

Palliative Care Consultations as American Football: Full Contact, or Just Touch?

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THE TERM *FULL CONTACT SPORT* is used when significant physical impact between players is allowed within the rules of the game; American football is a classic example. While thinking about our experiences as long-time palliative care clinicians, the analogy to sports struck us as we reflected on the spectrum of relationships between consultants and referring clinicians.

There is an inherent tension between meeting the needs of the referring clinician and the needs of patients and families when completing a palliative care consultation. On the one hand, a consultation is a request for help from a referring clinician to answer a clinical question: *How can I help this family that is conflicted over goals of care? How can I balance analgesia versus opioid toxicity? Is my patient appropriate for hospice services?*

Cornerstone principles of consultation etiquette are that the referring clinician is the primary stakeholder to which the consultant must answer, and that the consultant should work to limit his or her input to the consultation question.¹⁻⁵

On the other hand, enormous patient and family suffering may be uncovered during the course of the consultation that was never mentioned in the original consultation request. What is the consultant's responsibility to address these issues? How can this be done in a manner that balances respect for the referring clinician and simultaneously meets the needs of patients?

Often, these tensions are well aligned so that the needs of the referring clinician are concordant with those of the patient and family; however, this is not always the case. Many *palliateurs* fall prey to thinking they have automatically been asked to provide care for all possible issues, and then find they have offended their referral source by doing what to them is 'obviously the right thing to do.' Sometimes, referring clinicians see and prioritize clinical issues differently than we do, which we may view as roadblocks to timely symptom management or important conversations that we believe are necessary to meet urgent patient and family concerns. On occasion, these roadblocks are entirely appropriate, but all too often they represent referring clinician attitudes that are inappropriate to quality patient care, such as fear of discussing prognosis or fear of causing opioid addiction in the dying patient. In this setting, we can choose to confront the clinician and advocate for what we believe is best, or be more passive, backing off from confrontations that we fear might offend the referring clinician. Ultimately, how we manage these conflicts says much about our level of professionalism as palliative care clinicians.

This tension can be conceptualized at the extremes as being a choice of practice styles between 'full contact' or 'just touch.' In full contact consultation, the consultant will take on a strong advocacy role for unmet needs. In just touch, the consultant is more passive, thinking, *they didn't ask, so I won't offer an opinion or it's not my place to second-guess the clinician.*

To help illustrate these concepts and help you assess your own practice style, we present three scenarios that all palliative care consultants will quickly recognize.

Scenario 1

You receive a consult request from a cardiologist to see a 75-year-old man with congestive heart failure, hospitalized for 2 days with fatigue, nausea, dyspnea, and chest pain. The consult request is for assistance with pain and nausea control. You review the medical record and learn that the patient has been hospitalized six times in the past year, most recently 2 weeks ago. The medical record documents a gradual loss of function in the past year. Pre-admission function was bed-to-chair only, along with a 15-pound weight loss in the last 3 months. Immediately before you see the patient, the cardiologist's physician assistant calls you, saying, "Dr. X asked me to call and let you know that she has additional treatments to offer the patient. Please do not discuss prognosis or hospice." Choose the option below that you are most likely to follow:

Option A. Call the cardiologist before seeing the patient; clarify the cardiologist's intentions and negotiate how you will manage discussion of prognosis/goals during your assessment. Tell the cardiologist that, based on your review of the chart, the patient has a short prognosis and is likely eligible for hospice care. Inform the cardiologist that if you are asked about prognosis or inquiries are made about hospice, you will discuss these openly and honestly with the patient.

Option B. See the patient without calling the attending, and avoid any discussion of prognosis/hospice. If the patient asks you directly about prognosis or hospice, defer discussion to the cardiologist.

Scenario 2

You receive a consult request from a hospitalist to see a 55-year-old woman with pulmonary fibrosis, hospitalized for functional decline. The consult request is for assistance with goal-setting and possible hospice referral; the patient is DNR/DNI. When you enter the patient's room she is sitting on the edge of the bed, gasping for breath and unable to talk. The

patient's nurse tells you that the breathing worsened in the last 2 hours. The hospitalist was notified and ordered 0.5 mg sq morphine, administered 60 minutes ago with no effect. Choose the option below that you are most likely to follow:

Option A. You order an immediate dose of 2 mg morphine and ask the nurse to bring to you additional parenteral morphine so you can rapidly titrate morphine at the bedside to achieve symptom reduction. You will simultaneously place a call to the hospitalist to update him on your actions.

Option B. You leave the room to page the hospitalist to discuss management options.

