End of Life and Trauma: Facilitating A Good Death After Injury

No Conflicts of Interest…Except

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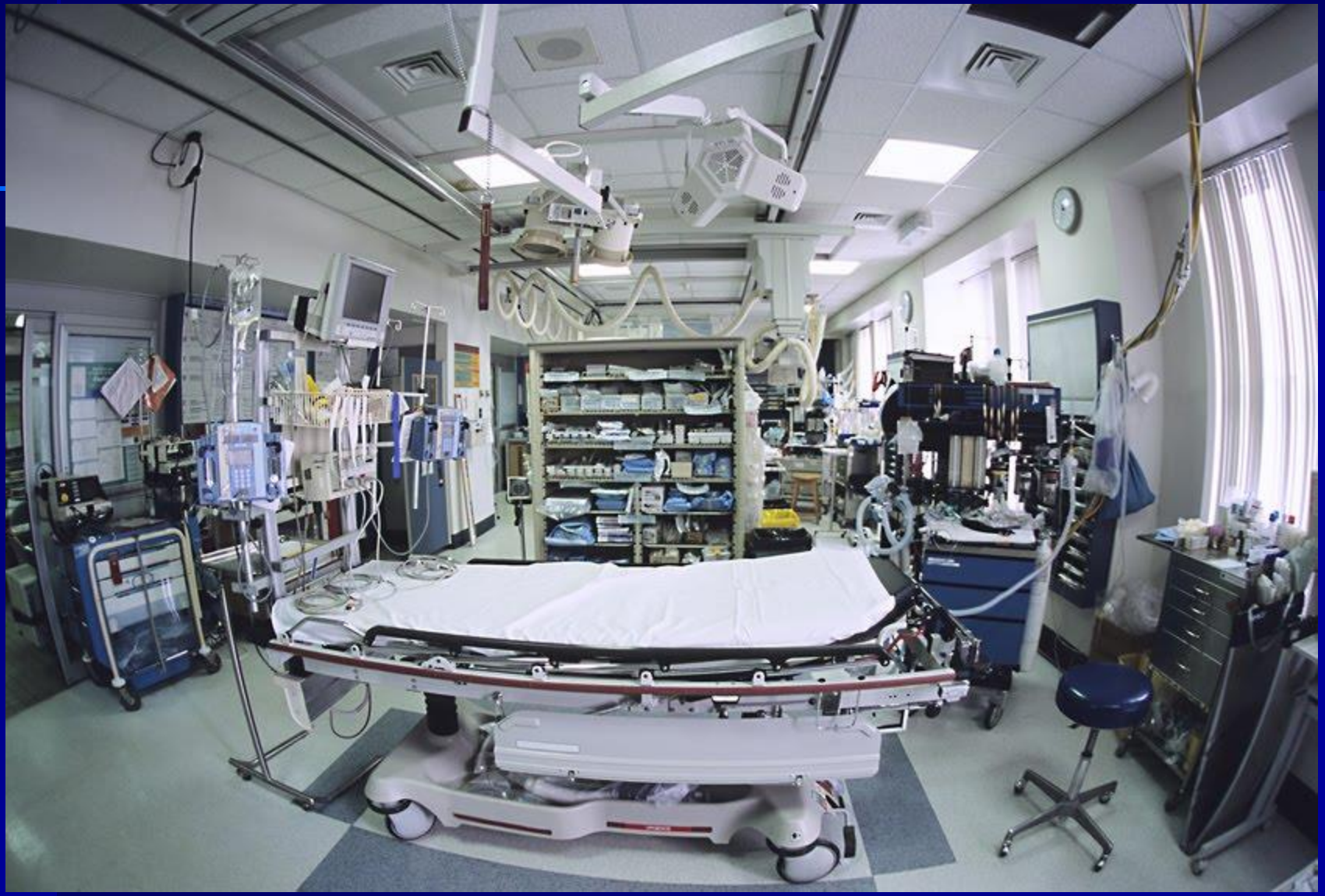
At the End of this Session the Participant will be able to:

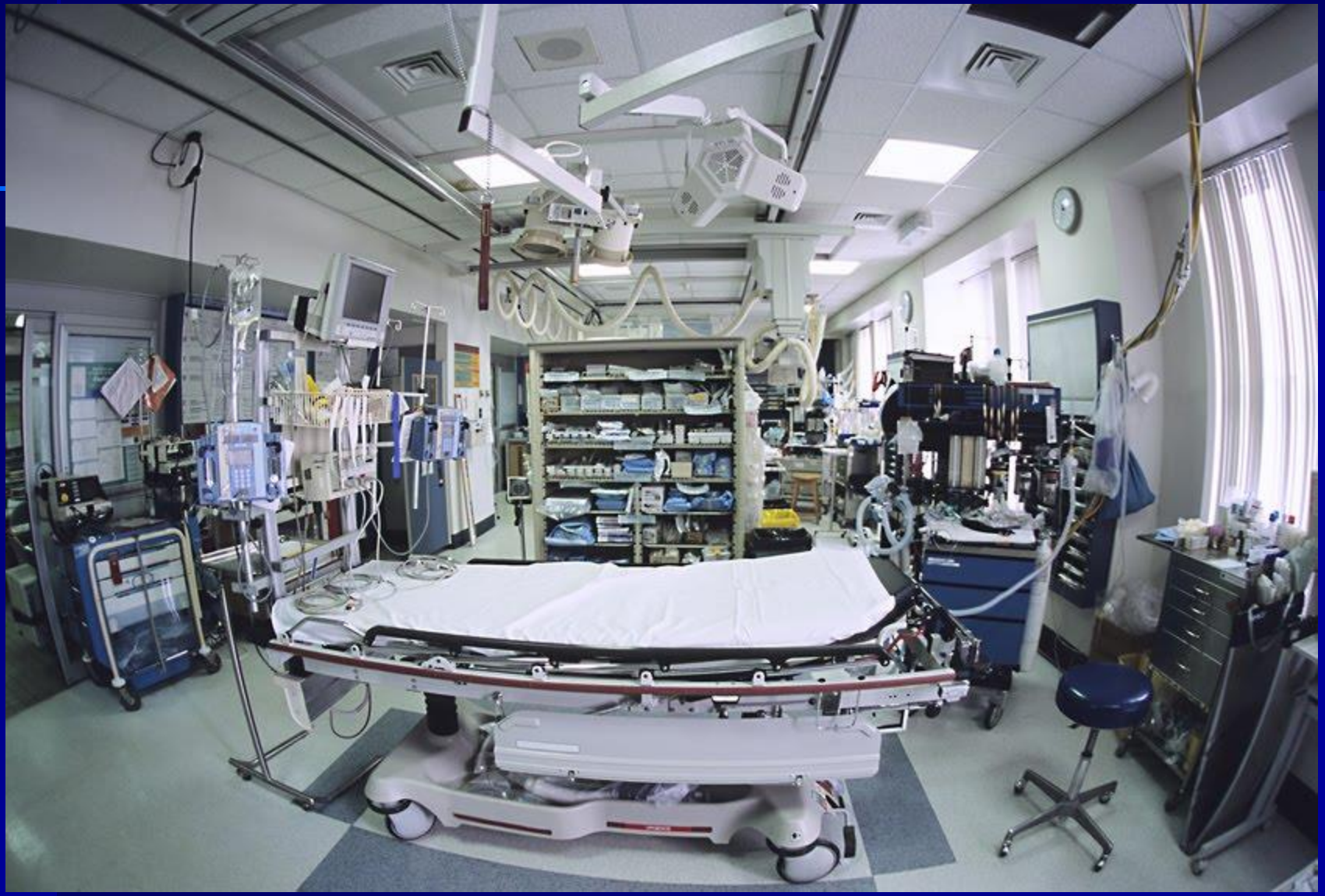
- Describe the conflicts in trauma EOL care
- Discuss the current definitions of futile and palliative care
- Define the issues preventing a "good death" in the trauma ICU
- Assimilate the issues associated with caring for the patient and family

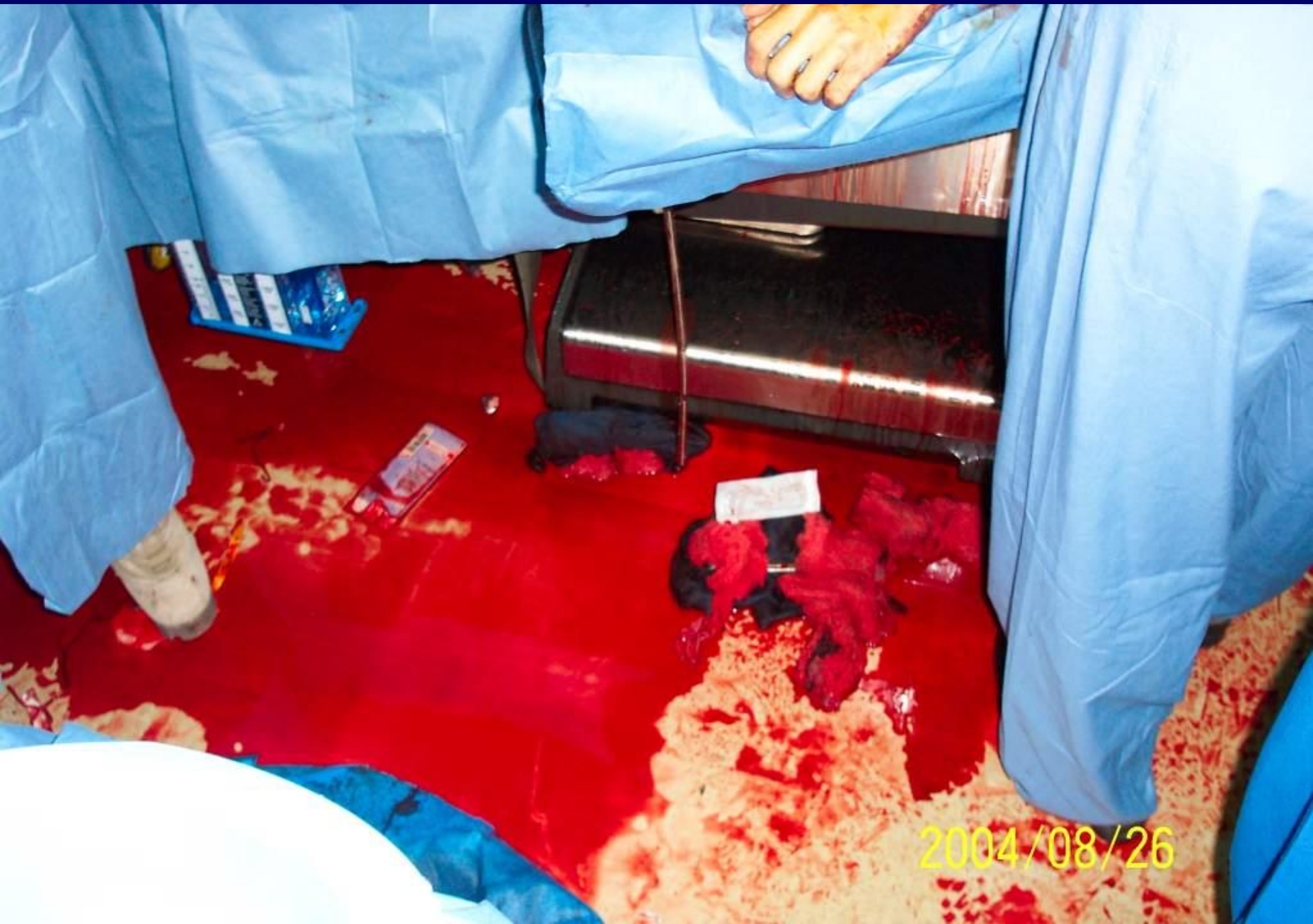
- ***Trauma is an irretrievable moment in time***
- ***Trauma is the only 100% preventable disease***
- ***We should make every effort to put ourselves out of work***

