PCM-3
END of LIFE
Session 2

Session Objectives

- At the conclusion of this PCM-3 session, students will be able to:
  - Analyze decisions to forgo life-sustaining treatments in terms of their underlying ethical and medical principles.
  - Develop a plan of comfort care for a dying patient
  - Reflect on professional experiences around death and loss
  - Begin developing personal strategies to cope with grief and loss
  - Demonstrate knowledge of the philosophy of hospice and the services provided by a hospice program

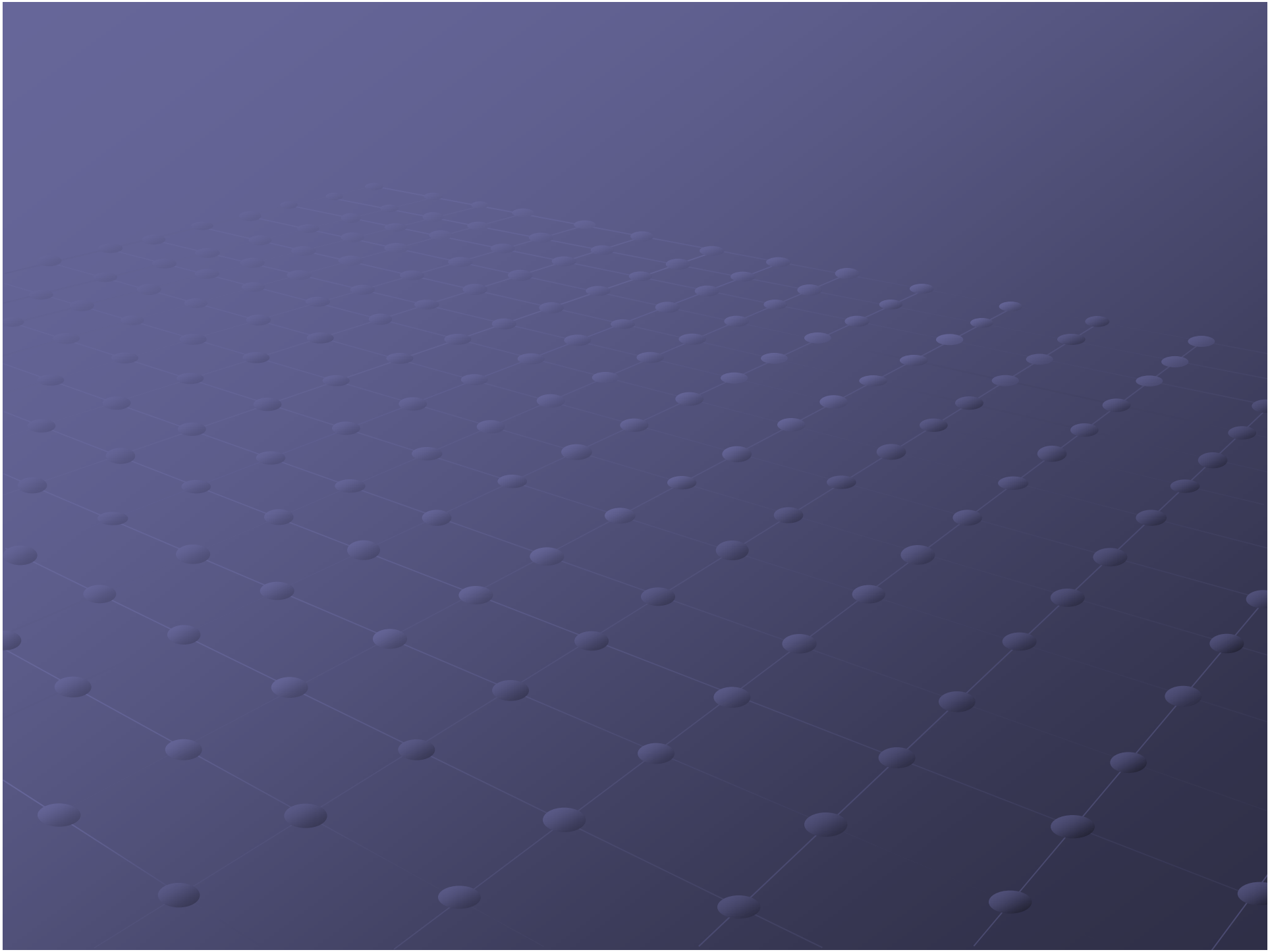
Session Agenda

- Introduction/Case 9:45-10:00am
- End of Life Ethics/Ethical Myths 10:00-10:45 am
  - Mark Kuczewski, PhD
- Caring for the Imminently Dying Patient/"Comfort Care" 10:50-11:35am
  - Theresa Kristopaitis, MD
- Panel Discussion: "The Ways We Cope: Physicians and Patient Loss 11:45-12:40pm
  - Drs. Eva Bading, Mary Boyle, Nate Derhammer, Dan Dilling, Arthur Sanford, Margot Shoup
- Nuts and Bolts of Hospice 12:45-1:15pm
  - Theresa Kristopaitis, MD

- *There's nothing certain in a man's life except this: That he must lose it.* ~Aeschylus, *Agamemnon*

