PCM3
End of Life Session 1

Today's Agenda

9:45-10:30 The Dying Process
Theresa Kristopaitis, MD

10:30-11 Organ Donation: Basics for Physicians
Eric Price D.M., M.Div., BCC; Gift of Hope

11:10- 12:10 End of Life Ethics/Ethical Myths
Katherine Wasson, PhD

12:10-12:45 "Comfort Care"
Theresa Kristopaitis, MD

12:45-12:50 Hand Hygiene
Jorge Parada, MD

12:50-1:00 Information on the Topics in Clinical Medicine 3 (TCM3) Exam

EOL Session 2 – April 2017

Giving Bad News

Discussing Code Status

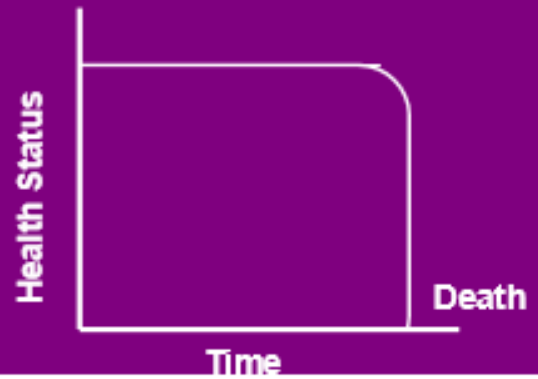
Hospice and Palliative Care

Faculty Panel Discussion– How We Cope

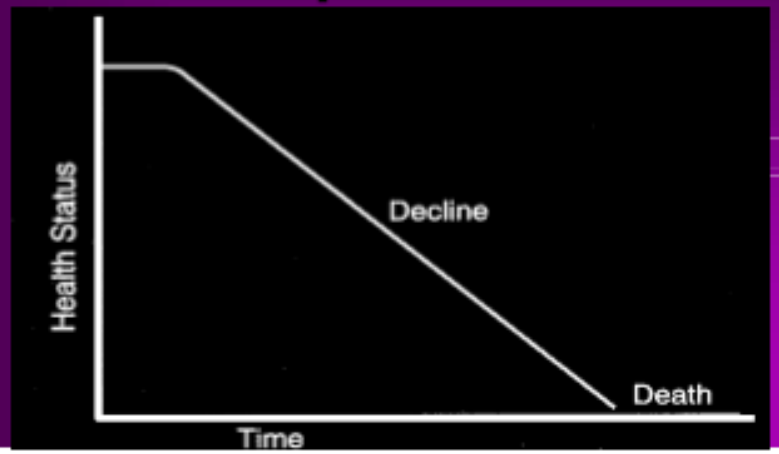
- A 57-year old man is diagnosed with widely metastatic pancreatic adenocarcinoma
- A 33-year old woman suffers multiple severe life-threatening injuries, including severe head injury, in an MVA.
- An 81 year old man with systolic heart failure (LVEF 45%), severe aortic stenosis, COPD, diabetes mellitus type 2, and mild dementia falls and sustains a complex pelvic fracture; the medical and orthopedics teams are discussing nonoperative vs operative management with the patient and his family
- An 11-year old with metastatic rhabdomyosarcoma has disease progression while on treatment
- A 27-year old man is declared brain dead after a skiing accident
- A 56-year old woman with advanced heart failure and multiple other medical problems is being evaluated for destination LVAD
- An 85-year old woman with severe dementia is hospitalized with aspiration pneumonia
- A 14-year old is shot while walking into his home and is moribound when paramedics arrive at the scene
- A 66-year old man with metastatic lung cancer is visited in his home by the hospice chaplain
- A 56-year old woman is hospitalized x 4 weeks with severe pancreatitis and has progressive ongoing multi-organ system failure
- A 33- year old woman is diagnosed with glioblastoma multiforme
- A 74-year old man has progressive ALS
- A full-term infant is still-born

Sudden death, unexpected cause

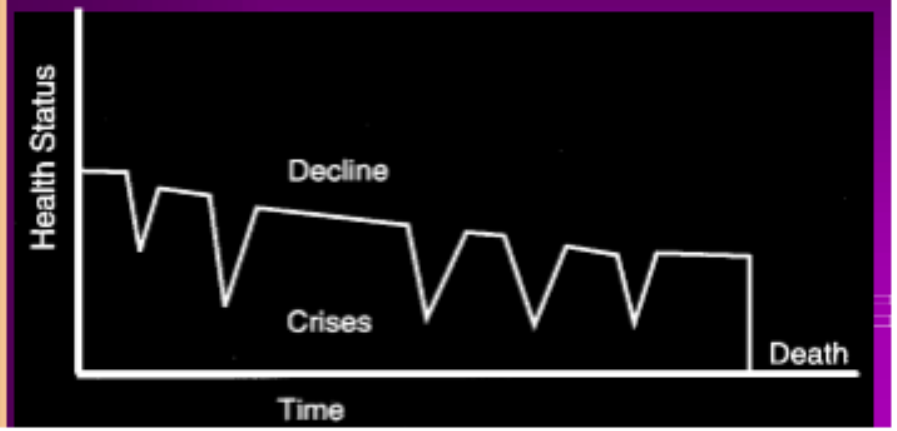
- < 10%, MI, accident, etc



Steady decline, short terminal phase



Slow decline, periodic crises, sudden death



For the majority….