Trauma is Here to Stay

- 2000 5 million people died as a result of injury
- Leading cause of death for those < 44
- By 2020 there will be 8.4 million deaths
- 1/3 will be from haemorrhagic shock

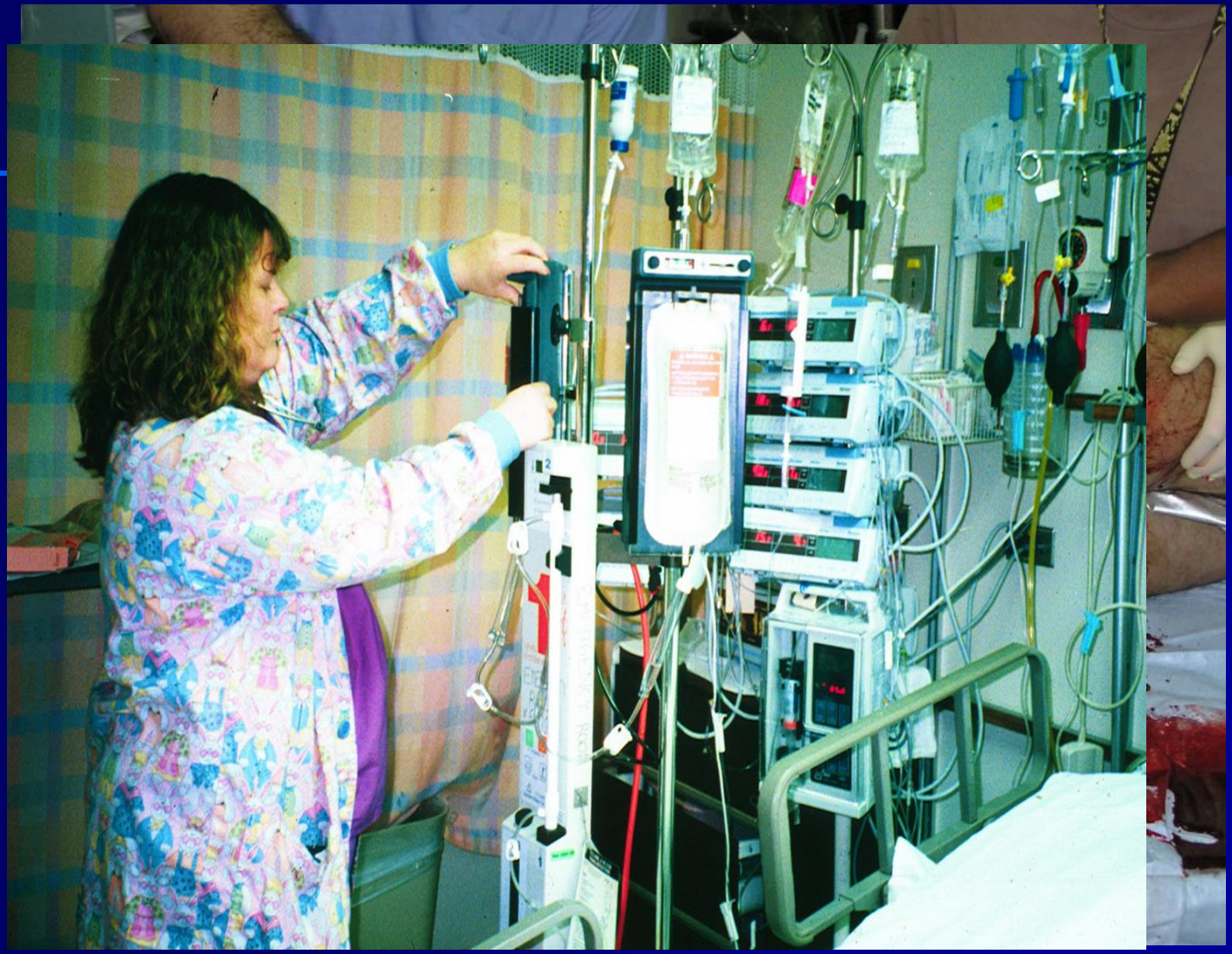





2004/08/26

The Trauma Care Showdown

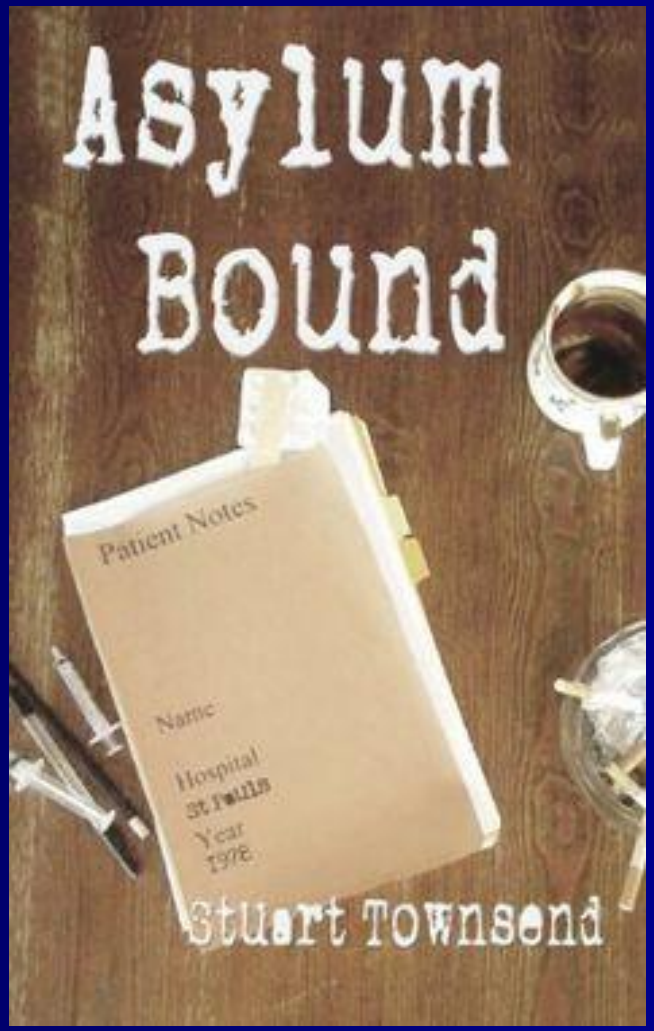

AIR-



Where are We Heading?

- ICU care has 2 major goals:
  - Save lives by intensive and invasive therapies.
  - Provide a peaceful and dignified death when death is inevitable.

Where We Often Feel We Are Heading!



What We See Daily

- Critical care and ED nurses attend to large numbers of dying patients
- An estimated 20% of critically ill and injured patients die while hospitalized
- Life and death decisions have to be made quickly
- Many of the patients are unconscious
- Discussion with patients about limitation of treatment occurs relatively infrequently
- DNR decisions are left until late in the illness, just days before death
- More common for patient's families to be the decision makers

Care at the End of Life

Cassell, 2013; Critical Care Medicine

- Ethnographic study of three hospitals
- Surgeons - most important goal is defeating death
- Intensivists - scarce resources and quality of life

Care at the End of Life

- Critical Care Surgeons - covenantal ethics:
  - surgeons define their relationship to the patient as a promise to battle death on behalf of the patient
  - choice is simple---life or death
  - quality of that life TRADITIONALLY ---not pertinent

Goals of Healthcare

- Restore health
- Relieve suffering
- These goals are not incompatible. The treatment being offered must be defined within the context of the goals.

Trauma Critical Care Today

ACS Survey 2015

- 10 % Global mortality for traumatic injury
- ~ 20% of trauma admissions to the ICU will die
- >35% after long, invasive, costly stay
- Most related to brain injury/SCI
- The Glasgow Coma Score was not significant
- Level of SCI was related to survival

- Most deaths were related to very late withdrawal of support, associated with pain, discomfort and agony for families
- **SUPPORT 1998**, (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment)
- 1998 ACS, promoted EOL in ICU

  2016 < 10% of surgical residents are getting training in EOL care traumatically injured

How Are Trauma Patients Different? What About Us?

Patients:

- Without advance directives
- Uncertain prognosis
- Often functional capacity severely limited
- Relying on surrogate decision makers
- Often themselves in crisis
- Bereaved families
- Die late in hospitalization after long, invasive, costly care

Us

- **Rapid resuscitative and aggressive care approach**
- Death=Failure
- Culture of cure
- Personal beliefs about prognosis and functional outcome
- Personal experiences
- Institutional resources
- Rehab and support network

EOL and Trauma-Paucity of Literature

Some Studies

Ball, et al, JOT 2010 survey of 420 MDs

- ~51% patients with EOL care guided by the CC team
- Ethics/Palliative care team available ~ 95% of the time and used < 29%
- Significant disparity of care

Sise, et al JOT

- 2013, Withdrawal of care-retrospective assessment for 10 years at a Level I TC
- Withdrawal or Limitation of Care (WLC) in 54% of all deaths and 93% of death within 24 hours
- Family conflicts seen on only 7% and ethics called 3%
- Linear escalation of consultation of Palliative Care Team

Background

- Majority of deaths involve the withholding or withdrawal of multiple life-sustaining therapies
- Decision making and communication about these end-of-life decisions are difficult
- Understanding hospital culture is critical

Do We Get it?

- Study of inpatient MD/family interactions:
  - MDs spend 75% of time talking
  - Missed important opportunities for patients/families to discuss personal values important goals of treatment
  - Majority of MD's felt they did a good job

Tulsky, J Gen Int Med 2013

Missed Opportunities

- Study of MD/family meetings Families of Critically Ill/Injured Patients:
  - MDs rarely explored patient/family goals and values
  - Avoided discussing uncertainty
  - Failed to explore reasons for choices
  - Failed to discuss quality of life after treatment

Tusky, *Ann Int Med* 2013

Ideal ICU Resuscitation Goal

- Both living and dying in the ICU system often involves focusing from the very beginning on comfort as well as cure. Palliative care must begin from the moment the patient and family enter the healthcare system. Providing the best possible patient and family-centered care, whether it is aimed at a "great save" or a "good death," should be our goal.

