



Fast Facts Core Curriculum

Palliative Care Teams

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**FAST FACTS AND CONCEPTS #22
WRITING A CONDOLENCE LETTER**

Ron Wolfson PhD and Elizabeth Menkin MD

Introduction One of the most meaningful acts of kindness you can do for a mourner is to write a letter of condolence. The words of sympathy and memory are comforting to the bereaved. More importantly, mourners are very appreciative that you took the time to sit and compose a personal message to them or share a memory of the deceased. For professionals who work with dying patients, writing a condolence letter is an opportunity to reflect on both the pain and the rewards of our work. When we can appreciate the privilege it is to bear witness to the courage, kindness, caring and dignity that our patients and their families exhibit under duress, it gives us strength to continue this work.

A good condolence letter has two goals: to offer tribute to the deceased and to be a source of comfort to the survivors. The best letters are like conversations, as if you were talking during a visit. Most often, they are written to the bereaved person to whom you feel closest, although it could be a general letter to the family. It should be written and sent promptly, generally within two weeks after the death. Use any standard stationery and write it by hand. Here are some specific guidelines for writing a good condolence letter:

- **Acknowledge the loss and name the deceased.** This sets the purpose and tone of the letter. Let the bereaved know how you learned of the death and how you felt upon hearing the news. Using the name of the deceased is a tribute that comforts most mourners.
- **Express your sympathy.** Use words of sympathy that remind the bereaved that they are not alone in their feelings of sadness and loss.
- **Note special qualities of the deceased.** Acknowledge those characteristics that you cherished most about the person who has died. These might be qualities of personality (courage, sensitivity), or attributes (funny, affable), or ways the person related to the world (religious, devoted to community welfare).
- **Recall a memory about the deceased.** Talk about how the deceased touched your life. Try to capture what it was about the person in the story that you admired, appreciated or respected. You may use humor – the funny stories are often the most appreciated by the bereaved.
- **Remind the bereaved of their personal strengths.** Bereavement often brings with it self-doubt and anxiety about one's own personal worth. By reminding the bereaved of the qualities they possess that will help them through this period, you reinforce their ability to cope. Qualities to mention might be patience, optimism, religious belief, resilience, and competence. If you can

recall something the deceased used to say about the mourner in this regard, you will really be giving the bereaved a gift. An example: *“I was (impressed, inspired, awed, strengthened) by the devotion you and your family evidenced during the period of Mort’s illness. Your presence (concern, care, attentiveness) was only one indication of your love for him.”*

- **Offer help, but be specific.** *“If there is anything I can do, please call”* actually puts a burden on those in grief who may be totally at a loss about what needs to be done. A definite offer of help is more appreciated. Whatever you offer, do it – don’t make an offer you cannot fulfill.
- **End with a word or phrase of sympathy.** Somehow, “sincerely,” “love,” or “fondly,” don’t quite make it. Try one of these: *“You are in my thoughts and prayers.”* Or, *“My fond respects to you and yours.”*

If you don’t have enough to say for a formal condolence letter, you may prefer to send a sympathy note. These are shorter communications that can be written on personal stationery or added to a commercially available card. As with a condolence letter, the major goal is to offer a tribute to the deceased and to offer comfort to the bereaved.

Reference

Wolfson, R. *A Time to Mourn, A Time to Comfort*. Woodstock, VT: Jewish Lights Publishing; 1993: pp 223-226.

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**FAST FACTS AND CONCEPTS #42
BROACHING THE TOPIC OF A PALLIATIVE CARE CONSULTATION
WITH PATIENTS AND FAMILIES**

Robert Arnold MD and David E Weissman MD

Introduction Palliative care consultative services are becoming commonplace in academic and community hospitals and clinics. Patients and families may have negative perceptions of palliative care and hospice – viewing such a discussion as signaling that the physician is “giving up on the patient” and that the reality of impending death must be faced. For the attending physician, the decision to convey to a patient and family that a consultation is needed can provoke anxiety. Physicians may fear such a discussion will provoke anxiety, anger or a sense of hopelessness. This *Fast Fact* provides tips for beginning a discussion leading to a visit by a palliative care consultation team.

First, decide why you want assistance from the palliative care team. Typically, physicians seek assistance in four domains: 1) pain and non-pain symptom assessment and management; 2) assistance in making difficult decisions, usually about continued use or withdrawal of potentially life-prolonging treatments such as feeding tubes, antibiotics, dialysis, or ventilators; 3) assistance in planning for the most appropriate care setting to meet patient/family goals for end-of-life care; and 4) providing psychological support to patients, families and the health care team.

Second, contact the palliative care team. Discuss your reason(s) for consultation along with pertinent details of the patient’s history and family support structure. Describe both what your goals are for the consultation, as well as what the family’s/patient’s goals may be. This is a good time to discuss any concerns you have about using the term *palliative care* with the patient or family.

Third, engage the patient/family in a discussion of the current medical condition and goals of care. Introduce the topic of a consultation by saying: *To best meet some of the goals we’ve been discussing (fill in with the goals mentioned by the family/patient) I’d like to have some consultants from the Palliative Care Team visit with you.* You can follow this by saying, *They are experts in treating the symptoms you are experiencing (fill in symptom).* *They are also good at helping your family deal with all the changes brought on by your illness; they can answer your questions about (fill in previously discussed patient questions).*

You should not say that the reason you are asking Palliative care to be involved is “that there is nothing more to do” or because “I have nothing more to offer.” Talk about the positive goals Palliative Care can help you and the patient achieve.

Finally, emphasize your continued involvement: *You and I will talk about the recommendations of the palliative care experts. I’ll make sure all your questions are answered.* This can help relieve fears of abandonment. If a patient or family reacts negatively to the suggestion for a consultation, explore their concerns. Someone may have mentioned palliative care and this may have negative connotations to them. Ask, *What experience do you have with hospice/palliative care? What are your concerns?* It may be important to discuss that palliative care is compatible with aggressively treating the underlying disease. Emphasize the positive aspects of what palliative care can do, rather than focusing on how the palliative care team will help them accept death and dying. After all, the goal of palliative care is to achieve the best possible quality of life through relief of suffering, control of symptoms and restoration of functional capacity, while remaining sensitive to the patient and family’s values. Palliative Care guides the patient and family as they face disease progression and changing goals of care, and helps those who wish to address issues of life completion and life closure.

