nutritional intake & PS4 (Requiring full nursing care)
- MRI: new soft tissue likely to represent recurrence
  - No further anticancer treatment/surgery
  - Ceiling of care: ward
  - PPC and PPD: home (ASAP!) nb implications for husband

CASE 2: WHAT HAPPENED

- Discharged to ward
- Open discussions with patient and husband regarding preferences for EoLC:
  - PPC and PPD
  - DNACPR
  - Support (and housing for husband)
  - Ceilings of care:
    - Po Abx
    - Care at home (hospice on standby)
    - No further nephrostomy changes/interventions
    - Discontinue PN
  - Discharge MDT with hospital and community professionals

CONSIDERATIONS AT THE END OF LIFE

INDICATORS

- Clinical information:
  - Examination
  - Blood tests
  - Imaging
  - Limited availability of and response to further anticancer treatments
  - Little or no response to medical interventions
- Patient:
  - Deteriorating/changing symptoms
- Families/carers:
  - Progressive physical decline and frailty
  - Lethargy
  - Reduced oral intake
  - Change in cognitive function
- Surprise question:
  - Would you be surprised if this patient were to die in the next 12 months?

PRINCIPLES AT END-OF-LIFE

- Good communication (patient, family, staff)
  - How often? By whom? Mixed messages?
- Identify priorities of care
  - Good symptom control
  - Minimise burden
  - Open communication (‘euthanasia’, feeding, fluids)
  - Privacy and Dignity
- Holistic approach
  - Remember cultural/spiritual needs
  - Family support (social/financial needs/children)
- Place of care and death

CEILINGS OF CARE

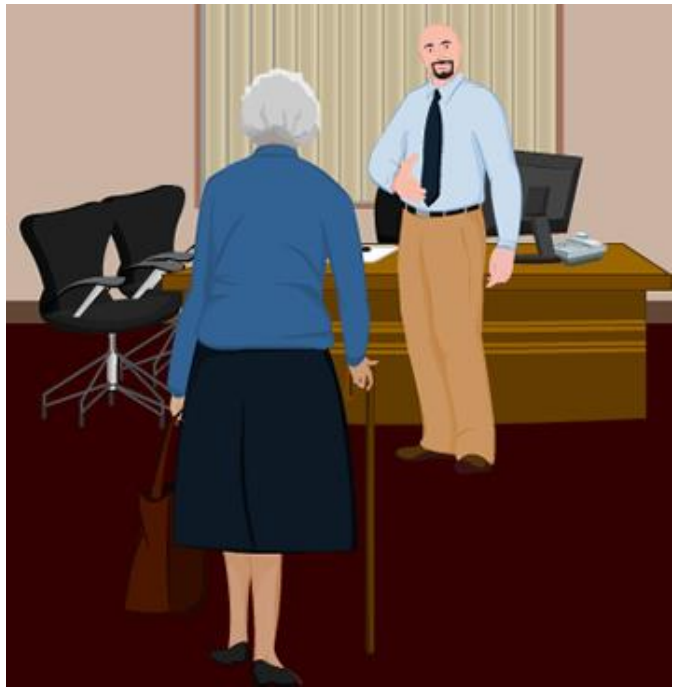
- Current monitoring/treatments
  - Regular monitoring of vital signs
  - Blood glucose monitoring
  - Blood tests
  - Current medications
    - Need (essential drugs likely to have changed…)
    - Route of administration
- DNACPR decision
- Assisted nutrition/hydration

COMMUNICATION AT THE END OF LIFE

IS COMMUNICATION REALLY A PROBLEM?

- UK:
  - Health service ombudsman (2012)
    - 16,333 complaints
    - Over 4,000 proceeded to an investigation
    - 50% rise in complaints about communication
    - Increase in patients feeling dismissed by family doctors
      - » Insincere apologies
      - » Careless communication
      - » Unclear explanations
  - NHS needs to improve listening to patients and responding to the concerns of patients and their families

People make decisions about each other in the first 10 seconds…..



WHAT IS GOOD COMMUNICATION?

- Two way process
- Perceiving the other person's responses and reacting with your own thoughts and feelings
- Listening:
  - An attempt to understand the meaning behind the words without interrupting or rehearsing how you will reply
  - Is not the same as waiting to speak!
- To facilitate:
  - Prepare the environment
  - Prepare yourself!
  - Stop talking
  - Listen to what is being said
  - Allow patients the opportunity to talk freely

E-end of life care for all (e-ELCA) https://www.e-lfh.org.uk/programmes/end-of-life-care/

BARRIERS TO GOOD COMMUNICATION

- Language barriers
- Not knowing what to say
- Fear of breaking down or getting upset
- Fear of taking too much time
- Feeling like there is no point in talking if there are no answers
- Tiredness or illness
- Fear of dealing with strong emotions
- Not knowing enough
- Feeling like a burden
- Feeling frightened of saying the wrong thing
- Blocking the conversation to avoid discussing a topic

Responding to the barriers:
Avoid:
- Giving false reassurance
- Medical jargon
- Normalising the patient experience as this can detract from his/her individual experience

USEFUL PHRASES…..

- How are you feeling today?
- I understand that you recently met with Dr X at the hospital…do you recall what he said to you?
- How did you feel about what was said?
- Did you have any questions after the meeting?
- Do you want to know more?
- What do you understand is happening now in terms of the treatment?
- How do you think you have been over the past few weeks/months?
- I am concerned that you haven't been as well recently…
- Have you talked much to your family, friends about your illness/your concerns?
- Is there anyone in your family you would like us to talk with about your illness?

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