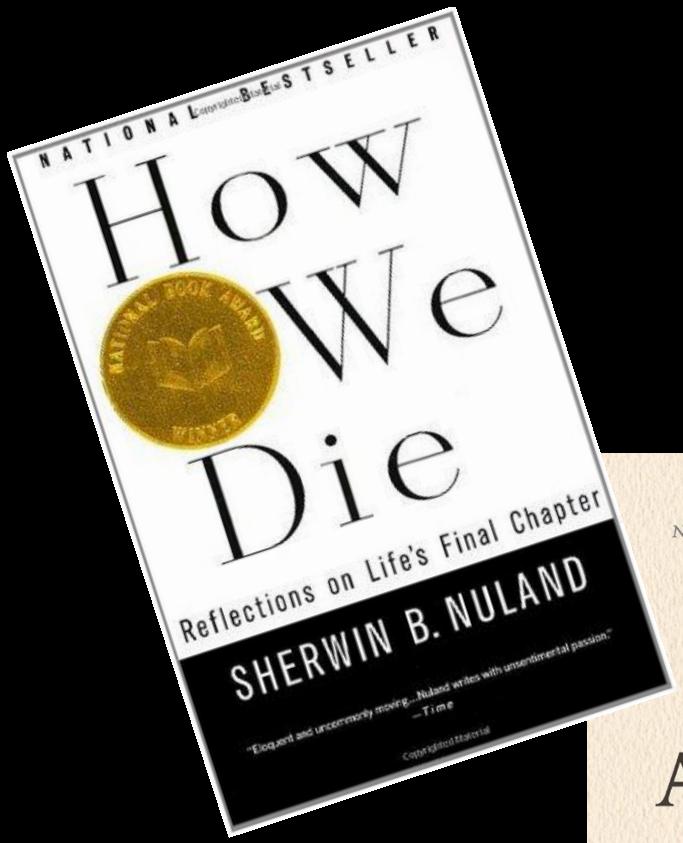
- Death is the final stage of life
- Death is less an event, than a process
- Death is a journey

Physician's Responsibilities Caring for Dying Patients & Patients with Life Limiting Illness

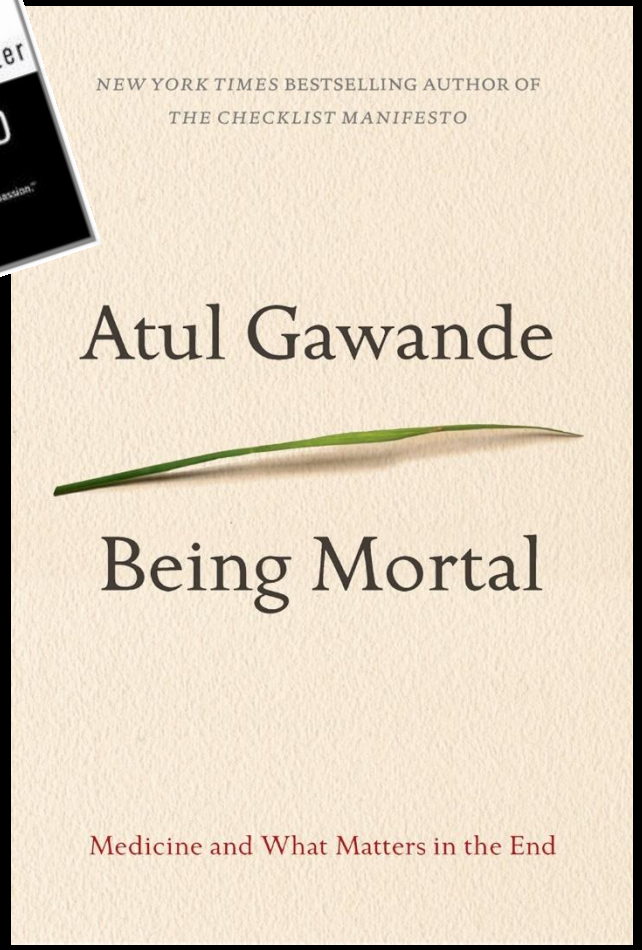
- Elicit Goals
  - Most people have priorities in life beyond living longer – ASK THEM
- Understand physiologic changes
- Manage symptoms
- Provide comfort
- Communicate honestly
- Plan of care of non-abandonment
- Educate patient, family, healthcare team
- Work as a team member
- Recognize ethical issues
- Complete responsibilities after a patient dies

