Crisis in Palliative Care

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Definition of Crisis in Palliative Care

Crisis means a time of great danger, difficulty or uncertainty when problems must be solved or important decisions must be made. To individuals, it is the subjective reaction to a stressful life experience that compromises the individual's stability and ability to cope or function.

Palliative care aims to improve quality of life by early identification, impeccable assessment and treatment of symptoms while meeting the needs of patients with advanced and progressive diseases. It comprises disease-specific and symptom-guided interventions, with emphasis on preparing patients and their families for foreseeable, distressing clinical problems. Hence, any unexpected change near the end-of-life may be considered as crisis to the palliative care patient, family and even staff until more information about the change can be obtained.

Crisis in palliative care is not exactly equivalent to medical or oncological emergencies which are defined by disease-specific processes, such as spinal cord compression, pathological bone fractures, superior vena caval obstruction, septic neutropenia, hypercalcemia, hyponatraemia. In these situations, we focus on “what can be done to save life?” with diagnostic or therapeutic algorithms, and aggressive treatment can sometimes enhance overall survival. However, towards the end-of-life when death is an expected and accepted outcome; we question the emergency nature of these situations, we question the mechanisms and algorithms used in standard emergency treatment to be used for crisis in palliative care. The priorities of palliative care gradually shift towards the end-of-life. Insteadad, we focus on “what is the appropriate treatment for this patient in this particular situation?”

Precipitating events and Assessment

When a crisis occurs near the end-of-life, the clinician should carry out an impeccable assessment including (1) identification of the precipitating events; (2) prompt understanding of the underlying disease-specific or pathophysiological processes; (3) determination on whether active/life sustaining treatment could prolong life or maintain quality of life; (4) prognostication – both tumour and co-morbidity related; (5) patient’s wish; (6) extent of clinical decline or course of expected illness; (7) attitude of family; and finally (8) overall care. All these might have a more decisive role than disease-specific features and the complexity of a therapeutic decision during crisis near the end of life usually requires the expertise of a multi-professional palliative care team. The precipitating events can be (i) physical-related, such as acute dyspnoea, acute delirium, acute pain or massive haemorrhage; (ii) psychological-related e.g. suicidal attempt; (iii) social-related e.g. acute decompensating family or caregiver such as caregiver fatigue / caregiver illness; and (iv) spiritual-related, e.g. existential distress. Clinician and the palliative care team should be familiar with the clinical approach in managing these precipitating events.

Decision making and its factors

At the time of crisis in palliative care, either category of decisions should be made, namely the decision to use potentially life-sustaining treatments or decisionsto use treatment modalities that emphasize quality of life & comfort care. However, such discussions on medical decisions can be facilitated prior to the occurrence of crisis. The optimal timing for this discussion is during a routine outpatient visit, during which the patient should have an opportunity to learn from the physician the anticipated disease course, the potential treatment options, and together with the physician, define the goals of care in case acute crisis arises. Needless to say, the physician has to balance the anxiety of alerting and preparing the patient and the family for such an event.

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against the likelihood of occurrence. Although not every crisis or possible intervention can be anticipated and discussed beforehand, beginning the conversation can enhance the physician’s understanding of the patient’s preferences, reassure the patient that the physician is open to discussing end-of-life care, and begin what may be a slow process toward acceptance of a terminal diagnosis.

There are many factors that can influence the decision making at the time of crisis, which are grouped into disease factors, patient factors and physician factors.\(^4\) (Figure 1) For example, for disease factors, the pattern of rapid functional decline in advanced cancer patients in the last few months is generally recognised by patients and families as the beginning of the dying process. Thus, discussions regarding the appropriateness of various treatment options during this time are held with the recognition that death is approaching. In contrast, there is often no clear dividing line for non-cancer diseases. Patients, families and even physicians are more likely to have difficulty recognising dying in non-cancer, and by implication, when further disease modifying therapies should be withheld. For physician factors, those who tend to adopt a curative approach as far as possible may feel perplexed in withholding or withdrawing life sustaining treatment near the end-of-life.

Sometimes, dying patients can accept the impending death but not the family or caregiver or those individuals whose live intersect with the patient through strong personal connections. In this situation, physician and his team can help by including them as active participants in discussing end-of-life care with patient. In this venue, patient is encouraged to express his/her feelings, desires, concerns and goals of end-of-life care. Patient and family members need reassurance that no matter what treatment option is chosen, ensuring comfort of patient is always of paramount importance.

The impact of crisis

The outcome of crisis is also dependent on the help available from palliative care team during the critical period. A “traumatic death” or “sudden death” may be perceived by the family in such crisis.\(^5\) Unsuccessful crisis intervention may lead to complicated grief or post traumatic stress disorder of the family members or caregivers. The common reactions arising include panic or fear, being upset or depressed, feeling overwhelmed or exhausted, being angry or frustrated; which may require psychiatric intervention. On the other hand, successful crisis intervention can contribute to good death of patient\(^6\) and personal growth of caregivers and staff.

Conclusion

Crisis does occur near the end of life. Its management begins with the team’s ability to anticipate and communicate crisis; assist patients in deciding the appropriate treatments by detailed exploration of the life-sustaining and palliative treatment options; honest and timely prognostic telling; affirm patient choices; be familiar with clinical approach to precipitating events (symptom-guided therapy); facilitate patient-family discussion and deal with conflicts and emotions; mobilise resources/supports that will institute relief; aim at good death and be supportive to family and staff.

References


Figure 1 – Factors that affect decision making during crisis

<table>
<thead>
<tr>
<th>Disease factor</th>
<th>Patient factor</th>
<th>Physician factor</th>
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<tbody>
<tr>
<td>Cancer vs non-cancer disease</td>
<td>Goals of end-of-life care</td>
<td>Attitude in adopting the curative approach</td>
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<tr>
<td>Prognosis of disease</td>
<td>Personality and psychological variables e.g. hope, denial, grief, depression</td>
<td>Accuracy in prognostication</td>
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<td>Risk vs benefit of treatments</td>
<td>Age &amp; life stage</td>
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<td>Symptom burden</td>
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