Effective Meetings

- Meeting early on and honest information is often helpful
- Most people make good decisions when given accurate information
- Those families that are comfortable with the concept of EOL care will be more amenable to palliative approach

Routine Family Meetings

- Diagnosis based
- Time based
- > 3 day ICU stay
- Initial meeting scheduled
- More often or comprehensive if needed

The Journal of TRAUMA
Injury, Infection and Critical Care

Giving Bad News: The Family Perspective

Gregory J. Jurkovich, MD, Becky Pierce, RN, Laura Pananen, RN, and Frederick P. Rivara, MD, MPH

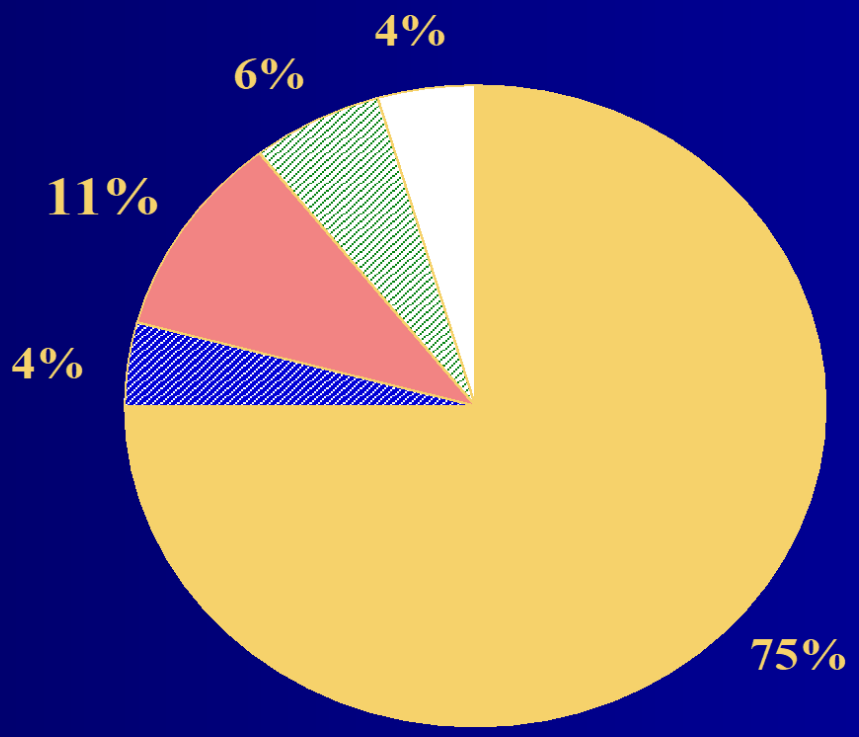
Background: Death from trauma frequently comes without forewarning. Relating the news of death to the family is often the responsibility of trauma surgeons. The purpose of this study was to investigate the key characteristics and methods of delivering bad news from the perspective of surviving family members.

in 69% of the patients and within 1 week in 83%. The most important features of delivering bad news were judged to be attitude of the news-giver (ranked most important by 72%), clarity of the message (70%), privacy (65%), and knowledge/ability to answer questions (57%). The attire of the news-giver

Results

- Conducted over 18 months; 119 deaths
- Families contact 2 m - 6 m after death
- Poor mail response (25%) n=20
- Excellent phone response (87%) n=34
- 54 family members
- 48 deceased patients

Mechanism



When Informed

- Before death 44%
- While patient agonal 26%
- After death 24%
- “Never” 6%

Who Gave the News?

- Attending 7%
- Resident 17%
- “Doctor” 57%
- Nurse 9%
- Family/Friend 6%
- Can’t recall 4%

Where Was the News Given?

Conference room	26%
Waiting room	19%
Phone	15%
Hallway	15%
Patient's room	13%
ICU/Hospital	7%
Other/no response	5%

Qualities Valued-HIGH

- Attitude
- Clarity
- Privacy
- Knowledge
- Sympathy
- Time for questions
- Autopsy info
- Clergy

Physical Contact

–Do not touch	30%
–Touch desired	17%
–Hand-shake only	7%
–No comment	46%

Nearly Every Respondent Commented on These Four Elements

- Empathy of the news giver
- Clarity of the message
- Attitude of the news giver
- Ability to answer questions

Comments

- 87% had a positive comment
  - 51% were about nurses or hospital staff
  - 19% remarked on skilled and professional care
  - 11% specified physicians
  - 11% detailed specific kindness, single act
- 74% had a negative comment
  - 12% about physicians
  - 12% parking and housing

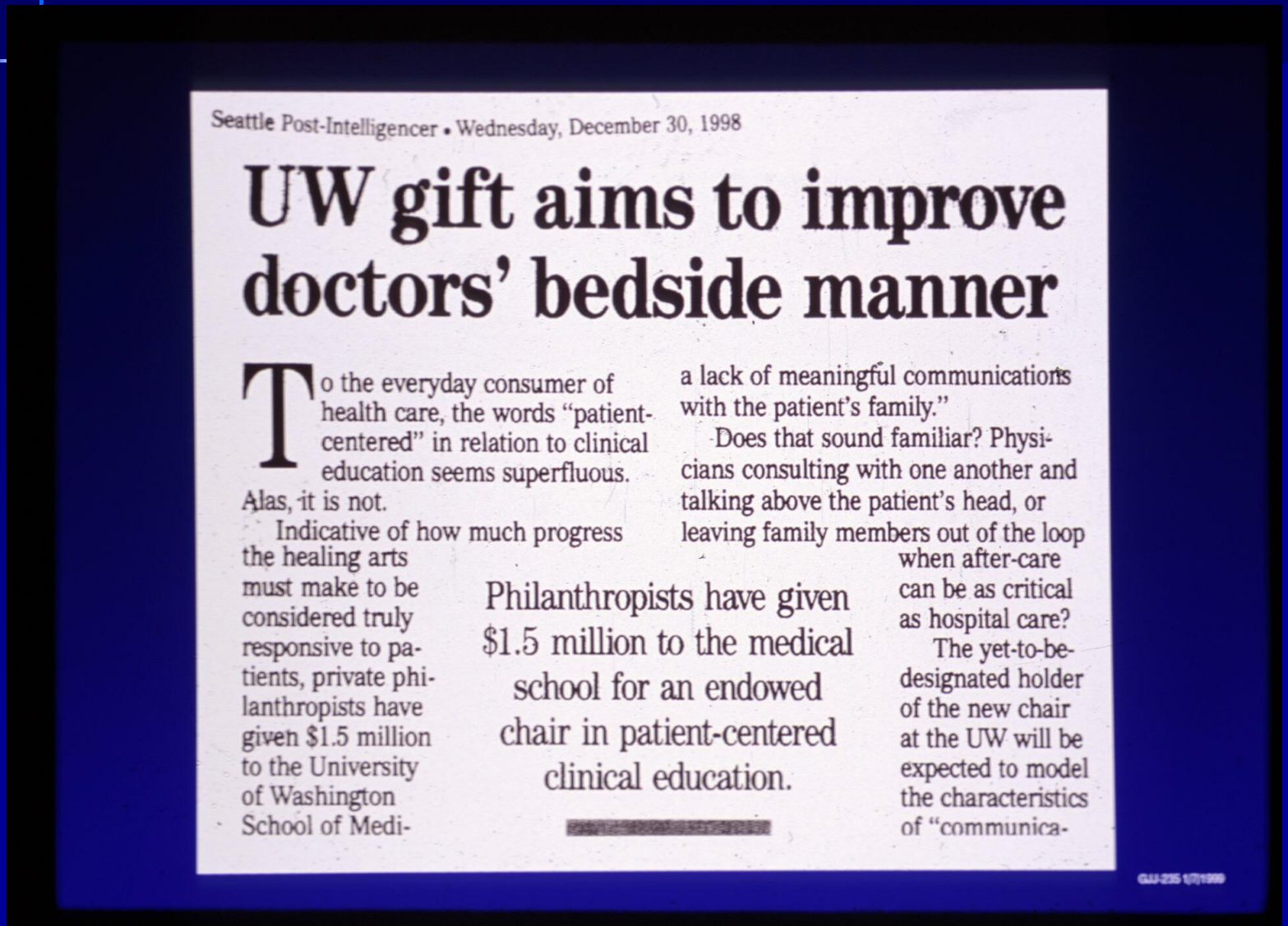
- "Be kind, direct and to the point. Look them directly in the eye and briefly share the pain."
- "The doctor who spoke with us asked us what kind of man dad was. It gave us a chance to talk about him. It was a very positive memory."
- "The ER doctor realized my mother was alone. He arranged for a neighbor and I to come be with her before telling her. I appreciate that more than you know."

How You Say it Matters !

Surgeons' tone of voice: A clue to malpractice history. Ambady et al, Surgery, 2012.

- Audiotaped 65 surgeons clinic visits in Portland, Denver, Salem
- 10 sec. clips, 2 patients each, begin and end of visit
- Scale 1-7 these areas: warmth, anxiety/concern, interested, hostile, sympathetic, professional, competent, dominant, satisfied, and genuine.
- Surgeons with a tone of voice that was more dominant and less concerned = surgeons more likely to have been sued.

Nothing New…



Seattle Post-Intelligencer • Wednesday, December 30, 1998

UW gift aims to improve doctors' bedside manner

To the everyday consumer of health care, the words "patient-centered" in relation to clinical education seems superfluous. Alas, it is not.

Indicative of how much progress the healing arts must make to be considered truly responsive to patients, private philanthropists have given $1.5 million to the University of Washington School of Medi-

Philanthropists have given $1.5 million to the medical school for an endowed chair in patient-centered clinical education.

a lack of meaningful communications with the patient's family."

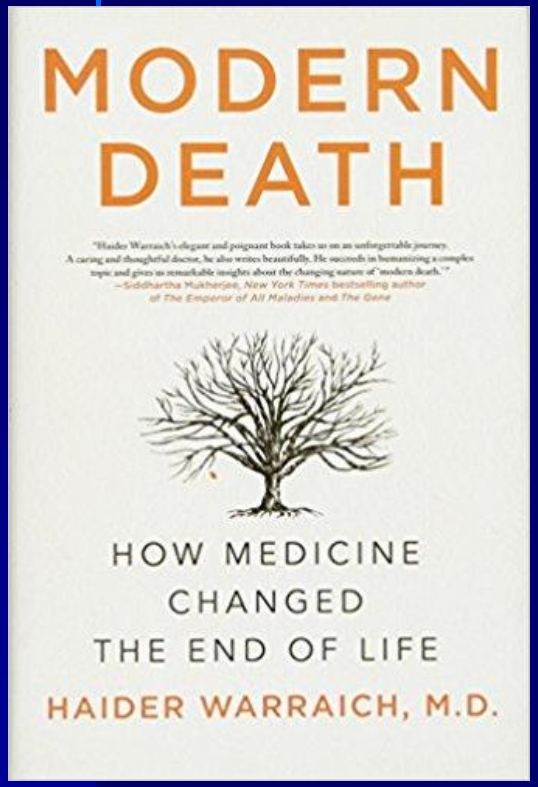
Does that sound familiar? Physicians consulting with one another and talking above the patient's head, or leaving family members out of the loop when after-care can be as critical as hospital care?