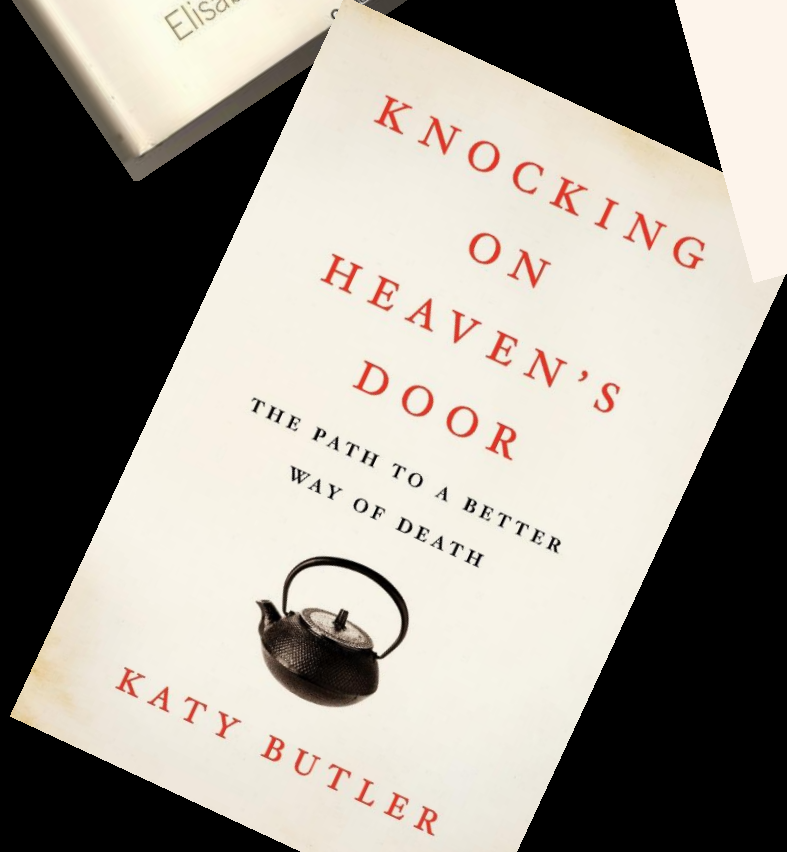
Challenges…

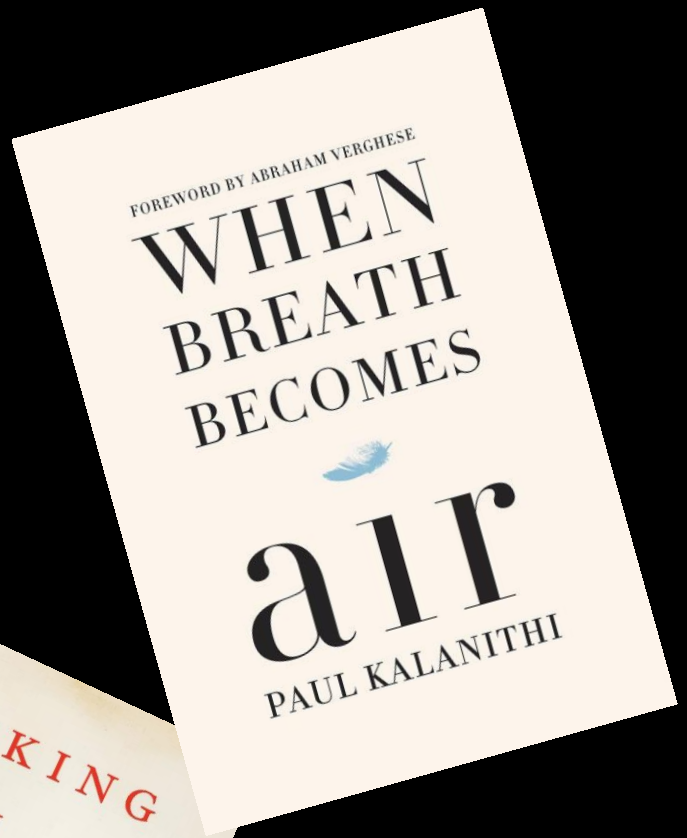
- “We” are uncomfortable discussing issues related to death and dying
- Death may be seen as a medical “failure”
- Advanced therapies
  - Burdens > Expected benefits
- Ethical issues: Withdrawal vs with-holding therapies, principle of “double effect”
- Decision-making
  - Many patients unable to make decisions as diseases progress
    - Medical team must communicate with healthcare proxies or surrogate decision makers
- Care not aligned with patient’s goals
- Patient, and family, distress
  - Physical, Social, Emotional, Spiritual


NATIONAL BESTSELLER
How We Die
NATIONAL BOOK AWARD WINNER
Reflections on Life's Final Chapter
SHERWIN B. NULAND


ON DEATH AND DYING
What the dying have to teach doctors, nurses, clergy and their own families
Elisabeth Kübler-Ross


NEW YORK TIMES BESTSELLING AUTHOR OF THE CHECKLIST MANIFESTO
Atul Gawande
Being Mortal
Medicine and What Matters in the End


KNOCKING ON HEAVEN'S DOOR
THE PATH TO A BETTER WAY OF DEATH
KATY BUTLER


FOREWORD BY ABRAHAM VERGHESE
WHEN BREATH BECOMES
air
PAUL KALANITHI

Goal is not a "good death"

Goal is helping our patients live a good life until death

Atul Gawande, MD

The Dying Process:
Key Concepts for All Physicians

Post Mortem Responsibilities

The Dying Process

Symptom management

Organ Donation

Ethical Issues

Comfort Care

Post-Mortem Responsibilities

- Pronounce the patient dead
- Communicate with next of kin (family)
- Determine if Medical Examiner should be notified
- Request Autopsy
- Complete Death Certificate
- Collaborate with Gift of Hope re Organ Donation

The Pronouncement

- Identify the patient
- Examination
  - Assess response to verbal, tactile stimuli
    - overtly painful stimuli unnecessary
  - Listen for absence of heart sounds; feel for absence of carotid pulse
  - Look and listen for absence of spontaneous respirations
  - Note position of pupils , absence of pupillary light reflex
- Record the time at which assessment was completed (time of death)

Communication

- Be straightforward, clear
  - **Say “dead” “died”**
    - “Expired”, “passed away” can be misinterpreted
- Ask if family has any questions
  - Answer simply, accurately
- Offer condolences
  - “I’m sorry for your loss...” Or – “This must be very difficult for you....”