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**FAST FACTS AND CONCEPTS #167
HEALTH PROFESSIONAL BURNOUT – PART I**

Linda Blust MD

Background Compared with other American workers, health care professionals suffer more burnout (1). Amongst US physicians burnout rates range from 30% to 65% across specialties, with the highest rates of burnout incurred by physicians at the front line of care (e.g. emergency medicine and primary care) and those who are frequently exposed to distressing emotional situations and profound suffering (e.g. palliative medicine) (2,3). Lack of attention to health providers' stress responses to the witnessed suffering contributes to the high prevalence of burnout in US health professionals. This has consequences for the provider and his/her interpersonal relationships. This *Fast Fact* will describe burnout and its risk factors, and review essential research regarding health professionals and burnout. *Fast Facts* #168-170 will address symptoms, consequences, avoidance and assessment of burnout.

- **Definitions: Burnout is a . . .**
 - “Psychological syndrome in response to chronic interpersonal stressors on the job” (7).
 - “State of mental and/or physical exhaustion caused by excessive and prolonged stress” (4).
- **Common features** (adapted from Maslach 1982)
 - A predominance of mental or emotional exhaustion, fatigue, and depression.
 - The symptoms are more mental and behavioral than physical.
 - The symptoms are work-related.
 - Burnout manifests in persons with no previous history of psychopathology.
 - Decreased effectiveness and work performance result from negative attitudes and behaviors.
- **Situational Risk Factors**
 - Physician Worklife Study: 2326 US physicians identified via AMA masterfile responded to a 38-item mailed questionnaire developed and validated for this study. Predictors of stress were:
 - Demands of solo practice, long work hours, time pressure, and complex patients.
 - Lack of control over schedules, pace of work, and interruptions.
 - Lack of support for work/life balance from colleagues and/or spouse.
 - Isolation due to gender or cultural differences.
 - Hospital consultants in the UK: 882 gastroenterologists, radiologists, surgeons, and oncologists responded to 12-item General Health Questionnaire and Maslach Burnout Inventory. Sources of stress were:
 - Work overload and its effect on home life.
 - Feeling poorly managed and resourced.
 - Managerial responsibility.
 - Dealing with patients' suffering.
- **Individual Risk Factors**
 - At risk earlier in career
 - Lack of life-partner
 - Attribution of achievement to chance or others rather than one's own abilities
 - Passive, defensive approach to stress
 - Lack of involvement in daily activities
 - Lack of sense of control over events
 - Not open to change

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FAST FACTS AND CONCEPTS #168
HEALTH PROFESSIONAL BURNOUT – PART II**Linda Blust MD**

Background As described in *Fast Fact #167*, burnout is a “psychological syndrome in response to chronic interpersonal stressors on the job” (Maslach 1982). This *Fast Fact* will explore symptoms of burnout and its personal and professional consequences. *Fast Facts #169* and *170* will describe avoidance and assessment of burnout.

Symptoms of each sequential stage of burnout

- **Stress Arousal:** anxiety, irritability, hypertension, bruxism, insomnia, palpitations, forgetfulness, and headaches.
- **Energy Conservation:** Work tardiness, procrastination, resentment, morning fatigue, social withdrawal, increased alcohol or caffeine consumption, and apathy.
- **Exhaustion:** Chronic sadness, depression, chronic heartburn, diarrhea, constipation, chronic mental and physical fatigue, the desire to “drop out” of society.

Consequences

- **Personal**
 - Depletion of emotional and physical resources.
 - Negative self-image: feelings of incompetence and lack of achievement.
 - Self-neglect: 35% of Johns Hopkins’ medical graduates had no a regular source of health care.
 - Questioning of previously held spiritual beliefs.
 - Neglect of family and social obligations.
 - Mental Illness: anxiety, depression, substance abuse, suicide.
 - Substance Abuse: MD lifetime risk is 10-14%.
 - MD suicide rates similar to general population for both genders
 - Relative Risk of MD suicide versus other professionals
 - Male MDs: 1.1-3.4
 - Female MDs: 2.5-5.7
 - Female MDs complete suicide as often as male MDs
- **Professional**
 - Longer Work hours: *If I work harder, it will get better.*
 - Withdrawal, absenteeism, and reduced productivity.
 - Depersonalization: attempt to create distance between self and patients/trainees by ignoring the qualities that make them unique individuals.
 - Loss of professional boundaries leading to inappropriate relationships with patients/trainees.
 - Compromised patient care. Burnout has been linked to
 - More medical errors
 - Diminished sense of empathy for patients
 - Impaired decision-making
 - 45% of University of Washington residents who self-report burnout also report providing “suboptimal care.”

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FAST FACTS AND CONCEPTS #169 HEALTH PROFESSIONAL BURNOUT – PART III

Linda Blust MD

Background *Fast Facts* #167 and 168 described burnout, its risk factors, symptoms, and consequences. This *Fast Fact* will address strategies to avoid burnout while sustaining personal and professional health, integrity, and growth. *Fast Fact* #170 will describe assessment tools validated for burnout.

I. Individual Strategies

- Reflection upon work: journaling, discussion with colleagues.
 - Am I burned-out/healthy?
 - Why do I do this/continue to do this?
 - What inspired/moved/surprised me today?
- Attend to health: diet, exercise, rest, regular health care.
- Plan activities that rejuvenate: Play!
- Professional supervision: Regular interaction with a mental health professional with the express purpose of exploring dynamics of the provider/patient relationship.
- Make time for yourself
 - Plan vacations at regular intervals.
 - Allow for “time-out” when stressors increase.

II. Interpersonal Strategies

- Give important relationships priority – strengthen existing relationships with family and friends.
- Expand your community beyond existing relationships through activism or spiritual engagement.

III. Professional Strategies

- Debrief emotional events:
 - Reach out to colleagues.
 - Seek out or strengthen a mentor relationship.
 - Write about your work for a larger audience.
 - Utilize your institution’s *Critical Incident Response Team* if available.
 - Psychosocial rounds with colleagues to explore these issues.
 - *Schwartz Center Rounds*: interdisciplinary hospital rounds to explore emotions surrounding provider/patient interactions.
- Advocate for change in your job, organization, or profession.

