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Palliative Care

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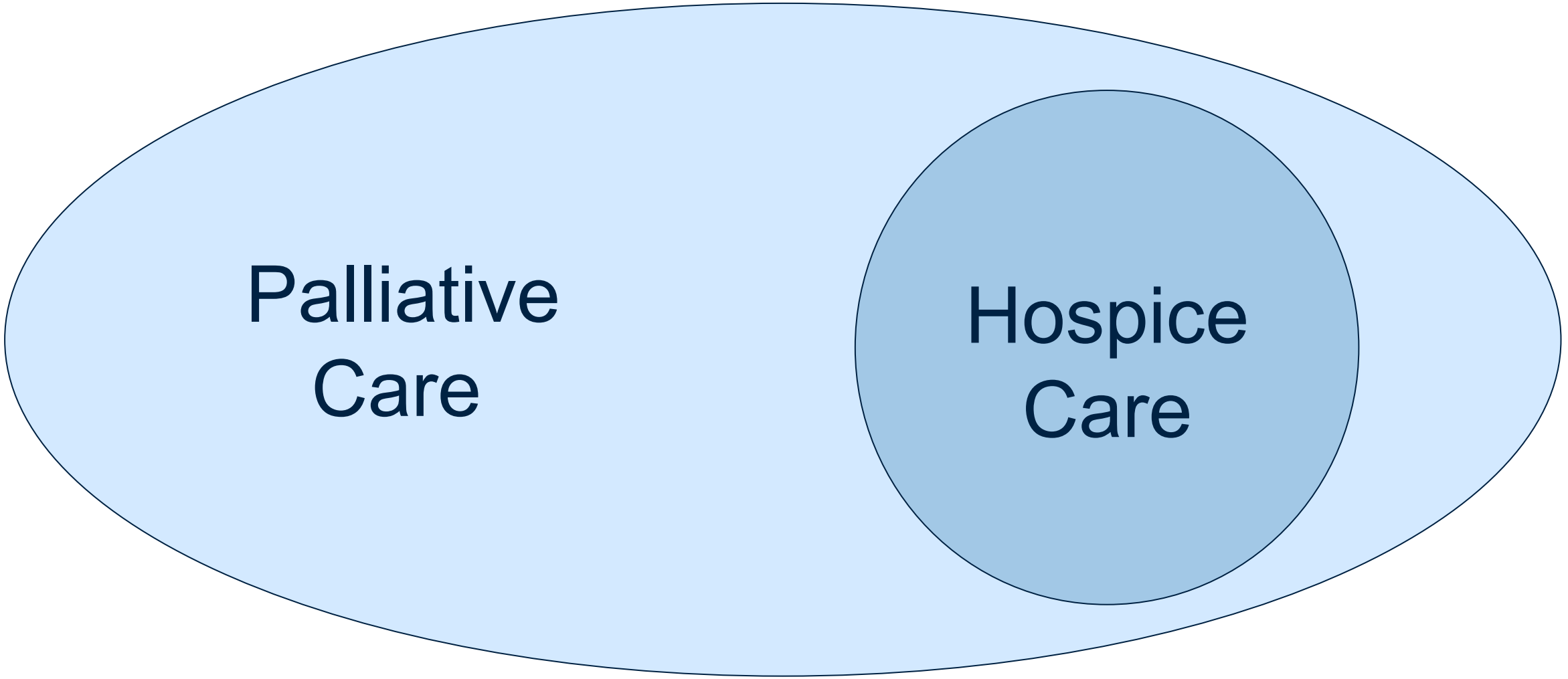
So …

raise your hand if you've heard of palliative care

Have you heard of palliative care?

If so, what do you know about it?