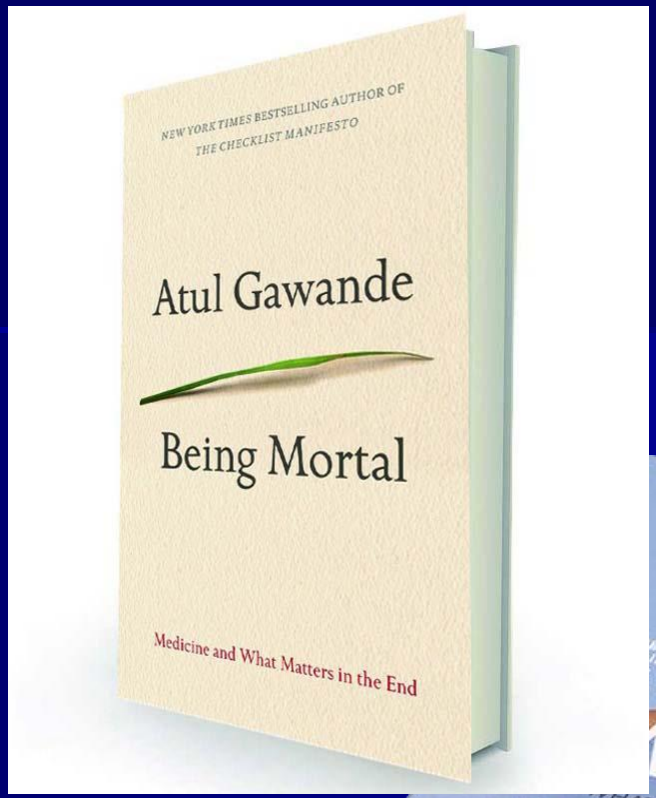
The yet-to-be-designated holder of the new chair at the UW will be expected to model the characteristics of "communica-

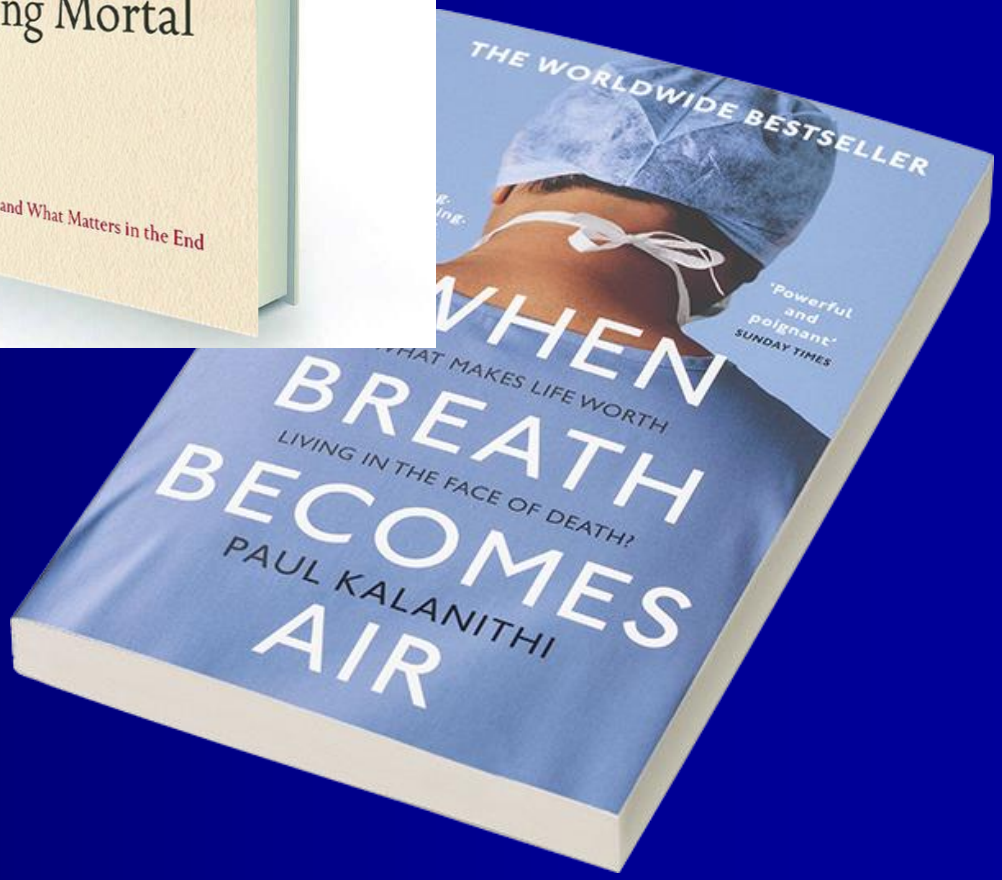
Terminal Care of Patient and Family

- We have not done a very good job over the last several decades
- 2004 RWJF "Means to Better End: A Report of Dying in America"
- 2009 TELOS Trauma End of Life Optimum Support (ATS)

  Best practice model, education, support


MODERN
DEATH
HOW MEDICINE
CHANGED
THE END OF LIFE
HAIDER WARRAICH, M.D.


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


THE WORLDWIDE BESTSELLER
'Powerful and poignant'
SUNDAY TIMES
WHEN
BREATH
BECOMES
AIR
PAUL KALANITHI

Terminal Care of Patient and Family

- Trauma is unique in that we do not know our patients before illness/injury
- There is a “suddenness” and unexpected nature of this disease
- Heavy weight on the patient’s life responsibilities

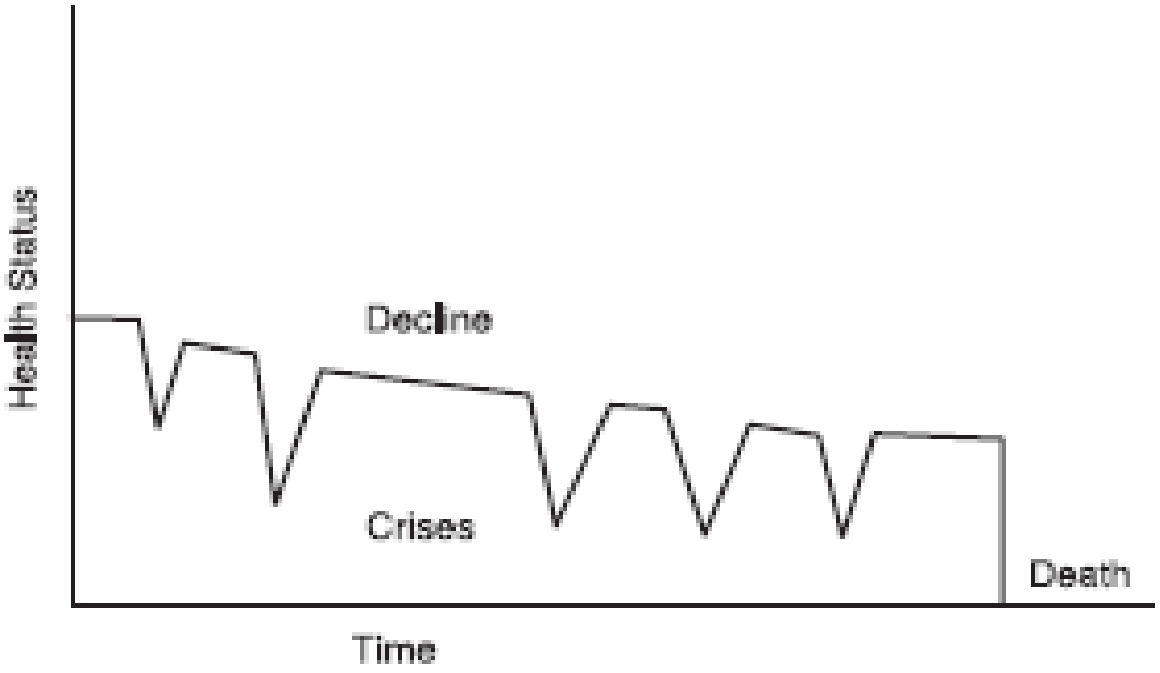


FIGURE 2. Death trajectory typical in chronic diseases. Reprinted with permission from *Approaching Death* ©1997, by the Institute of Medicine, Courtesy of the National Academies Press, Washington, DC.

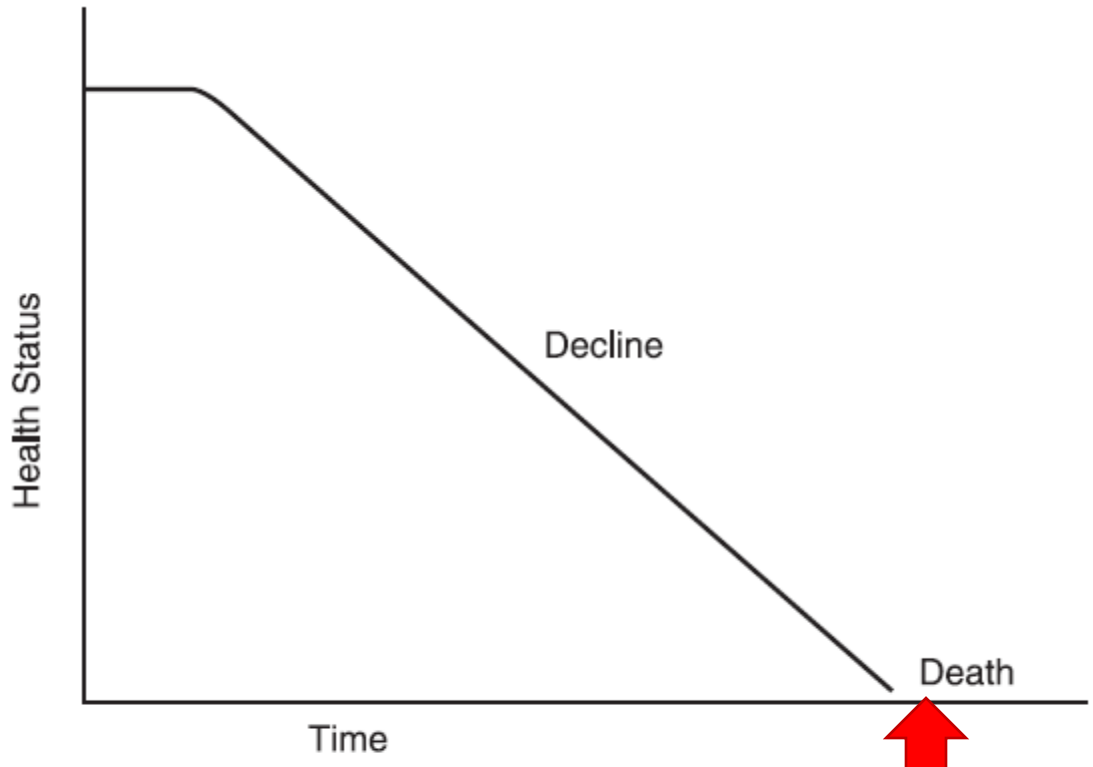


FIGURE 1. Death trajectory typical in cancer. Rep ted with permission from *Approaching Death* ©1997, by the stitute of Medicine, Courtesy of the National Academies Press, Washington, DC.

"Goals of Care" Discussion

Assess understanding:

"Tell me your understanding of your brother's condition…"

- "What have you been told so far about his prognosis?"

Determine "goals of care" for patient/family:

"What do you think/hope will happen from here?"