Triggers for Professional Counseling

- Persistent feelings of sadness, exhaustion, anger, worthlessness, hopelessness, suicidal ideation, or anxiety interfering with work or interpersonal relationships.
- Self-prescribing sedative/hypnotic medication.
- Substance abuse: alcohol, prescription, or non-prescription drugs.
- Other ‘addictions’ interfering with work/relationships: gambling, exercise.
- Persistent sleep disturbance: nightmares, difficulty initiating or staying asleep, early morning awakening.
- Loss of professional boundaries:
 - Inappropriate relationships with patients, families, or trainees.
 - Lack of attention to patients’ rights, safety, or autonomy.

If, after careful attention to the variables within your control, you still feel burned-out and at risk for serious consequences, it may be necessary to temporarily or permanently leave your current job to regain your health.

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**FAST FACTS AND CONCEPTS #170
HEALTH PROFESSIONAL BURNOUT – PART IV**

Linda Blust MD

Background *Fast Facts* #167-169 described burnout, its risk factors and consequences, and coping strategies. This *Fast Fact* will briefly describe assessment tools used in health professional research. Additionally, it provides a validated screening tool utilized widely in education.

1. **Maslach Burnout Inventory** (CPP, Inc.)
 - a. Designed for use in health care and other service industries.
 - b. Evaluates emotional exhaustion, depersonalization, and reduced personal accomplishment.
 - c. Well-validated; readily available; utilized by Physician Worklife Study.
 - d. 10-15 minutes to complete.
 - e. Cost: approximately \$1.25 per test, with additional fee for scoring key.
2. **General Health Questionnaire** (Bank 1980)
 - a. 12-item screen for symptoms of psychiatric morbidity
 - b. Reliable in community and occupational settings
 - c. Utilized in conjunction with Maslach Burnout Inventory in ongoing, longitudinal UK study of burnout and psychiatric morbidity in hospital consultants

3. **Self Assessment Exercise** (Girdin 1996)

How often do you . . .

a) almost always; b) often; c) seldom; d) almost never

1. Find yourself with insufficient time to do things you really enjoy?
2. Wish you had more support/assistance?
3. Lacksufficient time to complete your work most effectively?
4. Have difficulty falling asleep because you have too much on your mind?
5. Feel people simply expect too much of you?
6. Feel overwhelmed?
7. Find yourself becoming forgetful or indecisive because you have too much on your mind?
8. Consider yourself in a high pressure situation?
9. Feel you have too much responsibility for one person?
10. Feel exhausted at the end of the day?

Calculate your total score: a) = 4, b) = 3, c) = 2, d) = 1. Your total? _____

A total of 25-40 indicates a high stress level that could be psychologically or physically debilitating.

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FAST FACTS AND CONCEPTS #172 PROFESSIONAL-PATIENT BOUNDARIES IN PALLIATIVE CARE

Lise Taylor Barbour MD

Background Boundaries in patient care are “mutually understood, unspoken, physical and emotional limits of the relationship between the trusting patient and the caring physician or provider” (Farber 1997). Health professional boundaries represent a set of culturally and professionally derived rules for how health professionals and their patients interact. Boundaries serve to establish and maintain a trusting provider-patient relationship and help clinicians maintain “justice and equity in dealing with all of their patients”, not only a special few (Spence 2005). This *Fast Fact* reviews issues in health professional-patient boundaries in palliative care.

Causes of Boundary Problems In caring for seriously ill or dying patients it is common for strong emotional bonds to develop. However, when the limits of the provider-patient/family relationship are not clear or where normal professional boundaries are not respected, problems are likely to arise. Common reasons for boundary problems include:

- Personality styles or psychiatric disorders in which normal boundaries are not recognized or respected.
- Health professional stress/burnout (see *Fast Facts* #167-170).
- Cultural misunderstandings.

Examples Warning signs and examples of potential boundary blurring include:

- Gift giving from/to patient/family.
- Patients having or wanting access to provider’s home phone number, or other personal information.
- Patient/family expectations that the provider will provide care or socialize outside of clinical care settings.
- Patient/family requests that the provider participate in prayer (See *Fast Facts* #120).
- The health care provider revealing excessive personal information with patient/family.

Self-Monitoring Not all ‘boundary issues’ are detrimental to the provider-patient relationship – some clearly enhance compassionate care and serve to reinforce a trusting therapeutic relationship. However, it is important for the provider to self-reflect when boundaries are approached.

- *Am I treating this patient or family differently than I do my other patients?*
- *What emotions of my own does this patient/family trigger and are the emotions impacting my clinical decision-making?*
- *Are my actions truly therapeutic for the patient, or am I acting in a manner to meet my personal needs?*
- *Would I be comfortable if this gift/action was known to the public or my colleagues?*
- *Could this boundary issue represent a sign that I am experiencing professional burnout?*

Managing boundary concerns

- Set clear expectations with patients and families as to your role in the context of their care, your availability and best ways to communicate with you.
- Use professional colleagues or a mental health professional as a sounding board when you are uncertain about your own or your patient/family behaviors.
- Address issues as they arise with the patient/family. Acknowledge importance of feelings, emphasize the provider-patient relationship and the importance of maintaining objectivity; emphasize that the rejection of a requested behavior does not imply a lack of caring.
- Seek professional counseling for yourself or the patient/family when boundary issues impact your ability to provide objective, compassionate care.

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FAST FACTS AND CONCEPTS #253
PALLIATIVE CARE CONSULTATION IN THE ICU

Margaret L Campbell PhD, RN, David E Weissman MD, and Judy E Nelson MD, JD

Background The Intensive Care Unit (ICU) is the setting for high-intensity health care designed to resolve life-threatening illnesses and extend life. However, risks of mortality and severe morbidity remain high and virtually all ICU patients have palliative care needs. Integration of palliative care services into ICU care is increasingly seen as a method to improve clinical care (1,10). This *Fast Fact* reviews the role of palliative care consultations in the ICU along with options for more generalist palliative care services provided by ICU clinicians.

What occurs in an ICU Palliative Care Consultation

- Assess/treat distressing physical, psychological, and spiritual symptoms/problems.
- Communicate information about prognosis and treatment options to patient/family in concert with ICU, primary care and subspecialty colleagues.
- Establish/clarify goals of care that are realistic and appropriate in relation to the patient's condition, values and preferences, and help match treatments to these goals.
- Formulate a transition care plan that accounts for prognosis, goals of care and patient/family needs.
- Provide support for the families.
- Support the ICU medical team in making clinically, ethically, and emotionally challenging decisions.

