

## Case Report

# End of Life Conversations: Are we there Yet?

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**Submitted:** 15 September 2016**Accepted:** 06 October 2016**Published:** 08 October 2016**Copyright**

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**OPEN ACCESS****Keywords**

- Palliative care
- Goals of care
- Communication

**Abstract**

This case discussion outlines the importance of communicating prognosis and shared decision making regarding goals of care.

**INTRODUCTION**

The United States is the highest spender on health care. Data from the OECD (Organization for Economic Cooperation and Development) shows that the U.S. spent 17.5 percent of its gross domestic product (GDP) on health care in 2013. This is almost 50 percent more than the next-highest spender (France) [1]. Thirty percent of all Medicare expenditures are attributed to the 5% of beneficiaries that die each year, with 1/3 of that expense occurring in the last month of life [2]. EOL conversations by physicians significantly lower health care costs in the final weeks of life. Higher costs are associated with worse quality of death [3].

**CASE DESCRIPTION**

An 84 year old veteran who was living independently was admitted for elective neck surgery (C3 and T2 laminectomy and fusion) for slowly progressive LUE weakness in January 2016 at a university hospital. He developed acute hypoxic respiratory failure on post-operative day 2, requiring intubation and mechanical ventilation. He was treated with Vancomycin for MRSA pneumonia (methicillinresistant staphylococcus aureus). He was extubated 10 days later but required re-intubation after 4 days. He received multiple bronchoscopies that showed a lot of secretions and mucous plugging with moderate tracheo-bronchitis. His clinical condition was also complicated by encephalopathy, hypotension requiring pressor support, acute kidney injury and right upper extremity DVT (deep vein thrombosis). His family involved in decision making included his ex-wife, a daughter (clinical psychologist) and a son. They consented for atracheostomy and a PEG tube placement and he was placed in a long-term acute care facility (LTAC). Mechanical ventilation was weaned off approximately 6 weeks after transfer into the LTAC. He was then moved to a nursing home facility. He continued to be delirious, unable to have any effective communication with his family for almost the entire course with a few isolated moments of clarity. The last lucid moment the family remembered was 4 months before he passed away. He

was re-hospitalized July 2016 for worsening respiratory status, requiring ventilator support again. Palliative care team was consulted during this admission and the family elected comfort care. The veteran was subsequently transferred to the Dayton VA in patient hospice unit. During conversation with his daughter it was learnt that her father's main concern about the surgery was the anticipated 2 day post-operative stay at the hospital. He did not like doctors and hospitals. He did not have advanced directives and the family did not report any conversations about end-of-life issues prior to the surgery. The obvious question that comes to mind is whether the care the veteran received was the care he would have wanted if he was still able to make his own medical decisions? While the inpatient palliative care team was admitting the veteran, the daughter's immediate question was "how would we know if he is getting better?" The palliative care physician looked her in the eyes and said "the honest truth based on his current clinical condition is that he will not get better" She seemed very relieved and stated "I needed to hear that". The veteran continued to decline and passed away peacefully 2 weeks later with the family at his bedside.

**DISCUSSION****This case illustrates**

- Consequences of poor communication with the patient's family regarding prognosis and goals of care.
- Not having advanced directives in place leads to unnecessary interventions that are futile and emotional trauma to patients and their loved ones.

In this case, the patient's prognosis was not effectively communicated with the family. The family was confused about their loved one's likelihood of a meaningful recovery. Palliative Care was only involved a few days before his death. This once again highlights the importance of communication between the patients and the medical providers. The impact of invasive interventions like tracheostomy and PEG tube placement in patients with poor chances of meaningful recovery cannot be understated.

## CONCLUSION

Primary care providers and the respective consultants can play a major role in educating patients about their disease and the prognosis in early phase of a disease trajectory. This will enable patients to make better choices that are realistic while taking into consideration their fears and beliefs with the overarching goal of better quality of life. This will lead to avoidance of burdensome and often futile measures in end stages of life besides saving health care dollars.

## REFERENCES

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### Cite this article

Kahlon D, Kumar G (2016) End of Life Conversations: Are we there Yet? Arch Palliat Care 1(1): 1003.