"What would be important for your brother to be able to do to make his life meaningful?"

Restate and clarify the patient/family goals:

"So what I am hearing is that he has always been strong and has overcome a lot of challenges. You think that he can pull through this."

The Sister from Arkansas Arrives…

- Case scenario:
  - 85-year-old male, MVC, pelvic fx and facial fx
  - "Codes" in CT
  - CPR for 20 minutes
  - Brought to ICU
  - On 2 pressors with BP in 70s
  - His sister "wants everything done"

"Everything Done"

- Determine what the family means by "everything done."
- Most families want reassurances that their loved one did not have a survivable illness/injury and that all appropriate medical therapy was offered/done.

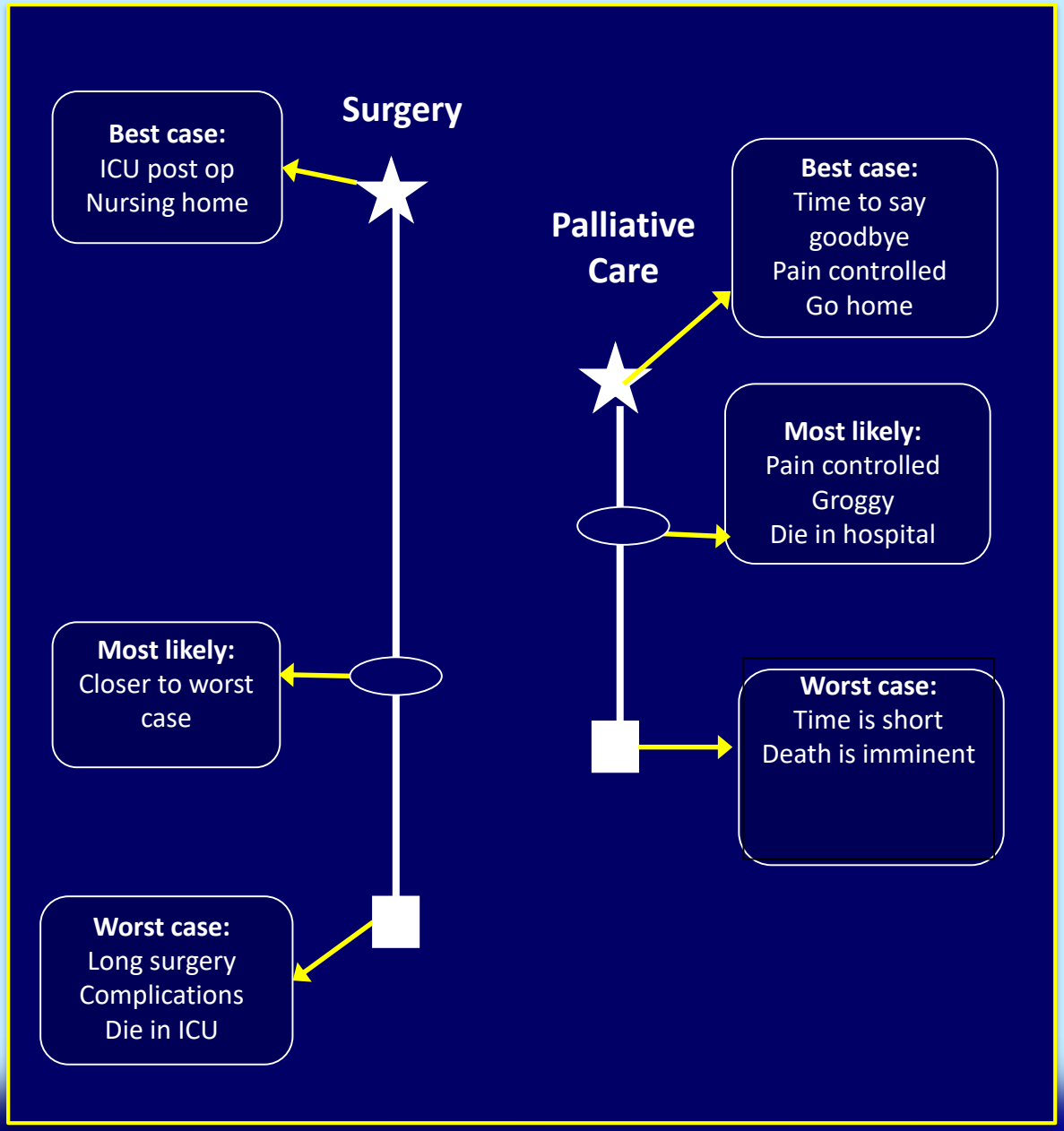
"Everything Done?"

- If goals **ARE MEDICALLY** reasonable:
  - Re-assess in a few days, discuss progress or lack thereof...
- If goals **ARE NOT** medically reasonable:
  - Try to negotiate: "I wish that were the case, but unfortunately most patients who are as injured as he is don't get well enough to … So if that is not going to happen, what else can we do to help him?"
  - Consider a time-limited trial: " We can continue supporting him in hopes that…kidney function improves after fluids, that his pneumonia will clear, but after 7 days of ABX, it will be unlikely…"

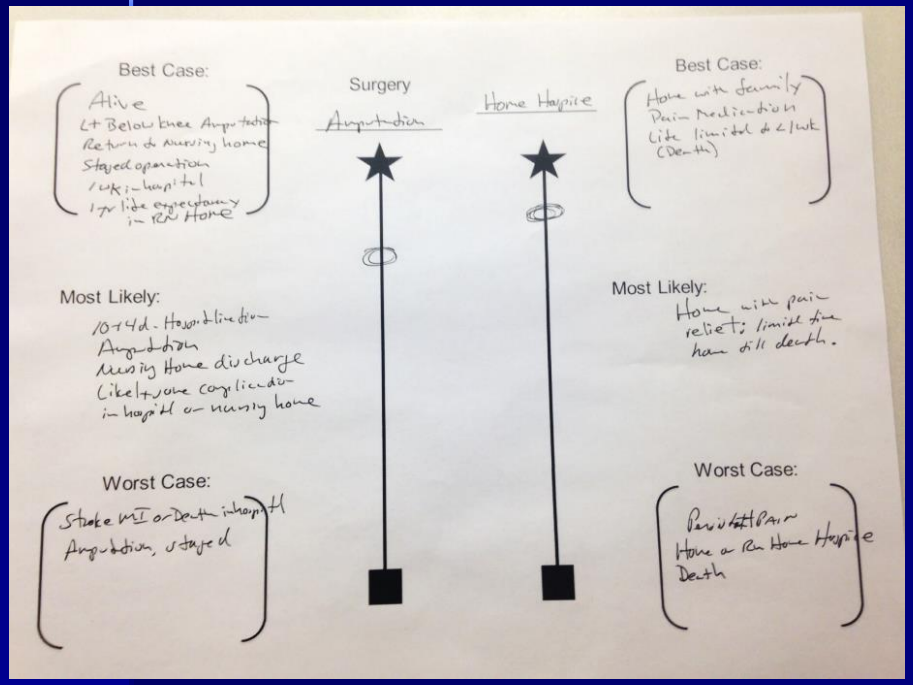
Can We Get The Information Across?

- Teaching surgeons how to use the **"best case/worst case"** communication tool will improve their ability to engage older patients and their families in treatment decisions and align treatment choices with patient preferences

Best Case/Worst Case Framework



How Surgeons Used BC/WC

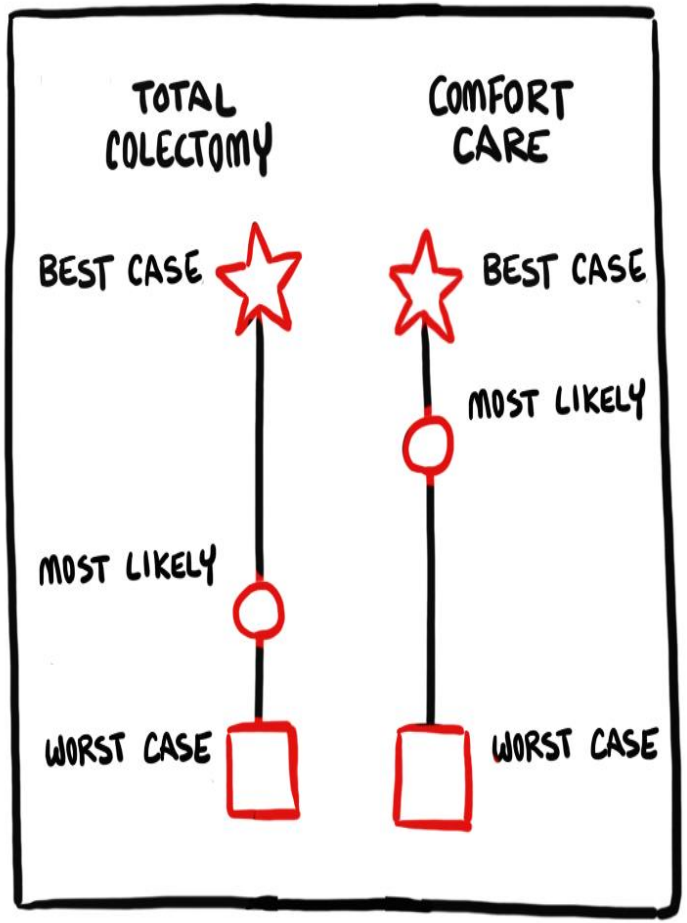


Surgeon: *"Even after surgery…she'd be really debilitated for having been in the hospital, and she would likely end up in the nursing home for the rest of her life."*

Family member: *"That's not something she would want."*

Surgeon: *"This is what I know about her…she didn't want a lot of these interventions…and we're gonna do a maximum amount of these things if we decide to go for surgery…so my general thought is that surgery, where she ends up in a nursing home, with complications from surgery, is not something that she ever wanted."*

BEST CASE/WORST CASE



TELL A STORY...

We Must Be Compassionate but Honest

"Physicians are not obligated to provide care they consider physiologically futile even if a patient or family insists. If treatment cannot achieve its intended purpose, then to withhold it does not cause harm. Nor is failure to provide it a failure of standard of care."

AMA

Presence During Resuscitation

- Sanctioned by National Consensus Conference on Family Presence During Pediatric CP Resuscitation
- ATS, ACS, ANA, AAP, AACN
- In the study nurses preferred to be with their loved ones in the resusc more than MDs at a rate of 2:1

Family Presence

- 75% desire presence
- 96% believe they deserve option
- 94% would make the same decision
- 100% believe that everything possible done
- Patient perspective
- Comforted
- Reminder of "person"
- Enhanced connection with family
- Positive impact on care

Lower bereavement scores 3 and 9 months after resuscitation event

Family Presence Concerns

- Ability to teach
- Volatility of family
- Not equipped to deal with both patient and family
- Inadequate training of facilitators
- Change care delivered

Cardiopulmonary Resuscitation (CPR)

- Developed in 1960s
- Intended for victims of unexpected death:
  - drowning
  - drug intoxication
  - heart attacks
  - asphyxiation
- >80% survival on television
- <15% survival of hospitalized patients

CPR

- Not intended as a routine at time of death to include cases of irreversible illness for which death was expected
- Unclear how it became the "standard of care"
- Unique among medical interventions as it requires a written order to preclude its use

Problems That Arise in DNR Discussions

- Expecting patients/family to make decisions without adequate information (i.e. *un*-informed consent)
  - Diagnosis
  - Treatment options
  - Prognosis
- CPR discussions *MUST* be framed in terms of the overall goals of care and care plan, not in isolation
- Weigh benefit/burden of each treatment option
  - *Can we do it? Should we do it?*

Communication

- Common phrases:
  - "What would you like us to do if the heart stops?"
  - "Do you want us to restart the heart if it stops?"
  - "Do you want us to do everything?"
  - "You don't want us to break his ribs, and shove a tube down his throat, and hook him to a breathing machine, do you?"