Research Data on Benefits of Palliative Care ICU Consultation

- Early identification of a dying trajectory leading to decreased time to institution of patient- and family-centered, comfort-focused treatment goals (2-3).
- Movement of appropriate patients to lower intensity care sites (ward, palliative care unit, home hospice) (5-6).
- Reduction in ICU length of stay for adult patients (2-4, 7).
- Reduction in the cost of care, without an increase in mortality, due to early establishment of realistic treatment goals leading to reduction in use of high-cost ICU resources/interventions (2-4, 7-8).
- Support for staff in challenging and emotionally draining/morally distressing patient/family care situations.
- Palliative Care consultation for hospitalized patients can reduce the need for ICU admission through establishment of treatment goals that preclude future ICU admission (7-8).
- Continuity of care when the patient transitions from the ICU to ward or palliative care unit as the Palliative Care team follows the patient.

ICU/Palliative Care Collaboration A range of options exist for integrating palliative care services into the ICU. At one extreme, ICU staff consult a palliative care specialist team for problems the ICU staff deems appropriate for consultative advice on an ad hoc basis. At the other extreme, the ICU embeds systems in place to provide ICU-led generalist palliative care services to all ICU patients, utilizing palliative care specialists for complex problems. Embedding systems that ensure the needs of all patients are met includes screening all patients on admission and daily for unmet palliative care needs, early identification of a surrogate, timely symptom management, and routinely-scheduled family meetings to discuss goals of care (1,9,10). Quality outcomes related to patient and family experience and to health care utilization should be tracked within the framework of available resources (1,11).

When to use Specialist Palliative Care Services Consultations can either be initiated on a case-by-case basis by ICU or other primary clinicians, or triggered proactively using a system to identify patients at high-risk for unmet needs (2-4). Key indications for consultation include:

- Difficult-to-control physical symptoms despite usual treatment approaches.
- Patients/surrogates wish to explore non-ICU supportive care options such as hospice services.
- Staff have questions about the appropriateness of life-sustaining therapies in the setting of advanced complex illnesses.
- There are complex family dynamics impacting decisions about use of life-sustaining treatments.

- There are disagreements among staff or between staff and patients/surrogates about prognosis and/or use of life-sustaining treatments.
- Patients are being readmitted to the ICU more frequently within a given time frame.

Summary Specialist palliative care consultations, together with integration of palliative care principles into the care of all ICU patients, can improve the patient/family experience, reduce length of stay and improve ICU throughput without increasing mortality, and lower health care costs.

Additional resources: *Fast Facts* # 122-123.

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FAST FACTS AND CONCEPTS #266
CONSULTATION ETIQUETTE IN PALLIATIVE CARE

Charles F von Gunten MD, PhD and David E Weissman MD

Background There are generally agreed upon rules for consultation (just as there are in social life) that can have profound consequences if they are breached. For those just starting to provide consultation services, it is wise to follow the rules until you develop enough familiarity to know when they can be breached. This *Fast Fact* reviews the rules of consultation etiquette for palliative care (PC) clinicians. See *Fast Fact #298* for more specific guidance on PC consultation in the Emergency Department.

1) Remember your stakeholders. Although the focus of the consultation is a patient/family issue, your primary stakeholder is the attending physician that requested the consultation. Unhappy referring physicians mean fewer palliative care consultations!

2) Make contact/clarify request. Before you see the patient, contact the referring service to acknowledge that you received the request and to clarify the nature of the request. Determine what questions the managing service wants answered. The phrasing of this is important. *'Please tell me a little about Patient X so we can be most helpful to you'* is an excellent open-ended query. Determine if there are areas that are "off-limits" and find out who the consulting team should talk with following your assessment – the referring clinicians or someone else on the care team. Remember, no matter what is written in the chart, the real story exceeds what is written, and the referring clinicians often have concerns/needs that are not evident from the chart. Particularly for palliative care consultations, this has an important secondary importance; in telling you about the patient, the service will receive emotional support in the telling the story. Be quiet and actively listen; acknowledge the underlying distress.

Cultural corollary: in some institutions the rank of the person calling should match or exceed the rank of the person called. Strictly applied, for instance, an attending speaks to an attending. This is not true of all institutions or physicians, but it is wise to know your local culture. When in doubt, or conflict occurs, following the cultural corollary of your institution connotes respect.

3) Negotiate roles. Many referring clinicians will want the palliative care service to play an ongoing role in the management of the patient and family. This may range from providing information and counseling, to actively managing symptoms including writing medication orders, to assuming principal care for the patient and family. Others will want the palliative care service to maintain a strictly consulting role while the primary service implements recommendations.

4) See the patient & gather your own data. This includes reviewing the medical record, pertinent laboratory and diagnostic tests, interviewing the patient and family, examining the patient, and offering information and counseling if that was part of the nature of the request.

5) Call the referring service. Before you write in the chart, call the referring service with details of your findings and recommendations. With experience and familiarity with frequent referrers, this step may not be necessary. If appropriate, contact other consultants and clinicians involved with the patient (housestaff, nurses, discharge planners, etc.).

Additional Tips

- **Brevity** (in general, try to limit your recommendations to ≤ 5) and **specificity** (e.g., exact morphine dose/route/schedule) are important to both communicate your key messages and increase the likelihood that your recommendations will be acted upon.
- **Plan ahead** – you are often in the best position to recognize likely future needs beyond the hospitalization; plan ahead to meet expected symptom control and other patient/family needs. Helping to expedite and simplify patient discharge is an easy and high-yield way of demonstrating your service's value to referring clinicians.
- **Honor turf** – you may be one of many consultants; when in doubt about the expectations and plans of the referring clinician, clarify by personal contact.

- **Be accessible** – a referring physician or service needs to know how to reach you easily. He or she will be put off if they can't reach your service. Indicate how you can be reached in your consult note.
- **Be responsive** – acknowledge receipt of the request as immediately as possible and plan to see the patient the same day or within 24 hours. If unable to do this, contact the referring clinician directly to discuss.