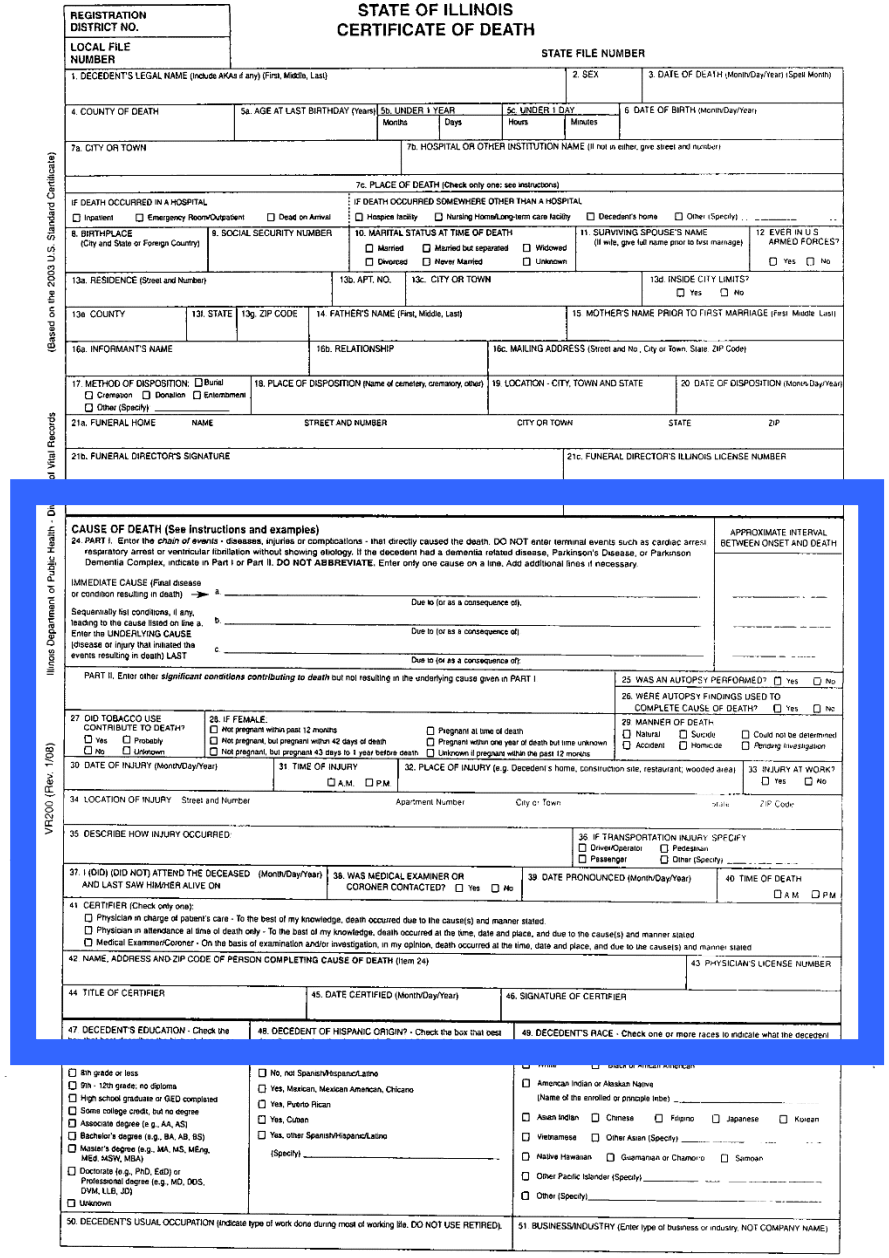
When to Contact ME Office?

- Violent deaths
  - trauma of any type
- Under influence of anesthesia, within 24 hours of anesthesia.
- Within 24 hours of admission
- industrial environment suspected as cause of the terminal disease
- illness began on the job
- "Dead on Arrival" in the Emergency Department
- Attending physician has no adequate or reasonable explanation of the cause of death.
- Addiction to alcohol or any drug contributory cause.
- Decedent was not attended by a licensed physician within the last 30 days.
- All deaths due to burns.
- Unexpected deaths.

Request for a medical autopsy

- Provide time for family to process death before requesting
- Request autopsy on ALL patients

Completing Death Certificate



REGISTRATION DISTRICT NO.

LOCAL FILE NUMBER

STATE OF ILLINOIS
CERTIFICATE OF DEATH

STATE FILE NUMBER

(Based on the 2003 U.S. Standard Certificate)

Illinois Department of Public Health - Division of Vital Records

VR200 (Rev. 1/08)

1. DECEDENT'S LEGAL NAME (Include AKAs if any) (First, Middle, Last) | 2. SEX | 3. DATE OF DEATH (Month/Day/Year) (Spell Month)

4. COUNTY OF DEATH | 5a. AGE AT LAST BIRTHDAY (Years) | 5b. UNDER 1 YEAR Months Days | 5c. UNDER 1 DAY Hours Minutes | 6. DATE OF BIRTH (Month/Day/Year)

7a. CITY OR TOWN | 7b. HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and number)

7c. PLACE OF DEATH (Check only one; see instructions)

IF DEATH OCCURRED IN A HOSPITAL
☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL
☐ Hospice facility ☐ Nursing Home/Long-term care facility ☐ Decedent's home ☐ Other (Specify) _____

8. BIRTHPLACE (City and State or Foreign Country) | 9. SOCIAL SECURITY NUMBER | 10. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Married but separated ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown | 11. SURVIVING SPOUSE'S NAME (If wife, give full name prior to first marriage) | 12. EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No

13a. RESIDENCE (Street and Number) | 13b. APT. NO. | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? ☐ Yes ☐ No

13e. COUNTY | 13f. STATE | 13g. ZIP CODE | 14. FATHER'S NAME (First, Middle, Last) | 15. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

16a. INFORMANT'S NAME | 16b. RELATIONSHIP | 16c. MAILING ADDRESS (Street and No., City or Town, State, ZIP Code)

17. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Other (Specify) _____ | 18. PLACE OF DISPOSITION (Name of cemetery, crematory, other) | 19. LOCATION - CITY, TOWN AND STATE | 20. DATE OF DISPOSITION (Month/Day/Year)

21a. FUNERAL HOME NAME | STREET AND NUMBER | CITY OR TOWN | STATE | ZIP

21b. FUNERAL DIRECTOR'S SIGNATURE | 21c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER

CAUSE OF DEATH (See instructions and examples)

24. PART I. Enter the *chain of events* - diseases, injuries or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest or ventricular fibrillation without showing etiology. If the decedent had a dementia related disease, Parkinson's Disease, or Parkinson Dementia Complex, indicate in Part I or Part II. **DO NOT ABBREVIATE.** Enter only one cause on a line. Add additional lines if necessary.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____ Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST
b. _____ Due to (or as a consequence of):
c. _____ Due to (or as a consequence of):

PART II. Enter other *significant conditions contributing to death* but not resulting in the underlying cause given in PART I

25. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No

26. WERE AUTOPSY FINDINGS USED TO COMPLETE CAUSE OF DEATH? ☐ Yes ☐ No

27. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☐ No ☐ Unknown

28. IF FEMALE: ☐ Not pregnant within past 12 months ☐ Not pregnant, but pregnant within 42 days of death ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Pregnant within one year of death but time unknown ☐ Unknown if pregnant within the past 12 months

29. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined ☐ Pending Investigation

30. DATE OF INJURY (Month/Day/Year) | 31. TIME OF INJURY ☐ A.M. ☐ P.M. | 32. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) | 33. INJURY AT WORK? ☐ Yes ☐ No

34. LOCATION OF INJURY Street and Number | Apartment Number | City or Town | State | ZIP Code

35. DESCRIBE HOW INJURY OCCURRED

36. IF TRANSPORTATION INJURY, SPECIFY ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____

37. I (DID) (DID NOT) ATTEND THE DECEASED (Month/Day/Year) AND LAST SAW HIM/HER ALIVE ON | 38. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ Yes ☐ No | 39. DATE PRONOUNCED (Month/Day/Year) | 40. TIME OF DEATH ☐ A.M. ☐ P.M.

41. CERTIFIER (Check only one):
☐ Physician in charge of patient's care - To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Physician in attendance at time of death only - To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Medical Examiner/Coroner - On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

42. NAME, ADDRESS AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 24) | 43. PHYSICIAN'S LICENSE NUMBER

44. TITLE OF CERTIFIER | 45. DATE CERTIFIED (Month/Day/Year) | 46. SIGNATURE OF CERTIFIER

47. DECEDENT'S EDUCATION - Check the
☐ 8th grade or less
☐ 9th - 12th grade; no diploma
☐ High school graduate or GED completed
☐ Some college credit, but no degree
☐ Associate degree (e.g., AA, AS)
☐ Bachelor's degree (e.g., BA, AB, BS)
☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)
☐ Unknown

48. DECEDENT OF HISPANIC ORIGIN? - Check the box that best
☐ No, not Spanish/Hispanic/Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
(Specify) _____

49. DECEDENT'S RACE - Check one or more races to indicate what the decedent
☐ White ☐ Black or African American
☐ American Indian or Alaskan Native (Name of the enrolled or principle tribe) _____
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
☐ Vietnamese ☐ Other Asian (Specify) _____
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan
☐ Other Pacific Islander (Specify) _____
☐ Other (Specify) _____

50. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED). | 51. BUSINESS/INDUSTRY (Enter type of business or industry. NOT COMPANY NAME)

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Cause of death

a IMMEDIATE Cause of Death

final disease or condition resulting in death

b Conditions leading to the cause of death listed on line a

What caused a?

c UNDERLYING Cause of Death LAST

disease or injury that initiated the events resulting in death (What cause b?)

Organ Donation

- via Gift of Hope

The Dying Process…
Technologies at the End of Life include…

- Mechanical ventilation
- Hemodialysis
- Defibrillators
- Pacemakers
- Left ventricular assist devices (LVADs)

The Dying Process…
Ethics of dying

- Euthanasia
- Physician Assisted Dying

Euthanasia (Voluntary Active Euthanasia)

- The physician intentionally
  - ends the patient's life
  - at the patient's request
  - with the patient's full informed consent

  - No state in the United States permits euthanasia
  - Euthanasia is legal only in the Netherlands, Belgium, Luxemburg, Columbia, and Canada (as of February 2016)

Physician Assisted Dying (PAD)

- A physician providing, at the patient's request
  - a prescription for a lethal dose of medication
  - that the patient can self-administer by ingestion
  - with the explicit intention of ending life

  - PAD has become a legally sanctioned activity, subject to safeguards, first in Oregon in 1997 and, subsequently, in other states - Washington, Vermont, California, Colorado; and by court ruling in Montana

American Academy of Hospice and Palliative Medicine (AAHPM) Statement on Physician Assisted Dying (June 2016)

….Social policy concerns notwithstanding, the Academy recognizes that in particular circumstances some physicians assist patients in ending their lives. Efforts to augment patients' psychosocial and spiritual resources so that they are better able to manage their **suffering,** may make palliative treatments of **physical symptoms** more effective, and may make these circumstances rarer. Nevertheless, some patients will continue to desire PAD…

Causes of “Suffering” in Seriously Ill and Dying Patients

- Nausea, vomiting
- Constipation
- Dyspnea
- Pruritus
- Fatigue
- Anorexia
- Pain
- Anxiety
- Depression
- Fear of dying
- Fear of leaving loved ones
- Loss of control
- Become a burden