- *Death is beautiful when seen to be a law, and not an accident - It is as common as life.* ~Henry David Thoreau, 11 March 1842, letter to Ralph Waldo Emerson

- *A dying man needs to die, as a sleepy man needs to sleep, and there comes a time when it is wrong, as well as useless, to resist.* ~Stewart Alsop



Case

- Mr. Jones
  - “but everyone should call me Johnnie”
- CC: Johnnie is sick x 3 days
- 82-year old man with moderately severe Alzheimer’s dementia

- Baseline
  - Takes steps from bed to chair with max assistance
  - Appetite “great”
    - chews slowly
      - food “goes down the wrong pipe” sometimes
  - Incontinent of urine and stool
  - Does not regularly recognize his 2 sons
  - Lives in his home of 50 years
  - Has a 24 hour hired live-in caregiver
  - “Still lights up when watching Chicago sports”

- Past several days
  - Coughing
  - Fever to 101.1^{0}F
  - Difficulty getting out of bed and walking
  - Decreased appetite
  - Less responsive

  - Caregiver brings him to the emergency room for evaluation

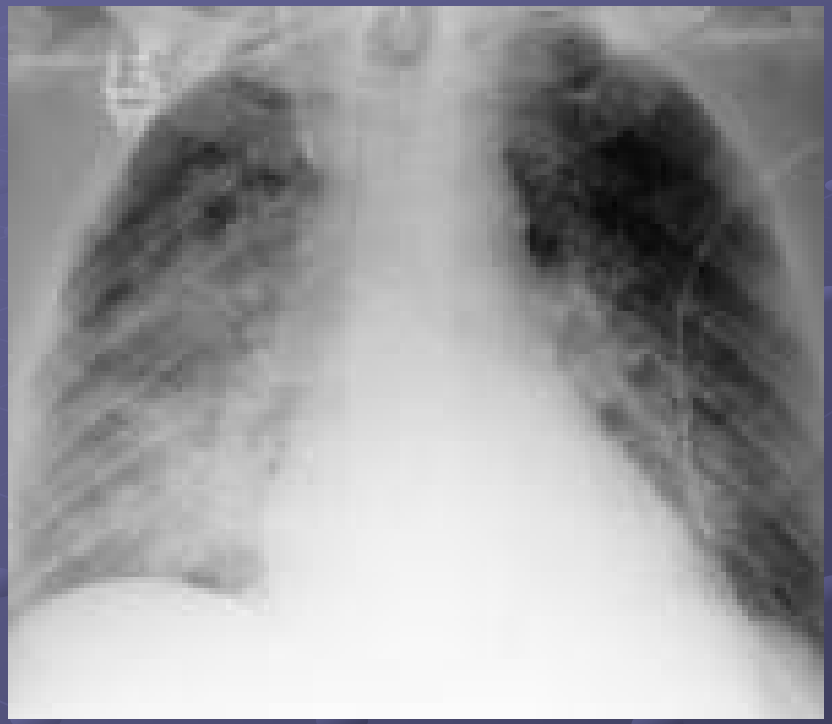
- PMHx
  - Alzheimer Dementia
  - Hyperlipidemia
- Medications
  - Memantine
  - Atorvastatin
- Allergies:
  - NKDA