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FAST FACTS AND CONCEPTS #267 WRITING THE CONSULTATION NOTE

Charles F von Gunten MD, PhD and David E Weissman MD

Background Documentation the consultation serves to: a) communicate your findings, b) document the service you provided and c) support your coding and billing activity. In *Fast Fact # 266*, the basic principles of consultation etiquette were reviewed as they apply to palliative care clinicians. This *Fast Fact* reviews key elements of the palliative care consultation note.

1) Reason for Consultation *I was asked to see this 87 year old man for problems related to shortness of breath and setting goals-of-care by Dr. Bligh. An older etiquette form that is appreciated is to begin the consultation note with the phrase: Thank you for asking me to see this....*

2) Summarize the Case, including your activities

- I have reviewed the medical record and the chest radiographs, interviewed the patient and family, and examined the patient. The following aspects are pertinent:
- Pertinent Current and Past History
- Pertinent Social/Family/Spiritual History
- Pertinent Medications and their effects
- Pertinent Review of Systems
- Pertinent Examination Findings
- Pertinent lab/x-ray/pathology
- Prognosis/Advance care planning/Goal setting information

3) Your Assessment Clearly and prominently indicate your assessment. This is where those who want to know "the bottom line" will look first. It is common practice in some institutions to put your assessment and recommendations at the very top of the note for readability. Encapsulate the case from your point of view. This should be as concise as possible, however it should contain adequate accounting of your medical decision making, particularly if your discussion could be surprising or unfamiliar to other clinicians (e.g., hospice eligibility in 'borderline' cases, opioid hyperalgesia).

- *This 87 year old man has dyspnea due to a combination of COPD and metastatic adenocarcinoma of the lung. He understands his diagnosis and prognosis. He and his wife made it quite clear that they do not want to suffer and would like to be cared for at home. They would like no heroic or extraordinary measures used to keep him alive. They agree to a hospice plan of care.*

4) Recommendations Number, bullet, and/or **bold** your recommendations; don't bury them in a dense paragraph. Be as specific as possible with recommendations and avoid vague statements like "start morphine for dyspnea."

1. *Initiate oral morphine 5 mg po q 1h to relieve dyspnea*
2. *Initiate dexamethasone 8 mg orally q am to diminish inflammation and add to relief of dyspnea*
3. *Enter a DNR order in the chart and give the patient documentation to take with him at discharge.*
4. *Refer the patient to Pershing Hospice which serves the area where he lives. Their telephone number is 111-222-2222. We would be happy to arrange this if you would like.*

5) Closure Indicate with whom you have discussed the recommendations and your plan for following-up the patient; conclude with the conventional etiquette.

- *I have discussed these recommendations with Dr. Bligh who concurs. Further, I have discussed my findings with the housestaff, nursing and social work staff caring for this gentleman.*
- *Dr. Bligh has asked us to continue to follow this patient during his hospitalization to supervise titration of morphine and to continue to provide counseling and information. If you need us, it is best to contact our nurse, Betty Blythe, RN at 444-4444,*
- *Thank you for permitting us to participate in the care of this patient.*

6) Signature Clearly indicate your name and a way that the service can contact you.

- Charles Feelbetter, MD; Office 333-3333; Pager 111-1111

7) Coding and Billing For coding and billing purposes, if you are using time to justify the level of coding, you should include start/stop times of your face to face patient contact (see *Fast Fact #48*).

- *I spent a total of 90 minutes on this consultation. 50 minutes of this time was spent in counseling and information giving to the patient and his wife, starting at 1530 and ending at 1620.*

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FAST FACTS AND CONCEPTS #298
PALLIATIVE CARE CONSULTATION IN THE EMERGENCY DEPARTMENT
Sangeeta Lamba MD, MS HPEd, Tammie E Quest, MD, David E Weissman, MD

Background Adults with chronic illnesses visit the emergency department (ED) several times in their last months of life, with over half of older Americans presenting in their last month and many dying in the ED. Hence, the ED serves many patients with unmet palliative care needs. Initial care decisions made in the ED also set the future hospital trajectory of care. Early palliative care (PC) engagement in the ED has the potential to impact these decisions. In this Fast Fact we discuss the opportunities and challenges of the PC consultations in the ED.

Indications for Palliative Care consultation in the Emergency Department

- Difficult-to-manage pain or other symptoms
- Symptom management for an actively dying patient
- Rapid consensus for goals of care (e.g. intubation decision) or complex decision making
- Clarify provisions in an advance directive
- Withdrawal of non-beneficial treatments (e.g. help with terminal extubation)
- Bereavement support (e.g. after sudden deaths in victims of trauma or death of a child)
- Challenging dispositions requiring care coordination (e.g. home hospice)

Consultation Etiquette ED clinicians are charged to provide excellent and efficient patient care, with a mandate to keep patient encounters as expedient as possible. ED providers often expect in-person consultation time within 30-60 minutes. Palliative programs should proactively discuss the consultation processes with the ED leadership to clarify when and how palliative care team members will be available for an ED consult, by phone or person. To best serve the ED staff, palliative care clinicians are encouraged to follow these principles of consultation etiquette:

1. Determine the question: What is needed from the ED team? Orders for symptom control, dialogue with family, guidance with disposition planning? Certain issues, such as symptom control, may be initiated or handled over the phone whereas more complex issues such as urgent goals of care discussions may need in-person support.

2. Establish urgency: Be explicit in asking the ED team for the timeline of expectations.

- Emergent (e.g. clinical status unstable; decision to intubate, decision to withdraw ventilator)
- Urgent (e.g. patient relatively stable; help needed for disposition planning)
- Routine (e.g. patient is being admitted, has non-urgent needs, can be seen as inpatient).

3. Who is needed and when? Clarify care issues to determine which IDT member is best suited to address the ED query. Be honest about timelines for in-person support and initiate telephone support as soon as feasible.

4. Personal contact: discuss your findings and/or recommendations with the appropriate member of the ED staff before initiating any definitive patient/family communication or intervention. Recognize that this ED clinician may not be the one who initiated the palliative team consult due to shift schedules.