Total Pain

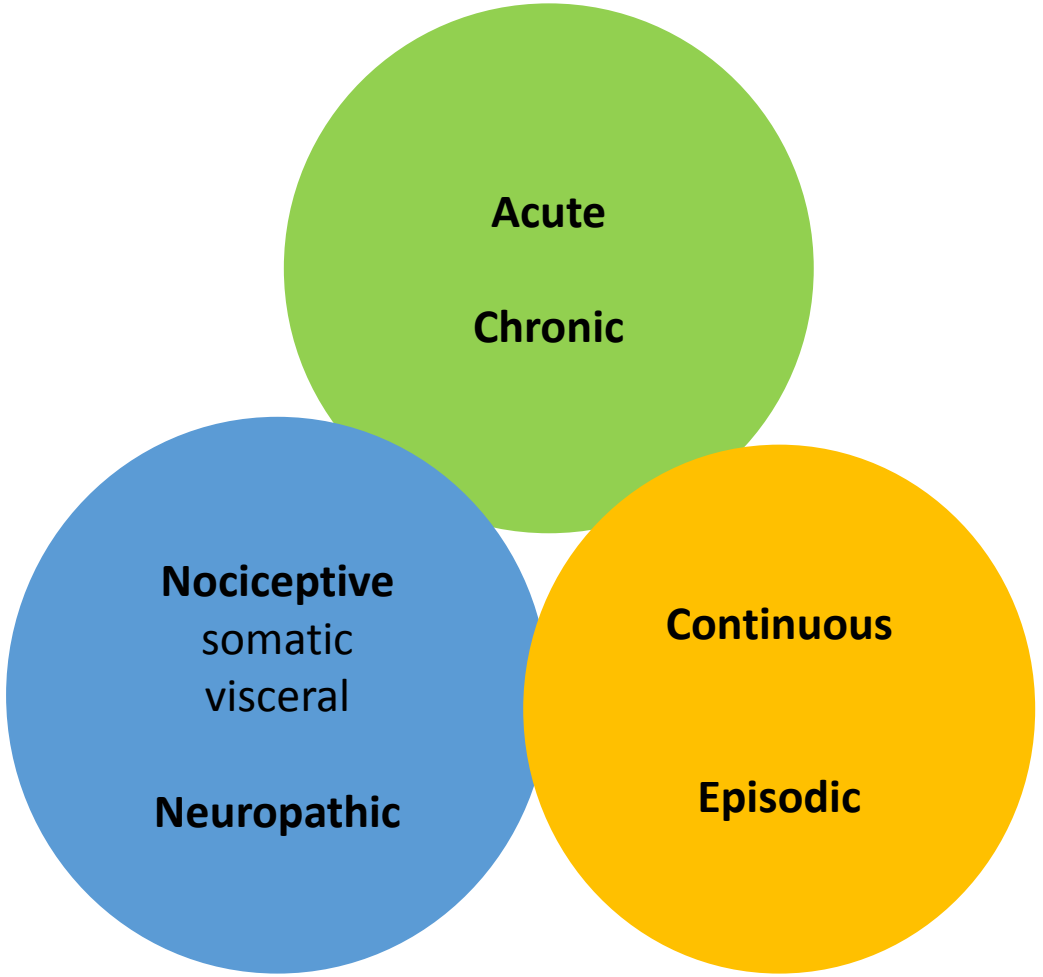
- Physical
- Emotional
- Social
- Spiritual

Cicely Saunders

Definition of Pain

- Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage
  - *International Association for the Study of Pain*

“Physical Pain”



Physical Pain

- Acute
  - Primarily symptom of pathological process or injury
  - Treating illness or injury typically will reduce or eliminate symptoms
  - Duration usually <3 months