Barriers to Patients Accepting DNR

- DNR *only* refers to this medical intervention
- Many patients and families fear that DNR="No Care"
- Unfortunately, medical teams often reinforce this fear:
  - *We can't take him to the ICU if he's DNR*
  - *He can't get antibiotics if he's DNR*
  - *We think the best thing is to "withdraw care"*

Communication

- Remember it often takes several discussions; people are processing tough information; give people time (if possible) and space
- Respond to ***effect with affect***
  - *I can see this is hard for you to hear (*reflect on emotion in the room*).*
  - Silence: *Can you tell me what your thoughts are? Have you thought about this before?*
  - Allow silence; let patient determine tempo of discussion
    - *To patient/family, this is an out-of-control situation. Try and give back as much control as possible*

Communication

- If you take something "off the table", put something back on:
  - Symptom control
  - Family support
  - Hospice care
  - Other
- *Reassure non-abandonment*
- "Even though we can't fix the illness, there is a lot we can do to help you and your family in this time. I want to hear what is most important to you and your family"

Does the Order Make Sense?

- Don’t let the sun set on a code status order that makes no sense
  - Only cardioversion (in a patient who will die a respiratory death)
  - Only one shock, then stop
  - Only for 5 minutes, then stop
  - Chest compressions without cardioversion
  - “He wants intubation, but he doesn’t want to be on a ventilator…”

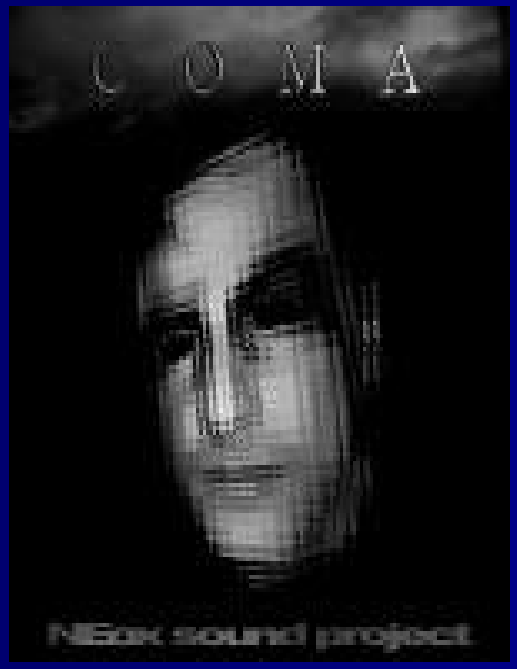
DNAR

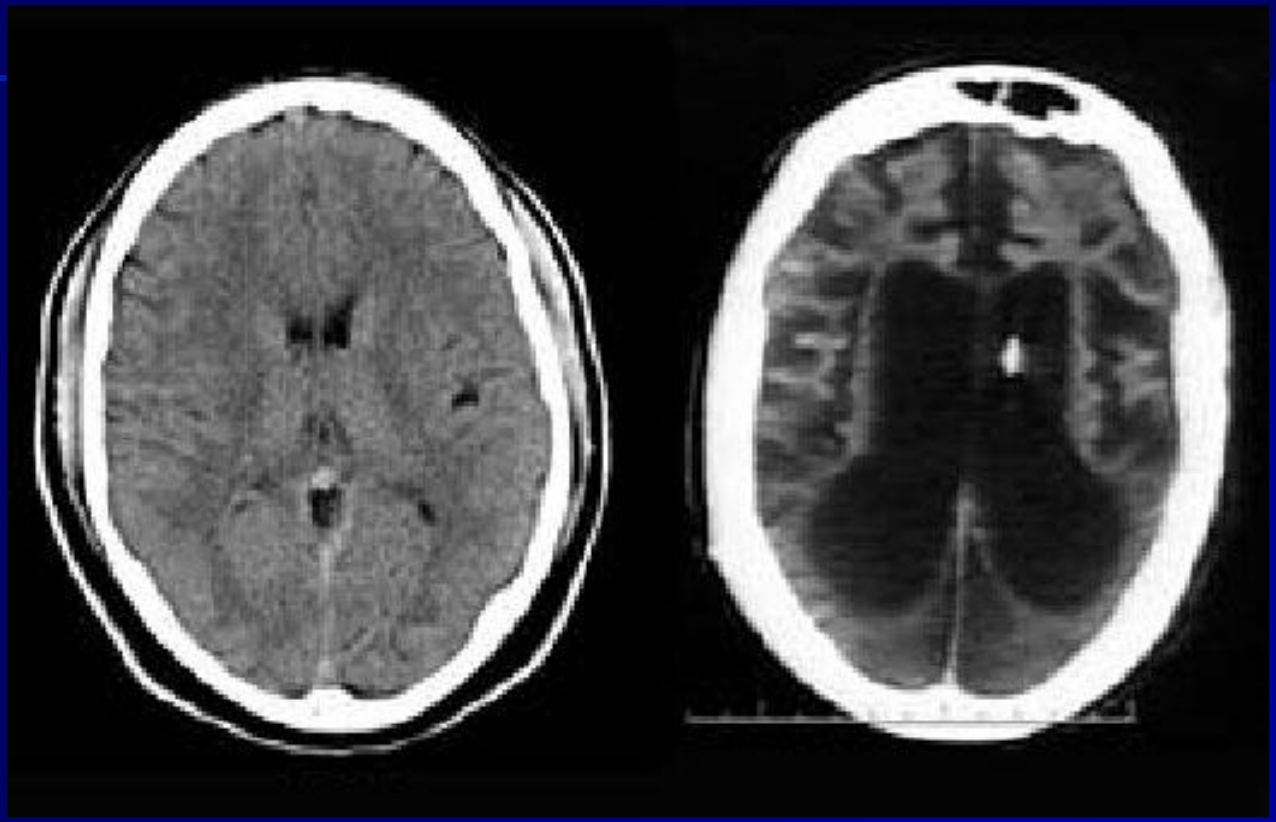
- "DNAR orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient."
  AMA


When I asked a patient what her code status was she said, "I Do Not Remember".
Sounds like DNR to me!
someecards
user card

Persistent Vegetative State

- Normal Sleep-Wake Cycles
- No Response to Environmental Stimuli
- Diffuse Brain Injury with Preservation of Brain Stem Function

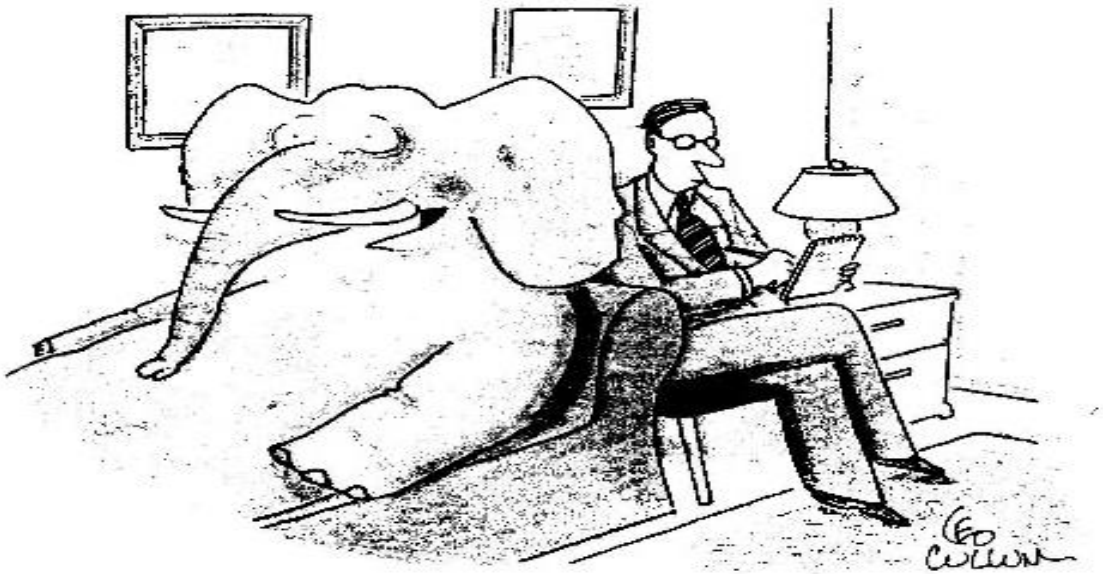

C O M A
NBox sound project



What is Palliative Care?