5. Gather additional data: To offer high quality care, the consultant will need to gather data independently.

6. Brevity: A verbal 2-4 minute summary of recommendations is useful immediately after the consult.

7. Specificity: Be explicit in disposition and treatment directions (e.g., *“begin with Morphine 5 mg IV and repeat every 15 minutes until pain is less than 5”*). Make sure your recommendations are feasible to implement and fit the ED policies and protocols. Clarify who will be contacting other stakeholders (home care, caregivers, etc) and what messages will be communicated.

8. Teach with tact: e.g. provide a *Fast Fact*, a protocol for pain, or an opioid equivalency table.

9. Provide continuity: Communicate the established plan of care to the patient, family, ED clinician and the provider for the patient’s next place of disposition (e.g. the hospitalist for a patient being admitted).

10. Honor the ED environment: Appreciate the patient load and competing emergency care demands of the ED staff. Expect and anticipate shift changes and the need to orient new staff to your role and plans.

Summary Often a consult initiated in the ED does not have ample time to fully address patient needs or change immediate outcomes. PC collaboration still serves a vital role in the ED as initial discussions begun in the ED (clinician discussions about poor prognosis and introducing palliative team as part of the next steps of care) can help prepare the patient and family for future care discussions with the palliative team. PC clinicians are encouraged to learn about the ED culture and develop positive relationships by joining in ED care rounds, serving as educational resources, and working collaboratively on institutional protocols.

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FAST FACTS AND CONCEPTS #310
THE ONCOLOGY-ICU-PALLIATIVE CARE INTERFACE
Mamta Bhatnagar, MD, Robert Arnold, MD

Background: Cancer patients may be admitted to an intensive care unit (ICU) at any point in the disease trajectory (1). When these patients have an advanced malignancy, and/or when their disease has progressed despite standard anti-cancer treatments, it is common for conflicts to arise between oncologists and the critical care team regarding appropriate management. This *Fast Fact* discusses an approach to conflict management for cancer patients in the ICU.

Same Patient-Different Opinions: Every specialty has a unique culture based on the type of diseases it treats and the attitudes learned from peers and teachers during training years. Having a general awareness of these cultural tendencies among various specialty groups could better enable Palliative Care (PC) clinicians to manage inter-specialty conflicts.

Oncologists ...

- See a wide range of patients, some who are cured and others who die.
- Are trained to examine all potential anti-cancer treatments to extend life.
- May view ICU care as nothing more than a “bump in the road,” noting that the prognosis of cancer patients in the ICU is similar to non-cancer patients. This point of view may be especially apparent in patients who have recently undergone a bone marrow transplant, but have not yet shown signs of bone marrow recovery – *reengraftment* (1,5).
- Often have long-term outpatient relationships with patients creating strong emotional connections.

Intensivists ...

- Are likely to see many cancer patients near the time of death when ICU care may represent a ‘last-ditch’ effort to sustain life.
- Often have brief relationships with patients/families during a time of crisis.
- Like many non-oncology specialties, they may have a more negative view of the potential benefits of anti-cancer treatments than oncologists.
- May worry about prolonging suffering through ICU interventions when death appears imminent (1).

How can palliative care help? By performing careful independent evaluations of the medical situation and exploring the points of view of the various specialty teams, the PC team members can serve as mediators who assist in creating a shared message for the family (2).

- **Neutral Caring:** An important trait of a PC consultant is the mindset of neutral caring. **Neutral** in that he or she should avoid taking sides between the different clinical teams but instead work to find a common story that they can agree on. PC consultants should be aware of their own potential biases or conflicts of interest, which could influence the direction of the patient’s care. For example, PC teams may be more likely to assume that a focus on comfort with a shortened hospital stay is preferred (3). **Caring** because the PC consultant needs to remember that all the clinicians are doing their best to care for the patient. Thus even if the PC clinician is sure that their view is “right”, they need to respectfully negotiate with other clinicians who also may be sure their view is correct.
- **Pre-meeting of clinicians:** Regardless of who initiates the consult, PC teams should reach out to both the oncologist and the intensivist to understand their points of view regarding disease, treatment options and prognosis. In many such circumstances, attending-to-attending level conversations are necessary. Given that prognosis is often uncertain, it may help to reach agreement on the best, worst, and most likely prognosis (4). This may identify areas of agreement among the specialist teams involved and clarify what medical data are needed to better forecast prognosis.

Managing Conflict: Multi-disciplinary goals of care meetings are often the most effective and efficient way to bring all specialty care teams together along with the patient and/or family and negotiate the best way forward (see *Fast Facts* #16, 65, 183-184, 222-227). If there is disagreement between specialty teams, it is critical that such attending clinicians talk directly before meeting with the family. Often reports of what one clinician said is from the family or another indirect source. Consequently, these descriptions

may be incomplete or filtered by the family's hopes. In cases in which medical agreement cannot be reached, the PC team can assist by presenting the differing opinions to the family as part of a cohesive medical reality on which the family can base their decisions or pursue a time-limited trial.

Summary: The goal of the PC consultant is to perform an independent evaluation in order to help the medical care team develop a unified medical narrative that is agreeable with all clinicians involved. As such, PC teams can be vital in conveying an accurate and understandable medical narrative to the families of critically ill cancer patients. By fostering an environment that allows regular clinician meetings to occur throughout a patient's hospital stay, PC teams can better ensure that medical teams talk directly to each other about the patient's prognosis and present a unified approach to the family and patient.

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**FAST FACTS AND CONCEPTS #334
THE ROLE OF CLINICAL PHARMACISTS ON THE INTERDISCIPLINARY TEAM**

Jennifer Pruskowski, PharmD

As experts in the rational, therapeutic use of medications (1), clinical pharmacists are uniquely suited to enhance palliative care services for adults and children through patient-specific medication considerations such as goals of care, care location, available routes of administration, pharmacokinetic and pharmacodynamic properties, and cost. This *Fast Fact* will review the role of clinical pharmacists within an interdisciplinary teams (IDT) with specific attention to hospice and palliative care teams.

Training and Certification: The Doctor of Pharmacy (PharmD) degree is awarded upon graduation from US Schools of Pharmacy. The program requires at least 2 years of specific pre-professional (undergraduate) coursework, followed by 4-academic years of professional study (2) in which much of the pre-clinical content mirrors that of US medical schools. Pharmacists may then choose to complete a 1-2 year post-graduate residency (3,4) and/or fellowship (5). Specific pain and palliative care traineeships and online masters programs are also available for pharmacists in the US (6-9) and Canada (10).

