Journal of Palliative Care & Medicine
ISSN: 2165-7386

Ramesh, J Palliat Care Med 2015, 5:5
DOI: 10.4172/2165-7386.1000e135

Editorial Open Access

Palliative Care at the Eleventh Hour

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Received date: August 09, 2015, **Accepted date:** August 10, 2015, **Published date:** August 13, 2015

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Editorial

It was 4 AM, and I was emotionally and physically exhausted after twenty hours without food or sleep on my first shift as a senior resident in the Intensive Care Unit. I had spent much of the night at one patient's bedside, Mr.G. He was an elderly gentleman dying of volume overload in the setting of kidney failure. Our therapeutic options were limited as he had previously declined hemodialysis. I watched helplessly as his blood counts dwindled and his electrolytes climbed to dangerously high levels. I took in the scene, appreciating his impressive height and once broad physique, now gaunt from years of wasting. His eyes were glassy, half covered by swollen lids. He was gasping for air. I listened to the crackles in his lungs with each laboured breath he took. I felt his legs, letting my fingers sink into his swollen legs. I asked him if he was in pain, if he was suffering, if there was anything we could do for him. No response.

I had met with the patient's wife, who was Mr. G's medical decision maker, earlier in the day along with the rest of our team. We expressed our concerns, including his worsening dyspnoea and confusion, and poor response to our interventions. She was adamant about prolonging his life, urging us to continue aggressive care. However, she maintained that she didn't want him to be intubated or resuscitated in the event of a cardiac arrest, and reiterated that his wishes were to not pursue hemodialysis. I tried to clarify the extent to which we should pursue testing and interventions, but she said, "Just do what's best for him." Not for the first time as a resident, I was left in the nebulous gray of having to decide what degree of care was appropriate for a patient who could no longer speak for himself.

I walked away from that conversation knowing that we could do nothing that would meaningfully help Mr. G, but would invariably cause suffering in his last hours of life. I watched as he went from somnolent to unresponsive. I put him on a non-invasive breathing assist device and started him on strong antibiotics and medications to support his blood pressure. We had failed to obtain accurate blood pressure readings, so I was forced into putting in an arterial blood pressure catheter in his wrist. His intravenous catheters oozed out of his body because of the swelling. I felt distressed as I pierced his neck to place a central venous catheter. He groaned in agony.

Family members and care providers endure distressing scenarios like this one far too frequently. As a resident, I have been involved in the care of several patients who I helped guide towards comfort care in these last, desperate moments, after a flurry of futile invasive procedures. These situations made me think about the systemic problems that snowball over time and ultimately land on the shoulders of a few care providers in these final moments. Patients with life limiting illnesses often don't have advanced directives that describe their wishes in end-of-life situations. Even in situations where an advanced directive has been prepared, it fails to account for the many nuances and decisions that arise in clinical medicine. A patient might globally endorse an unwillingness to endure prolonged artificial ventilation, but still may end up with a tracheostomy as it is seen as a bridge to weaning from the ventilator. However, patients and family members cannot and should not be expected to create rules for each of these decisions points, especially prior to the development of a critical illness. Instead, providers must do a better job of ensuring that advance directives reflect a patient's overall values and goals of care. In concert with a power of attorney, these values might better serve providers to make decisions that are in line with a patient's wishes. One patient I took care of included this in her advanced directive prior to aortic valve replacement surgery: "If in the days after the surgery, I don't have the strength or ability to walk, garden, go to the market and live independently, I don't want my life prolonged."

A further barrier to providing patient-centric care at the end of life is medical handoffs. Though residents are encouraged to standardize their sign-outs to include code status, sign-out about a patient's limits on escalation of care is not as routine. With multiple residents and providers involved in the care of any given patient, it becomes all the more important to be very specific during sign-out about patients' wishes. Residents receiving sign-out need to be trained to ask salient questions that go beyond "DNR/DNI." For example, "would this patient want a central line placed, would this patient want to be started on vasopressors, are we treating any pain that might be present, does the patient still need lab draws?"

Lastly, medical providers should involve palliative care consultants more routinely and earlier on in a patient's course. Palliative care consultants can help clarify goals of care and address untreated symptoms that might be distressing to patients or their family members. Further training should be incorporated into medical student and resident education about how to conduct end-of-life discussions and provide primary palliative care for patients.

After examining Mr. G once again, my moral distress reached a breaking point. I called his wife to come in to the hospital. We met at his bedside, and shared tender moments of silence. She looked at him lovingly. Feelings of doubt, guilt, and failure overwhelmed me and tears welled in my eyes. I broke the silence, "I'm so sorry Mrs. G, there's nothing more I can do." She said, "Oh honey, you've done the best you can. You were there for my husband when he needed you. I think it is his time. He has suffered long enough."

In these last moments, Mrs. G was taking care of me much more than I was taking care of her or her husband. She gave me a hug and asked if I would do one last thing for Mr. G, if I would relieve his suffering. I assured her I would, though I knew I couldn't undo the pain I had already caused. I transitioned Mr. G to comfort care, starting a morphine drip and stopping his antibiotics, vasopressors, and blood draws. I sat at his bedside, watching the sun rise, and sighed as he breathed easier.

Acknowledgement

The author would like to thank Dr. Desale for critical review of this manuscript.