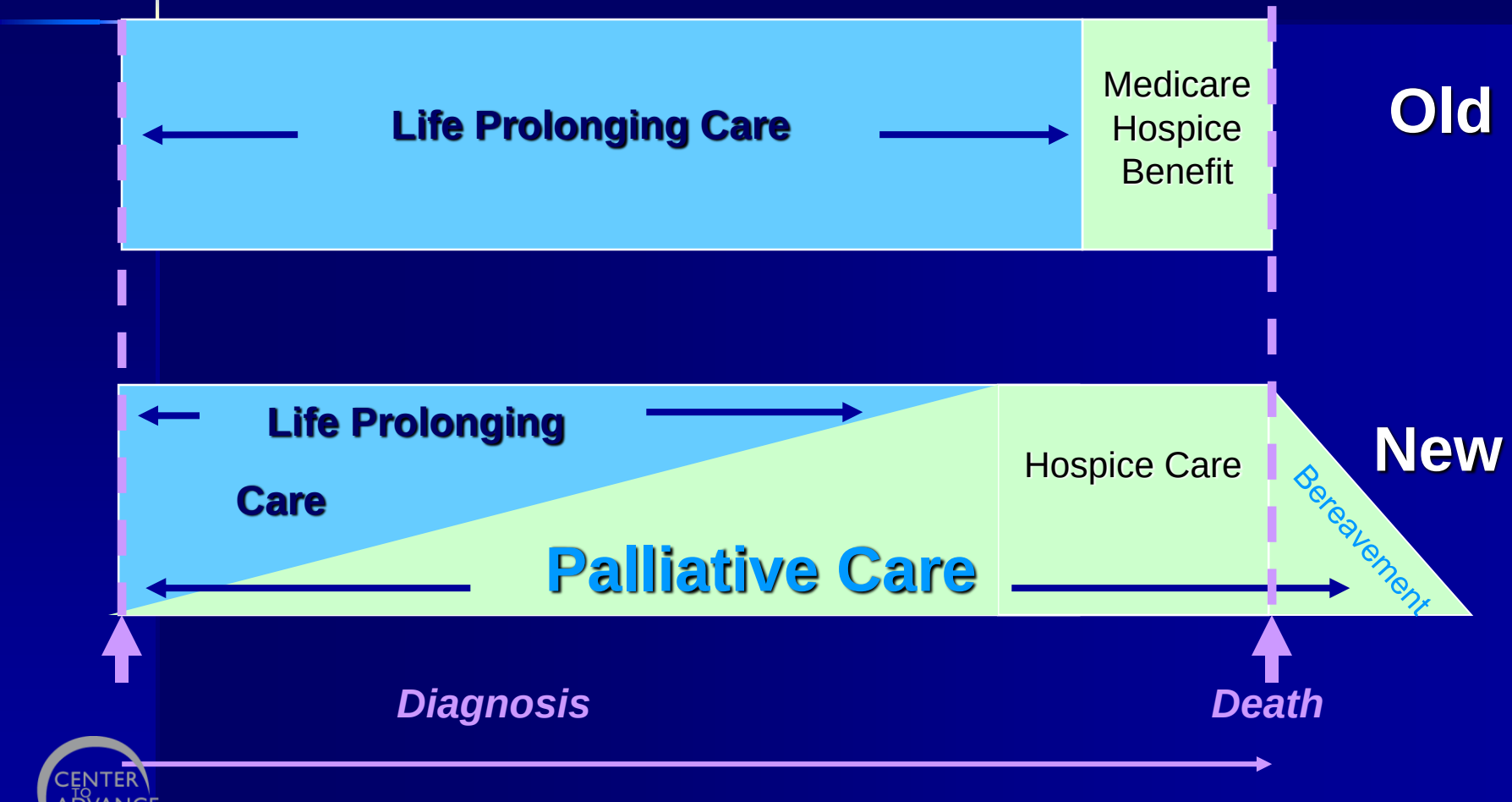
- The National Consensus Project for Quality Palliative Care (NCP) definition:
  - Care is provided and services are coordinated by an interdisciplinary team
  - Patients, families, palliative and non-palliative health care providers collaborate and communicate about care needs
  - Can be delivered concurrently with life-prolonging care or as main focus of care

National Consensus Project for Quality Palliative Care, 2013



"I'm right there in the room, and no one even acknowledges me."

Conceptual Shift for Palliative Care



CENTER TO ADVANCE PALLIATIVE CARE

End of Life Care

	Standard Care	Early Palliative Care	P-value
Aggressive EOL care*	54%	33%	0.05
Resuscitation preferences documented	28%	53%	0.05
Duration of hospice care	4 days	11 days	0.09
ER visits within 30 days of death	30%	22%	
Hospitalizations within 30 days of death	54%	37%	
Survival	8.9 months	11.6 months	0.02

*chemo within 14 days of death, no hospice care, or admission to hospice ≤3 days

Temel JS et al. N Engl J Med 2012;363:733-742

National Quality Forum: Palliative Care is One of Six National Priorities for Action

- Patient and Family Engagement
- Population Health
- Safety
- Care Coordination
- Palliative and End-of-Life Care
- Overuse

A Vision for World-Class, Affordable Healthcare

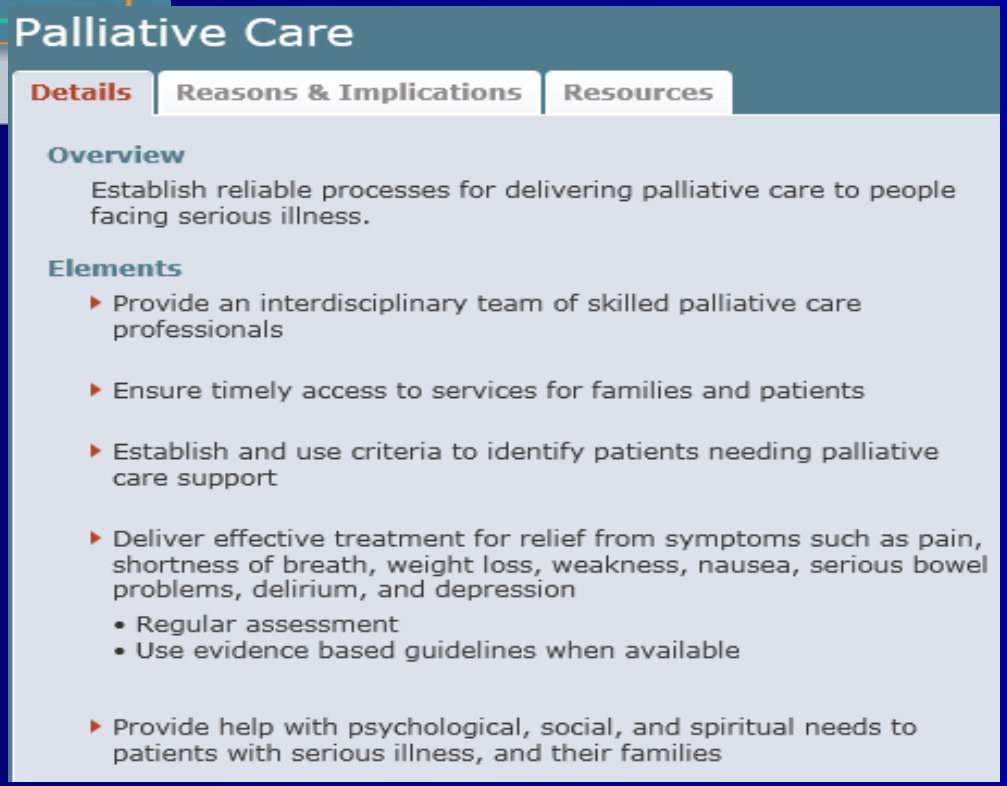
National Priorities Partnership
Convened by the National Quality Forum

The current economic crisis highlights the imperative to transform America's healthcare system, and the opportunity to do so has never been greater. The National Priorities and Goals address the greatest challenges facing the healthcare system: eliminating harm, eradicating disparities, reducing disease burden, and removing waste.

Through the National Priorities and Goals, the Partners are working to bring about safer, more affordable patient-centered healthcare. The collective action of the Partners on these six

http://www.nationalprioritiespartnership.org/Priorities

Palliative Care: "on the map" with IHI



http://www.ihi.org/IHI/Programs/ImprovementMap

IPAL-ICU

- Improving Palliative Care in the ICU Project
- Mt. Sinai School of Medicine
- NIH, Dept of aging support
- Proven tool for selective criteria, consultive pathways, care trends, education
- Open vs. closed units
- > 7 days mortality increased to > 35%
- Overcoming barriers, education of MD (frequent changes of care/patriarchal), use of RN, APN

Strategic Partnerships

C-Change
Collaborating to Conquer Cancer

American Cancer Society

ABIM
American Board of Internal Medicine

The Joint Commission

American Hospital Association

Institute for Healthcare Improvement

Commission on Cancer®
A multidisciplinary program of the American College of Surgeons

National Quality Forum

FCA
Family Caregiver Alliance
National Center on Caregiving

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

LIVESTRONG

Common Symptoms and Medications in Palliative Care after Injury

- Pain
  - Opioids
  - Steroids- spinal cord compression, increased ICP, pain related to nerve compression, visceral distention
  - Anticonvulsants (gabapentin)
  - NMDA receptor antagonists (ketamine, methadone)
  - Antidepressants (Cymbalta, Elavil)
  - Topical anesthetic (lidocaine patch)

Common Symptoms and Medications in Palliative Care after Injury

- Dyspnea
  - Assess and treat underlying cause when possible; when no longer possible, focus is symptom relief
  - Opioids- most studied and effective medication for relieving dyspnea
    - principle of double effect
    - concerns about sedation accelerated death
  - Anxiolytics

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02

- There may be a benefit but > 75% of patients are not hypoxic with EOL care
- Placebo effect seen-same effect with a fan blowing over the face
- May be hypoxic without dyspnea or visa versa
- Opioids/Benzos/cool packs/dark room

Principle of Double Effect

- e.g. use of narcotics to relieve pain and suffering

Nursing Interventions

- Williams et al (2016) looked at family perceptions of how nursing staff supported and facilitated family presence near end of life
  - Keeping the family informed
  - Providing reassuring attentiveness
  - Being a compassionate presence
  - Facilitating final acts by supporting family presence, last goodbyes and private time after death (PTSD)
  - Honoring patient dignity

Nursing Interventions

- All nurses provide care as stated in the American Nurses Association *Code of Ethics for Nurses* to alleviate suffering, and to provide interventions to relieve pain and other symptoms in the dying patient, even when those interventions entail risks of hastened death

Nursing Interventions

- It's all about goals!

"Nurses continue to be called to care and to demonstrate it everyday in spite of the restrictions of staff, cost-containment, and more with less. Long ago nurses moved beyond the worship of cure and knew that care could be successfully rendered to all patients."

Ruffolo

Palliative Care Bundle

- Adequate pain relief
- Adequate relief of anxiety
- Code status known
- Advance directives known
- Social services, pastoral care involved
- GI symptoms controlled
- Dyspnea relieved
- Family comfort addressed
- Goals of care known
- **REVIEW DAILY**

Futile Care Defined

- How is medical futility defined?
  - Disease must be terminal
  - Disease must be irreversible
  - Death must be imminent
  - Merely preserves permanent unconsciousness or cannot end dependence on intensive medical care
  - Clear legal definition does not exist

The Futile Equation

- **Physiologic futility:**

  Treatment physiologically unable to achieve desired result

  – Surgery to stable cervical spine but permanent cord injury

- **Quantitative futility:**

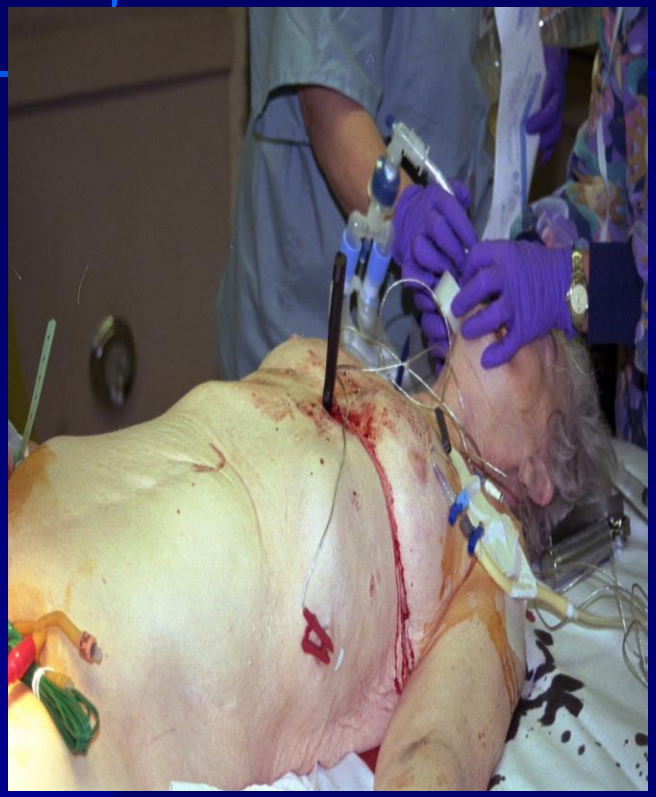
  Likelihood of desired result is low, but NOT zero.