Scope of Practice Clinical pharmacists are the “translators” between the pharmacology of medications and the clinical care of patients. Their skill set originates from their ability to identify and manage potential drug therapy issues (11). Examples include: assistance with renal and hepatic dosing, drug-interactions, opioid conversions, brainstorming alternative therapies or routes for refractory symptoms, and selecting rational, cost-effective therapies. They can provide direct and indirect patient care services:

Direct patient care services:

- Medication Management: clinical pharmacists can perform regulated symptom assessments either independently or alongside IDT members to write orders or make treatment recommendations (12). Many states permit ‘advanced practice pharmacists’ (akin to advance practice nurses). Based on the individual state laws and health system’s collaborative practice agreements, this can include the prescribing of opioids and other controlled substances.
- Patient education: provision of medication counseling to improve patient adherence.
- Deprescribing (see *Fast Fact* #321): clinical pharmacists can incorporate the goals of care conversations performed by the IDT as well as the estimation of the patient’s prognosis and functional status to conduct medication-specific optimization conversations and minimize the number of medications prescribed (13,14).

Indirect patient care services:

- Administrative and formulary management
- Education to other IDT members regarding pharmacotherapy issues

Roles of a Palliative Care Clinical Pharmacists in Various Health-care Settings (15)

- Inpatient (Hospital): Performing a comprehensive or targeted medication review at admission, discharge, and as needed. This includes a chart review and face-to-face interaction with the patient to detect adverse drug events and medication misuse as well as reconciling the appropriateness of all inpatient medications with their outpatient regimen (16).
- Outpatient (Clinic) (17-19): Clinical pharmacists can identify patients on long acting opioids and ensure an appropriate bowel regimen is co-prescribed to prevent opioid induced constipation or review state-wide drug monitoring databases. If transitions in goals of care occur, clinical pharmacists can utilize this information to deprescribe medications or identify new medications or routes of administration in the palliation of new or anticipated symptoms.
- Senior Communities (Skilled Nursing Facilities): In this setting, deprescribing is especially relevant in minimizing iatrogenic harm and ensuring a smooth transition to hospice when appropriate. In this regard, clinical pharmacists can direct medication-specific optimization conversations with the patient and their families and/or caregivers. They can also focus on the pharmacokinetic changes that occur with aging, and research non-traditional routes of administration for medications.
- System-Level Positions: Clinical pharmacists can be instrumental in optimizing direct patient-care services, procedural guidelines, electronic medical order entry systems, medication formularies, and/or policies to improve medication usage across entire health-care systems (20). This can include improve the availability of medications necessary for the management of refractory or end of life symptoms such as: ketamine, lidocaine, methadone, glycopyrrolate, etc.

- **Hospice:** Beyond identifying drug-related problems and recommending appropriate drug therapy at hospice IDT meetings (21), they must be familiar with medication reimbursement requirements. The Centers for Medicare and Medicaid Services (CMS) stipulates that hospices are responsible for the costs associated with medications if related to the terminal diagnosis and related conditions. (22) Therefore, clinical pharmacists should be involved from the point of hospice admission to review medications for appropriateness. They can also provide efficient mechanisms for extemporaneous compounding of nonstandard dosage forms (23).

Efficacy in Improving Patient Care: Retrospective evidence suggests clinical pharmacists may be associated with a reduction of hospital admissions, length of hospital or ICU stay, 30-day readmissions, drug-induced adverse reactions, and cost (22).

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FAST FACTS AND CONCEPTS #347
THE ROLE OF CHAPLAINCY IN CARING FOR THE SERIOUSLY ILL
Rebekah Schmidt, BCC

Background: Spirituality refers to the way individuals seek and express meaning, purpose, and connectedness with the sacred or significant (1). Patients and families dealing with serious illness often experience spiritual distress or desire spiritual support. Chaplains' roles are often misunderstood as being religious faith leaders for patients, but a more accurate description would be that of spiritual care specialists who identify and support patients with spiritual distress or unmet spiritual needs (1,2). This *Fast Fact* addresses the scope of clinical chaplaincy practice within an inter-disciplinary team (IDT).

Why is Spirituality a Key Component to Quality Care? Studies have shown that many patients want their clinicians to ask them about spirituality, as many utilize spirituality to cope with health threats to their mortality (1,3). Inattention to spiritual distress by clinicians has been associated with higher end-of-life costs, including more ICU deaths and less hospice utilization (4). By addressing spiritual needs, chaplains provide a safe forum for patients and families to acknowledge their sources of spiritual distress, as well as identify ways to improve their spiritual health. A qualitative study identified the following common spiritual needs and sources of spiritual distress in patients nearing the end-of-life (5):

Spiritual Needs

- To finish business: such as forgiveness, reconciliation, or to review their lives for meaning.
- To have involvement and control: in their care plan, medical decisions, hospital or home environment.
- To maintain a positive outlook: by utilizing spiritual strengths and personal resources to keep an open mind and live in the present.

Sources of Spiritual Distress

- Fear: of death, the afterlife, separation from loved ones, pain and suffering, and not leaving a legacy.
- Losses or grief: such as a loss of independence, mobility, life, control.
- Other negative emotions: despair, anger, frustration, helplessness

Who are Chaplains? Board Certified Chaplains (BCC) complete graduate-level theological training and at least 1600 hours of supervised clinical training called "clinical pastoral education." Subsequently, they appear before a national committee for approval, and participate in continuing education to maintain certification. No matter what their own faith tradition may be, BCCs are interfaith, meaning they are trained to assist patients and families of any faith as well as those of no faith or those unsure of their faith.

How Can Unmet Spiritual Needs Be Identified? As spiritual care generalists, nurses, social workers, physicians, and other IDT clinicians have the responsibility to screen for spiritual distress and spiritual needs as part of the consultation or history and physical process (see *Fast Facts* #19 and 274) (7). This includes listening for phrases which may indicate a need for spiritual support such as: "*Why is this happening to me?*", "*What God would allow this?*", "*I still have things to do in my life!*" or "*I've lost touch with my faith leader since I've been in the hospital.*" Alternatively, when pain or other physical symptoms are refractory, clinicians should consider whether spiritual or existential distress may be present. Clinicians should refer to a chaplain if unmet spiritual needs and/or spiritual distress are suspected.