Relationship of palliative care to hospice care

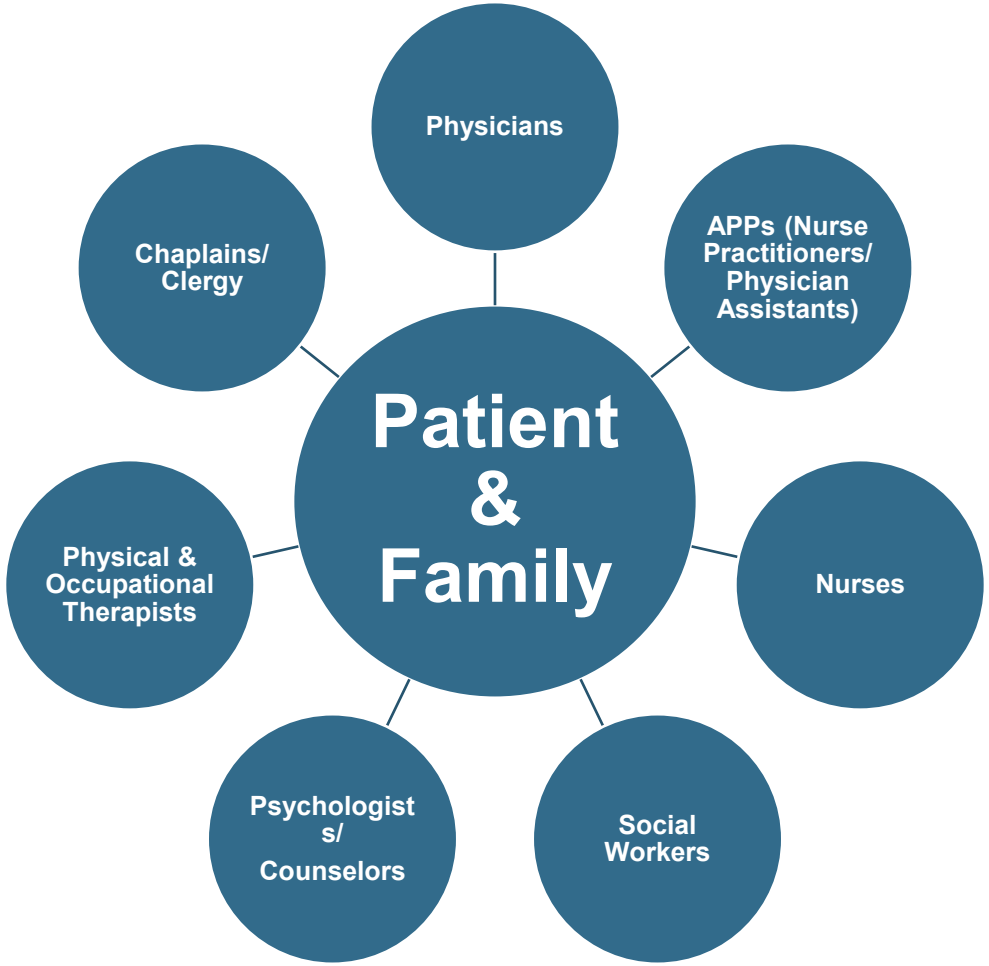


Palliative and hospice care share …

… a focus on quality of life
and relief of suffering

To “palliate” means to relieve

Palliative care teams are interdisciplinary…



Palliative care is appropriate …

- **At any stage in a serious illness** and can be provided together **with treatment aimed at cure or living longer**

Hospice care is available when …

- A patient is **not expected to live more than 6 months**
- And is **ready to stop all disease-directed treatment**

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Components of Palliative Care

Symptom & Side Effect Management
Relief of physical suffering

Emotional & Spiritual Support
Relief of emotional and existential suffering

Advance Care Planning & Goals of Care
Clear communication and decision-making

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Symptom & Side Effect Management
Relief of physical suffering

Pain
Shortness of breath
Loss of appetite/Weight loss
Constipation/Diarrhea

Fatigue
Insomnia
Nausea/Vomiting
… and others

- Relies on both pharmacologic (medication-based) and non-pharmacologic interventions (e.g., acupuncture, massage, etc.)

Relief of Fatigue

- Physical activity
- Nutrition
- Energy conservation
- Stimulants (e.g., Ritalin)
- American/Wisconsin ginseng

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Emotional and Spiritual Support

Relief of emotional and existential suffering

- Antidepressant/Anti-anxiety medication
- Counseling/Therapy
- Support groups
- Mindful meditation
- Clergy/Chaplains
- CANCER SUPPORT COMMUNITY GREATER PHILADELPHIA

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Advance Care Planning & Goals of Care

Clear communication and decision-making

- Complex medical decision-making
- Restorative vs palliative (comfort-based) goals
- Health care proxy/Surrogate decision-maker
- Advance care planning document/Living will
- Code status (Full code vs. DNR/DNI)

Clear, regular communication is an essential part of palliative care

- Help making complex medical decisions
- Goals-of-care discussions at key moments in a disease trajectory
- Family meetings, often at inflection points in patient care

ARIADNE LABS

A joint center for health systems innovation at Brigham and Women's Hospital and Harvard's T.H. Chan School of Public Health

www.ariadnelabs.org

Serious Illness Conversation Guide

EXPLORE

"If your health was to get worse, what are your **most important goals**?"

"What are your biggest **worries**?"

"What **gives you strength** as you think about the future?"

"What **activities** bring joy and meaning to your life?"

"If your illness was to get worse, **how much would you be willing to go through** for the possibility of more time?"

"How much do the **people closest to you know** about your priorities and wishes for your care?"

"Having talked about all of this, **what are your hopes** for your health?

CLOSE

"I'm hearing you say that ___ **is really important to you** and that you are **hoping for** ___. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your **care reflects what's important to you. How does this plan seem to you?"**

"I will do everything I can to support you through this and to make sure you get the **best care possible."**

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Start the conversation!

What if you got sick or injured and you couldn't tell anyone what medical care you wanted?

Who would you want to make decisions about your health care if you can't make them on your own?

What should that person know about your values and wishes to be able to decide what you'd want?

Durable Power of Attorney for Health Care or Health Care Proxy

A legal document that appoints another person (a "proxy") to make health care decisions for you if you can't speak for yourself

Advance Directive or Living Will

A written statement of your wishes about medical care to help make sure those wishes are carried out if you can't tell a doctor on your own

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Advance Directives

- In the absence of documentation: state by state determination
- In Pennsylvania (Act 169-2006):
  - Spouse (if divorce not pending)
  - Adult child
  - Parent
  - Adult sibling
  - Adult grandchild
  - Close friend
  - Healthcare facility director

If you want someone other than your state's default decision-maker, it is essential that you put your choice in writing.

Advance Directives

- Five Wishes
  - http://www.agingwithdignity.org/forms/5wishes.pdf
- State by State forms
  - http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289
- Pennsylvania's:
  - http://www.dsf.health.state.pa.us/health/lib/health/publicnotices/Sample_Forms_for_Advance_Directives.pdf
- Penn Medicine's "Our Care Wishes"
  - http://www.ourcarewishes.org

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Components of Palliative Care

Symptom & Side Effect Management	*Relief of physical suffering* Pain Shortness of breath Loss of appetite/Weight loss Constipation/Diarrhea Fatigue Depression/Anxiety Nausea/Vomiting … and others
Emotional & Spiritual Support	*Relief of emotional & existential suffering* For patient and family/caregivers
Advance Care Planning & Goals of Care	*Clear communication & decision-making* Complex medical decision-making Restorative vs palliative (comfort-based) goals Health care proxy/Surrogate decision-maker Advance care planning document/Living will Code status (Full code vs. DNR/DNI)


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