  – Return to functional state after severe TBI (1-3%)

Clinician Distress During Futile Care

We are PEOPLE

- We want to minimize suffering
- We are reluctant to provide care that they would not want for themselves or family
- We know this not a good use of resources
- Seeing family not following recommendations
- We have feelings of distaste at inflicting physical abuse on dead or dying people



While there is still a hole in a named blood vessel, what is the best fluid resuscitation strategy to keep the victim alive until hemostasis can be achieved and to promote intact survival?

Withdrawal of Treatment

- Discontinuing a therapy that has disproportionate burden without achieving reasonable clinical goals
- Withdrawing treatment is distinguishable from purposely hastening death (intent)

Withholding of Treatment

- Not initiating a therapy that has a disproportionate burden without achieving reasonable clinical goals

Withdrawing vs. Withholding

- Withholding a treatment is viewed as equivalent to withdrawing an intervention.
- Distinction between failing to initiate and stopping therapy is artificial.
- Justification that is adequate for not commencing treatment is sufficient for ceasing it.

Withdrawal and Withholding

- 1988 - 50% of ICU deaths preceded by decision to withdraw or withhold treatment
- 2010 - 90% of ICU deaths
- Includes DNAR orders
- AND = Allowing Natural Death

Withdrawal of Mechanical Ventilation

N Engl J Med, 2016

- 15 ICUs
- Examine clinical determinants associated with withdrawal of mechanical ventilation
- 851 patients:
  - 539 weaned (63.3%)
  - 146 died (17.2%)
  - 166 withdraw (19.5%)

Withdrawal of Mechanical Ventilation

Subjective criteria:

- Need for inotropes or vasopressors
- Physician's prediction of survival < 10%
- Physician's prediction of limitation of future cognitive function
- Physician's perception that patient did not want life support used

Withdrawal of Mechanical Ventilation

- **Not predictors:**
  - age
  - severity of illness
  - organ dysfunction

Withdrawal of Mechanical Ventilation

- Emphasize that life-sustaining therapy was not able to reverse the underlying disease.
- Removal of life-sustaining therapy is allowing disease to take its natural course.
- Aggressive palliative treatment

Terminal Wean

- Indicat
- Prep w
- Policy
- Proced

It is OK …

- ANA and the Presidents Commission for the Study of Ethical Problems in Medicine and Biomedical Research:

  Supports the rights of competent patient's or their representatives to withhold or withdrawal life-sustaining and/or prolonging therapy

Protocols

- Indications:
  *Comfort measures
  *Imminent death/brain death
- Physician orders!!!!!!
- Goal:
  *Gradual withdrawal
  *Immediate withdrawal

- **Shift of Priority:**

  *Involve the family early on-this relationship is vital

  *Careful monitoring signs of discomfort, anxiety, WOB and pain

  *Most patients undergoing terminal wean will be in altered state of consciousness but will still require medications

The Process

- ✓ Be certain everyone is on board
- ✓ Suggest an attending level is present
- ✓ Minimize the environment, lighting, restraints, side rails, equipment
- ✓ Good venous access
- ✓ Use only monitor devices that contribute to comfort (BIS, HR-silenced)
- ✓ Be certain NMB is reversed
- ✓ Suction before initiation
- ✓ Place patient in upright position

- ✓ Use of sedation/analgelsia as directed by MD or protocol
- ✓ Usually with continuous analgelsia infusion before onset
- ✓ There have been multiple studies proving there is no correlation between the amount of sedation/analgesia and the duration of survival

Goal:

- Gradual Withdrawal
- Short increments of reduction of rate, PEEP/PS
- Assessment for agitation, pain, WOB and medicated per protocol
- When rate, PEEP at zero then removed from ventilator and blow-by 02
- Extubation can contribute to stridor and observed WOB

Immediate Ventilator Withdrawal

- Same process without weaning
- Place on blow-by 02
- Medicate additionally as needed and directed by protocol/MD
- Refrain from extubation

The Death Rattle

A Successful Protocol

Pham, et al J of Burn Care 2012

- Withdrawal of LS after severe injury
- Instituted in 2001 but not as effective as expected and added specific order set
- A Standard Check list of criteria, indications
- Physician lead
- Housewide education…

- Identified appropriate care early on
- Discontinue all other orders
- Obtain DNAR
- Remove invasive devices/monitors
- Remove equipment from room
- Liberalize visiting hours
- Analgelsia/anxiolytics

With training of new staff/nurses as advocates/team approach a significant improvement in EOL after injury

- Approach When Relative Are Present:

**Assure the family

**Communicate

**Promote presence

**Be present as needed

**Lower side rails

**Let them touch the patient

**Arrange a dignified goodbye

**Families want privacy

Us and Them: The Good The Bad and the Ugly

From: Trauma Death: Views of the Public and Trauma Professionals on Death and Dying From Injuries

Arch Surg. 2008;143(8):730-735. doi:10.1001/archsurg.143.8.730

Table 1. Preferences Regarding End-of-Life Care in the Prehospital Environment

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)	*P* Value
If a person is dead at the scene of an accident, to which facility would you prefer that your loved one be transported?			
Hospital	50.1	36.8	<.001
Morgue	41.1	35.0	<.001
Other	1.7	13.6	<.001
If you prefer that the person be taken to the hospital, what is the main reason?[b]			
You hope something might be done	47.3[c]	13.4[d]	<.001
More comfortable with a hospital	48.1[c]	84.6[d]	<.001
If there were an alternative facility with religious and counseling services, which would you prefer?			
New facility	29.4	63.4	<.001
Hospital	37.9	11.4	<.001
Morgue	26.1	13.6	<.001
Would you pay for insurance coverage for a new facility?			
Yes	34.8	28.4	<.001
No	56.7	50.9	.01
Would you pay an extra fee to bring your loved one to the hospital?			
Yes	58.5	29.5	<.001
No	36.8	52.2	<.001

[a] Responses of do not know or refused to answer are not included.
[b] Asked only of those who indicated hospital in the previous question.
[c] Sample size was 500.
[d] Sample size was 292.

From: Trauma Death: Views of the Public and Trauma Professionals on Death and Dying From Injuries

Table 2. Preferences for Family Presence and a Comfort Focus

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)	*P* Value
If a loved one needs resuscitation, in which would you prefer to be?			
Treatment room	51.9	62.7	<.001
Waiting room	40.9	29.6	<.001
If you were to see large amounts of blood or other difficult sights in the treatment room, in which would you prefer to be?[b]			
Treatment room	73.1[c]	83.8[d]	<.001
Waiting room	17.7[c]	11.4[d]	<.001
If your loved one was a child, in which would you prefer to be?			
Treatment room	79.0	78.7	.85
Waiting room	17.3	14.7	.15
If you were in an accident and were likely to die despite treatment, which would you prefer the medical team to do?			
Focus on making you comfortable	57.3	72.7	<.001
Do everything to keep you alive	34.5	22.9	<.001
If the patient were a loved one, which would you prefer the medical team to do?			
Focus on making him or her comfortable	46.8	67.8	<.001
Do everything to keep him or her alive	41.9	24.8	<.001

[a] Responses of do not know or refused to answer are not included.
[b] Asked only of those who indicated treatment room in the previous question.
[c] Sample size was 588.
[d] Sample size was 526.

From: Trauma Death: Views of the Public and Trauma Professionals on Death and Dying From Injuries

Table 3. Preferences for Goals of Care and Limited Resources

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)	*P* Value
If doctors believe there is no hope of recovery, which would you prefer?			
Life-sustaining treatments should be stopped and should focus on comfort	72.8	92.6	<.001
All efforts should continue indefinitely	20.6	2.5	<.001
Should these efforts continue regardless of the financial cost?[b]			
Yes	86.2[c]	33.3[d]	<.001
No	9.0[c]	42.2[d]	<.001
Should efforts continue if they take medical resources and personnel away from other patients more likely to survive?[b]			
Yes	28.8[c]	23.3[e]	<.001
No	56.1[c]	62.8[e]	<.001
Would you support or oppose that patients in the ICU who are expected to die be transferred to a regular hospital room where comfort care is the focus?			
Strongly support	38.9	62.1	<.001
Somewhat support	23.8	19.4	.02
Somewhat oppose	10.9	9.8	.52
Strongly oppose	19.7	4.7	<.001
Same question as above but now there is a limited number of ICU beds?			
Strongly support	47.6	61.2	<.001
Somewhat support	23.6	21.4	.29
Somewhat oppose	9.4	8.3	.44
Strongly oppose	13.8	4.8	<.001
If the ICU were full, should patients expected to die be transferred to make room for others with a greater chance of survival, or should ICU admission be on a first-come, first-served basis?			
Move those expected to die	72.1	77.3	.01
First come, first served	17.8	9.7	<.001

Abbreviation: ICU, intensive care unit.
[a] Responses of do not know and refused to answer are not included.
[b] Asked only of those who indicated that efforts should continue indefinitely in

From: Trauma Death: Views of the Public and Trauma Professionals on Death and Dying From Injuries

Table 4. Responses Regarding Demanding Care and Goals of Care for Those in a Persistent Vegetative State

Question and Responses[a]	Public, % (n=1006)	Professionals, % (n=774)	*P* Value
Do patients have the right to demand care that doctors think will not help?			
Yes	72.4	44.3	<.001
No	20.2	44.8	<.001
If a patient demands such care, who should pay for it?			
Insurance company	48.5	30.5	<.001
Government	6.1	1.4	<.001
Patient personally	37.0	54.8	<.001
Should the government pay for long-term care of persons in a PVS?			
Yes	33.6	31.3	.30
No	58.1	44.2	<.001
If you were ever to be in a PVS, would you prefer to be kept alive or die?			
Be kept alive	10.8	3.2	<.001
Die	84.8	94.2	<.001
Do you believe that someone in a PVS could be saved by a miracle?			
Yes	61.3	20.2	<.001
No	32.5	57.0	<.001

Abbreviation: PVS, persistent vegetative state.
[a] Responses of do not know and refused to answer are not included.

Care vs. Cure

- On assessment of > 100 institutions there were consistent guidelines, protocols, orientation tools, etc for nursing and end of life care but few for the physicians and if they were in place were outdated or had limited compliance

The Split

- Palliative Care and Curative Care are not mutually exclusive after trauma
- They are not dichotomous
- Trauma docs are more and more agreeing with the trajectory of EOL care but it is still nurses that are making it happen
- The nurses are the ones reported and spoken of by families after the death

Strategies for a Successful EOL Protocol

- Convene a work group that includes the key players
- Review the past approach to EOL
- Use elements of both the consultative and integrative models
- Establish how to handle open units
- Systems approach with guidelines/criteria for initiation, care patterns, team members and follow up
- Meet regularly
- Educate EDUCATE EDUCATE

- Death is a process, not an event.
- Dignity in dying is as important as preserving life.
- Palliative treatment is a crucial part of trauma care
- Withdraw and withholding are equivalent.
- Early and frequent communication with families is vital

We Have An Incredible Opportunity to "Shape" our Practice