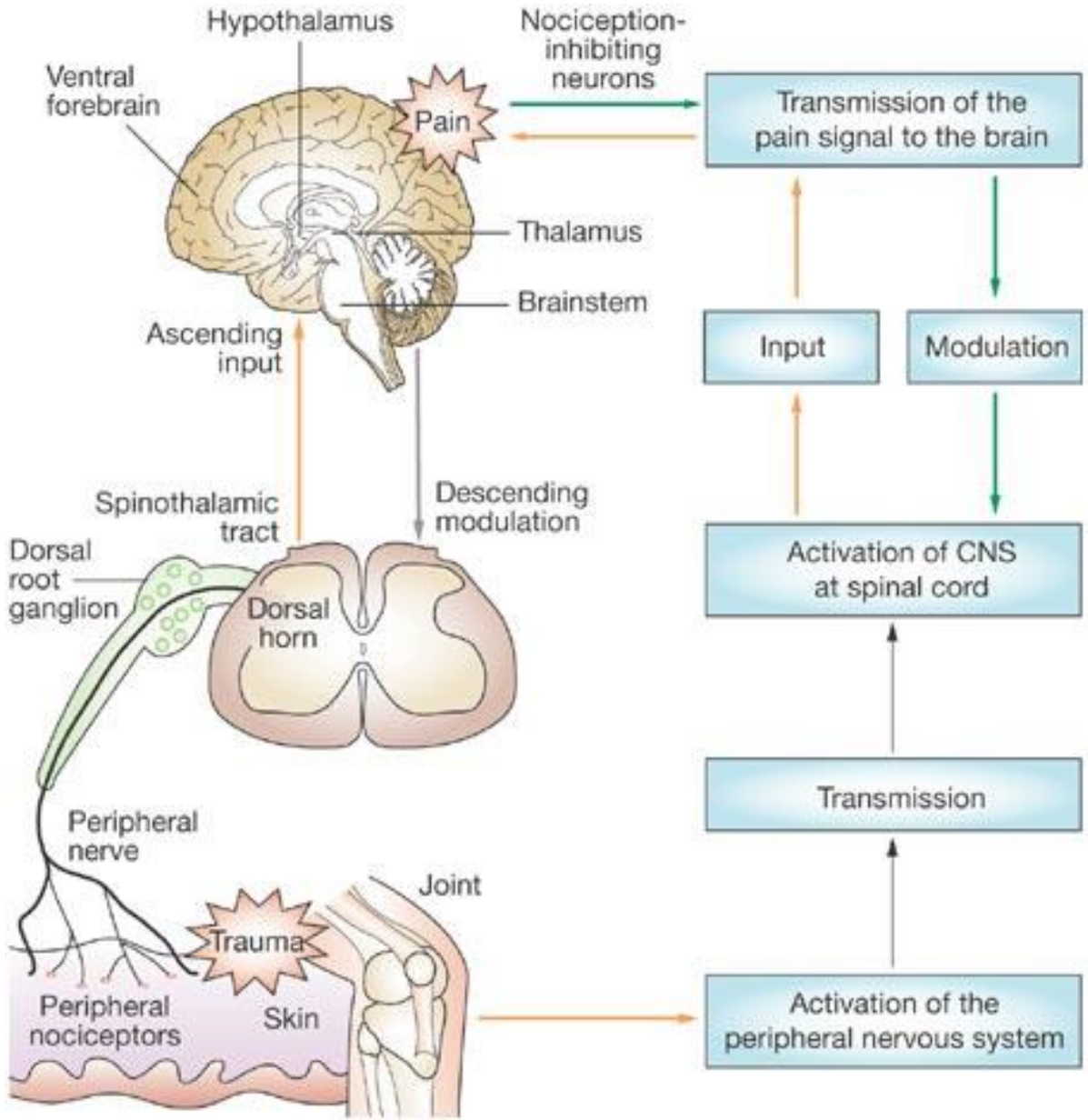
- Chronic
  - Pain which lasts beyond ordinary duration of time that an insult or injury to the body requires to heal
  - Typically lasting > 3-6 months
    - A*cute pain* evolves into *chronic pain* in ~20% patients

Physical Pain

- **Nociceptive**
  - Somatic
    - Body surface tissue or musculoskeletal tissue
    - Localized, sharp
  - Visceral
    - Result of compression, obstruction, infiltration, ischemia, stretching, inflammation of thoracic, abdominal or pelvic visceral
    - Not well localized

- **Neuropathic**
  - Damage to or dysfunction of peripheral or central nervous system, rather than stimulation of pain receptors
  - Burning, lancinating, shooting

Nociceptive Pain Pathway



General Principles for Pain Management

- Assess pain thoroughly
- Know pharmacologic and nonpharmacologic options
- Dose to reduce pain by at least 50%
- Reassess frequently

WHO 3-Step Ladder

Step 1 - Mild

Aspirin

Acetaminophen

NSAIDs

Step 2 - Moderate

Codeine/…

Hydrocodone/…

Oxycodone/…

…/acetaminophen or NSAID

Tramadol

Step 3 - Severe

Morphine

Hydromorphone

Methadone

Oxycodone

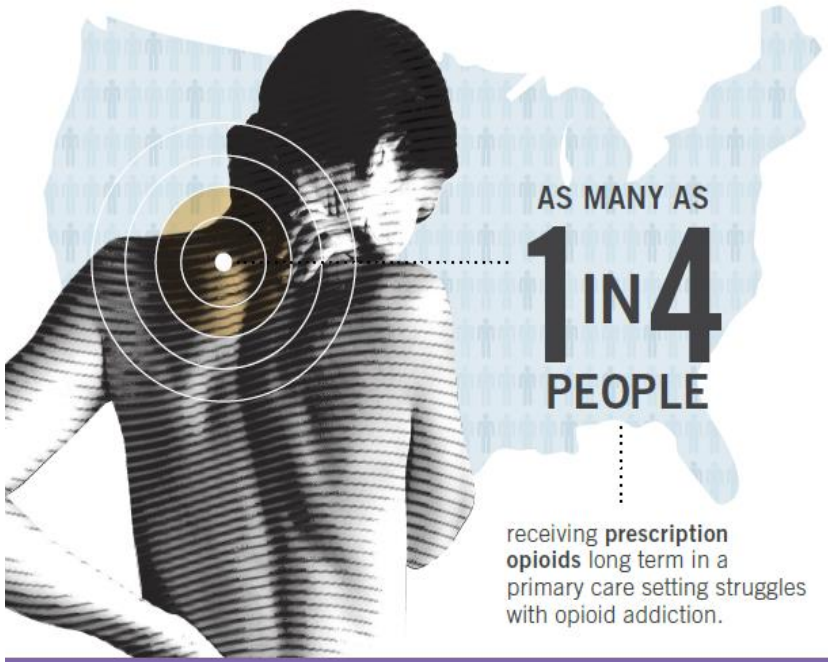
Fentanyl

Always consider adding an adjuvant Rx

“Adjuvant Analgesic”

- Drug which has a primary indication other than pain management
- Acts as analgesic in certain painful conditions
  - Antidepressants
  - Corticosteroids
  - Anticonvulsants
  - Local anesthetics
  - Osteoclast inhibitors
  - Radiopharmaceuticals
  - Muscle relaxants
  - Benzodiazepenes

KNOW THE RISKS



AS MANY AS

1 IN 4

PEOPLE

receiving **prescription opioids** long term in a primary care setting struggles with opioid addiction.