Scenario 3

You receive a consult request from an oncologist to see a 35-year-old man with a retroperitoneal sarcoma, hospitalized for 1 week with intermittent small bowel obstruction. The consult request is for assistance with pain and nausea control. You review the medical record and learn that the cancer has progressed after first-line chemotherapy. The retroperitoneal mass has almost doubled in the past month and the patient's performance status has been rapidly declining. When you see the patient, he tells you that the oncologist is planning a new chemotherapy regimen after the hospitalization. You estimate his palliative performance score at 30–40 and know that, for most situations, chemotherapy is not indicated for patients with a performance score <50. You ask the patient if anyone has discussed prognosis; he tells you that the oncologist told him that prognostic information is not specific for an individual patient; he has not been given any information about his prognosis, but in his heart, he believes he has 1 to 2 years to live. Choose the option below that you are most likely to follow:

Option A. Following your interview with the patient, you call the oncologist to discuss future treatment plans. The oncologist tells you that he wants to start the patient on a new chemotherapy regimen after discharge because the patient is only 35 and "he wants to do everything." You tell the oncologist that your assessment is that the patient has a poor and rapidly declining performance status, and you understand that chemotherapy for this type of cancer in patient with a poor performance status is unlikely to impact the cancer. You could imagine that, if his performance status improves, you could see why he would want to give chemotherapy, but you think the performance status is not going to improve, and the data suggest the patient has only weeks to live. You suggest an honest discussion of prognosis and assessment of patient goals. You offer to assist the oncologist with this discussion.

Option B. Following your interview with the patient, you call the oncologist and describe your assessment and recommendations for pain and nausea control. You ask the oncologist to let you know when he is ready to stop further chemotherapy and you will be happy to assist in transition management to hospice care.

We hope these scenarios have made you think about your own practice style. If you answered "A" to all three questions, we would classify your practice style as a 'full contact', or perhaps a better term is *active* palliative care practitioner. If you answered "B" we would suggest you are a 'just touch' practitioner. No matter where you fall on the spectrum,

the scenarios should prompt you to ask these follow-up questions:

- *How do I decide for any given case whether to lean more toward the full contact or just touch side of consult interactions?*
 - Your level of personal comfort with the referring clinician?
 - The specialty of the referring clinician relative to your primary training?
 - Your level of energy/fatigue as the day progresses?
 - Your discomfort with conflict?
 - The urgency of the clinical situation?
- *How well does my practice style meet the needs of patients and families?*
 - Are distressing symptoms met in a timely fashion?
 - Are key discussions taking place to meet patient and family needs?
 - Are patients and families asking important questions that are going unanswered?
- *Does my practice style lead to frequent problems that might be ameliorated by a shift in practice?*
 - Prolonged hospital or ICU length of stay?
 - Poorly managed symptoms?
 - Frequent readmissions due to failure of advance care planning and goal setting?
 - Frequent team conflict about how best to manage conflict with the referring clinician?
 - Personal moral distress when you are unable to meet the needs of patients and families?

We suggest that palliative care teams consider these scenarios and the follow-up questions as a team self-assessment activity. In case you had any doubt, our own practices, and what we believe to be in the best interest of patients and families, is to lean toward the full contact side of clinician encounters. To be clear, we are not advocating independent action without input from the referring clinician. We are advocating full contact with the managing service to advocate for unmet needs that you find in the course of seeing the patient. We believe that this approach, if combined with a respectful manner of communicating with referring clinicians, which includes keeping conflicts out of the medical record, results in the best possible clinical outcomes and more satisfaction from the referring clinician in a manner that is concordant with the growing research base documenting the benefits of palliative care.⁶ These include reduced symptoms, improved quality and satisfaction, fewer Intensive care unit days, and reduced health system cost. It seems obvious that a more passive approach would diminish the likelihood of these benefits, and if pervasive, it could even threaten the credibility of our field.

We realize there is a wide spectrum of how other palliative care clinicians view this issue. Over the years, we've heard many justifications for why clinicians choose a just touch practice style:

- *I'm not an oncologist, how should I know when it is time to stop recommending chemotherapy?*
- *I am just a palliative care clinician; intensive care unit physicians know so much more.*
- *It takes too much energy to track down and arm wrestle with referring clinician.*

- *I don't have a long-term relationship with the patient.*
- *I'm afraid of losing future consult business.*
- *Who am I to second-guess the referring clinician.*

We would argue that none of these comments are worthy of physician professionalism. We, the community of palliative care professionals, have worked hard to achieve specialty status; it is incumbent on us to use our knowledge and skills to the fullest, and not let our fear of confrontation with other clinicians stand in the way of working to meet patient and family needs. Furthermore, we are all trained as full-service physicians before we specialize in palliative medicine with a duty to provide care for the entire patient. We should bring "all of us" to the consultation, not just the palliative medicine part.

Many of us came to this work out of deep distress about unmet patient and family needs in the setting of a serious illness. We recognize that the work is very demanding of our time and energy and that there are days when we don't have the strength to fight every battle. But most days we should at least make the effort, first and foremost, to do what we believe is in the best interest of the patient and family. Our collective experience is that the battles are worth fighting and that, when all is said and done, our referring clinicians respect us more, not less, for being strong patient advocates.

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