Social History

- Divorced x 2; widowed x 1
- Has two sons from his first marriage
  - 1 lives several miles from his father
  - 1 son lives 1000 miles away
- Never smoked cigarettes
- Has “1/2 shot-glass of Jack” with dinner
- Occupation: ”best damn used car salesman there ever was”
  - Worked since high school graduation until age 66

Physical Exam

- Patient appears younger than stated age, moaning
- Temp: 38.9^{0}C, Pulse: 101, BP: 96/52, RR: 28; Pulse Ox 82% RA
- Wearing Cubs cap, White Sox shirt, Bears boxers, Black Hawk stockings
- Dry oral mucosa
- Scattered course breath sounds right >left lung field
- No skin break down



Plan of Care

- Medical Therapy
- Are there Advance Directives?
- What are the Goals of Care?
- What is the Resuscitation Preference?

Page to Primary Care Physician

- “I’ve taken care of Johnnie for many years. I asked him so many times ‘Johnnie, what are we going to do if things are starting to go not so good?’ He saw his third wife suffer from ALS. He seemed to understand what dementia was when we first talked about it. No matter how I tried to help him and his sons with decisions, he pleasantly dodged me”.

- Johnnie’s respiratory condition deteriorates within 3 hours of admission.
- After an urgent discussion with his son who lives locally, a decision is made to intubate and mechanically ventilate

- ICU course:
  - Hypotension
  - Acute renal failure
  - NSTEMI
  - GI bleed

- Hospital Day #7 – Family Meeting
- Both sons present
- “Let’s keep on trying”

Hospital Course Days 7-14

- Poor weaning parameters
- Sacral skin breakdown
- Intermittent fevers - ?source
- Fluid overloaded
- Creatinine uptrending - 3.2

Summary

- Patient has an advanced progressive neurodegenerative disease for which there is no cure.
- Patient has multi-organ system failure after 2 weeks of maximal medical therapy.

Hospital Day #15 - Family meeting

- “Local Son”
  - “My dad is a fighter. He should get whetever he needs - the dialysis, the trach and the feeding tube. Nobody should suffocate or starve to death”
- “Out of Town Son”
  - “My dad loves life. He loves it more than anybody. But he would not want all the tubes and machines at this stage. Let nature take its course”.

Plan?

END of LIFE ETHICS and ETHICAL MYTHS

Mark Kuczewski, PhD

Case Continued

- No clear improvement over next 5 days
- Additional dialogue
- Decision made to pursue “comfort measures”
  - “DNR” code status
  - Johnnie is extubated
  - Breathing on his own!?
  - Lethargic
  - Prognostication: Death hours to day(s)?
  - Transferred out of ICU to a private general medical floor room after 24 hours observation


UBS

Care of Imminently Dying Patient
"Comfort Care"

Theresa Kristopaitis, MD

Case continued

- Two days after Johnnie is extubated, his primary care physician visits him. As he/she leaves the room, he/she tells his nurse “I’m gonna’miss that ol’ guy. He became my patient not long after I finished residency”.

- Johnnie dies twenty four hours later with his sons at his bedside

The Ways We Cope: Physicians and Patient Loss

Panel Discussion

Dr. Eva Bading
Dr. Mary Boyle
Dr. Nate Derhammer
Dr. Dan Dilling
Dr. Arthur Sanford
Dr. Margot Shoup