MANAGE YOUR PAIN, MINIMIZE YOUR RISK.

Chronic pain can be devastating, and effective pain management is essential to get your life back. Talk to your doctor about ways to manage your pain that don't involve prescription opioids, such as:

- Non-opioid pain relievers, such as acetaminophen (Tylenol®), ibuprofen (Advil®), or naproxen (Aleve®)
- Physical therapy and exercise
- Cognitive behavioral therapy
- Certain antidepressants and anticonvulsants

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

LEARN MORE | www.cdc.gov/drugoverdose/prescribing.guideline.html

Opioids for Patients with Life-Limiting Illness

- Routes of administration
  - **Oral**, Intravenous
    - subcutaneous, transdermal, transmucosal, rectal, spinal

- Oral Opioid formulations
  - Immediate Release
  - Extended release

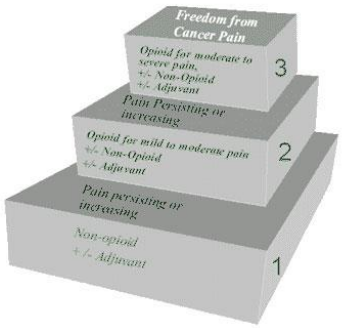
Immediate Release Oral Opioids

- Administered as
  - single agents
  - combination products

- Peak analgesic effect occurs in 60-90 minutes
- Expected total duration of analgesia of 3-4 hours

- Single agent
  - Generally q 4 hour dosing
    - “as needed” for episodic pain
      - May be at intermittent q 2 hour intervals
    - “scheduled” for continuous pain

Combination opioid/nonopioid



>50 different combination products

- Contain either acetaminophen, aspirin or ibuprofen, with an opioid
- Range of tablet strengths and liquids
- Typically used for moderate pain that is episodic
  - Generally Q 4 hours PRN dosing
  - For continuous pain administered on around-the-clock basis

The dose limiting property of all the combination products is?

- aspirin, acetaminophen or NSAID

Extended-release opiate preparations

- Morphine
  - Morphine ER, MS Contin, Kadian, Avinza
- Oxycodone
  - Oxycodone ER, Oxycontin
- Fentanyl
  - Transderm patch (Duragesic)
- Hydrocodone, Hydromorphone

Extended-release opioid preparations

- Dose q 8, 12, or 24 h (product specific)
  - Do not crush or chew capsules
  - No capsules down feeding tubes
- Adjust dose q 2–4 days (once steady state reached)
- Fentanyl transderm q 72 hours
  - Adjust dose at 6 days (once steady state achieved)
  - Recommend immediate release opioid for “Breakthrough Pain”

Important Tool – Equianalagesic Table

Equianalgesic Dose

Drug Name	Oral (mg)	Parenteral (mg)
Morphine	30	10
Hydromorphone	7.5	1.5
Oxycodone	20	N/A
Hydrocodone	30	N/A
Morphine	200	130

Opioid Side Effects

- Constipation
  - *He/She who writes the opioid prescription writes the bowel regimen*
- Nausea, vomiting
- Urinary Retention
- Pruritus
- Lethargy, mental clouding
- Somnolence
- Respiratory Depression

- Hypogonadism
- Secondary adrenal insufficiency

Key points:

- Treating pain is an ethical imperative
- Balance of benefits vs side effects
- If using opioids
  - Control uncontrolled pain with short acting opioids
  - Long-Acting Opioids
    - For chronic, around the clock pain
    - Begin once pain is controlled with short acting agents
      - Need short acting opioid for breakthrough pain
- Use of adjuvants when appropriate

Case

A 62-year old woman with a history of breast cancer presented with 10/10 back pain and was diagnosed with new multiple level vertebral metastases. She has a history of bleeding duodenal ulcer and diabetic nephropathy with CKD stage 2. She is taking 2 tablets of oxycodone/acetaminophen 5/325mg nearly every 4 hours for the past two weeks. Her pain is constant. She rates her pain ~-3-4/10 after her "pain medicine kicks in“ and then increases back up to 9-10/10. She is being assessed for radiation therapy. Which of the following is the best next step in her pain management?

a. Increase the oxycodone/acetaminophen 5/325 to 3 tablets every 4 hours
b. Change to 2 tablets hydrocodone/acetaminophen 5/325 every 4 hours
c. Change to extended release oxycodone 30mg capsules every 12 hours
d. Change to oxycodone extended release 30mg capsules every 12 hours with oxycodone 7.5 for breakthrough pain every 2 hours as needed
e. Change to hydromorphone 4mg tabs every 4 hours
f. Begin ibuprofen 600mg every 6 hours
g. Begin gabapentin 100mg tid

a. Increase the oxycodone/acetaminophen 5/325 to 3 tablets every 4 hours

b. Change to 2 tablets hydrocodone/acetaminophen 5/325 every 4 hours

c. Change to sustained release oxycodone 30mg capsules every 12 hours

d. Change to oxycodone extended release 30mg capsules every 12 hours with oxycodone 7.5 for breakthrough pain every 2 hours as needed

e. Change to hydromorphone 4mg tabs every 4 hours

f. Begin Ibuprofen 600mg every 6 hours

g. Begin gabapentin 100mg tid

- Pain Management Practice…..

- LUMEN – End of Life Vertical Integrated Curriculum

http://www.stritch.luc.edu/lumen/MedEd/softchalkhdht/kristopaitisendoflife/index.html

The Dying Process:
Key Concepts for All Physicians

Post Mortem Responsibilities

The Dying Process

Symptom management

Organ Donation

Ethical Issues

Comfort Care