What Do Chaplains Do? Chaplains serve as the spiritual care specialists on an IDT. They perform an independent assessment of the patient and family's spiritual needs, as well as cultural and religious factors which may be influencing medical decision-making. They utilize their training to design an individualized spiritual care plan. Interventions may include reflective listening, prayer, empathetic support, contacting the faith community, performing a life review, and assisting patients in integrating their spiritual beliefs with their new medical reality (6).

How Can Chaplains be Effectively Utilized? There is no “one-size-fits-all” approach to utilizing chaplaincy. Ideally, a hospice or palliative care program would have a chaplain integrated into their IDT, but many must rely upon unit-based chaplains. Examples of potential approaches include:

- Routinely informing patients and families of the availability of chaplains.
- Involving chaplains in the discussion of patients during IDT meetings. Chaplains add a spiritual lens which helps IDTs with identifying patients with spiritual or existential sources of suffering.
- Incorporating chaplains into usual IDT care practices by performing bedside rounds with the chaplain. By doing so, the IDT can address spiritual issues in real time and demonstrate spiritual care priorities to patients and families. Chaplains can also role-model and educate best spiritual care practices to IDT members or trainees.
- Involving chaplains when cultural or religious beliefs are cited as reasons for disagreement with medical recommendations, as chaplains may be able to function as cultural/religious translators.
- Including chaplains in goals-of-care discussions. Often, non-medical factors influence patient or surrogate decision-making. Chaplains listen for spiritual or religious coping influences during goals-of-care meetings and offer a unique, real-time perspective.

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FAST FACTS AND CONCEPTS #360
THE SURPRISE QUESTION AS A PROGNOSTIC TOOL
Kate S. Jennings, MD¹, Sean Marks, MD², and Hillary D. Lum, MD, PhD^{1,3}

Background: Clinicians have been encouraged to utilize the surprise question (SQ) -- “*Would I be surprised if this patient died within 12 months?*” – to identify patients at high 1-year mortality risk. When clinicians answer “No – I would NOT be surprised if this patient died within 12 months,” the SQ may help clinicians identify patients with unmet palliative care needs who could benefit from advance care planning discussions and/or a palliative care referral (1). This *Fast Fact* reviews the clinical utility of the SQ.

Rationale of the SQ: As difficult as it is for clinicians to prognosticate accurately, multiple studies have shown that patients with incurable disease desire more prognostic information the sicker they get and prognosis is a major factor in preferences for rehospitalizations, life support, and CPR (2-4). Although, patients and surrogates often want *temporal prognostic predictions* (the clinician’s estimated length of time he or she predicts the patient will live), clinicians are more accurate and willing to offer *probabilistic predictions* (the clinician’s estimate, often in a percentage, of the chance of death in a set time frame, such as 1 year) (4-6). The SQ was designed as a clinical tool that generalist clinicians would utilize willingly and routinely to identify patients at risk of death in a year and thereby lead to more appropriate advance care planning, goals of care discussions, symptom management, and hospice referrals.

Effectiveness of the SQ: Although variations on the SQ have been described in the published literature including “*Would I be surprised if this patient died this hospitalization?*” or “*Would I be surprised if this patient died in 3 months?*”, the SQ most commonly referred is “*Would I be surprised if this patient died within 12 months?*” This SQ has been studied in diverse populations, including a general inpatient setting (7), high-risk primary care clinic (8), pediatric patients (9), advanced kidney disease (10-12), cancer (13,14), acute surgical patients (15), emergency department settings (1,16), and nursing home settings (17). In general, the SQ has performed modestly well in identifying patients with a prognosis of < 1 year across these various patient populations (18,19). Notable findings from these studies include:

- A meta-analysis of the SQ among 26 studies across these patient populations found that it had a pooled accuracy of 75%, a sensitivity of 67% and specificity of 80% (18).
- “Yes” answers appear to be much more accurate than “No” answers. The predictive value of a “Yes” answer was 93%, while only 37% for a “No” answer (18). This means that the SQ is likely better designed to identify patients who will live more than a year vs the patients who live less a year. It also suggests that there is “false positives” are relatively common when clinicians answer “No” to the SQ.
- The SQ may be slightly more accurate for cancer patients (pooled accuracy 79%) and renal patients (76%) vs other disease groups (72%) (18). This may reflect a more predictable illness trajectory in cancer and renal disease. See *Fast Fact* #326 for more information on illness trajectories.
- In most studies, the SQ was utilized as one aspect of a broad prognostic assessment which included clinician gestalt and/or other prognostic tools. Hence, used in isolation, its accuracy is unclear (18).

Implementing the SQ Into Clinical Practice: The SQ can be helpful in identifying patients at risk of medical decline and death in a certain time frame when used as part of a larger prognostic assessment (19). Yet, considering the relatively high false positive rate of a “No” answer, it is not established if the SQ is a cost-effective tool nor an effective way to trigger a palliative care consultation on its own. A consensus panel of experts suggested that a “No” answer trigger generalist clinicians to perform a primary palliative care assessment or screening for unmet palliative care needs (20). Sentinel medical events like hospitalization, decline in performance status, or disease progression are reasonable triggers to implement the SQ into clinical practice. Note templates, medical rounding tools, and electronic medical record prompts are potential system-based approaches to accomplish this. Reasonable components of the primary palliative care assessment triggered by a “No” include (20):

- Assessment for distressing physical, psychological, social, or spiritual concerns.
- Identification of whether the patient completed an advance directive such as a health care power of attorney that is available in the medical records.
- Assessment of patient, family, and/or surrogate's understanding of the underlying illness, treatment options, and prognostic trajectory.
- Assessment of decision-making capacity.
- Engagement in honest conversations about prognosis and medical expectations.
- Elicitation of the patient's care preferences and values.
- Consideration of whether a hospice referral would be appropriate.
- Consideration of whether a palliative care consultation may be beneficial.

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**FAST FACTS AND CONCEPTS #368
THE PRE-FAMILY MEETING HUDDLE
Mamta Bhatnagar MD, MS and Robert Arnold MD**

Background Family meetings are important events in the care of hospitalized patients to ensure that patients & families understand what is happening medically, to support the patient and family emotionally, and to promote shared decision-making (1). Common topics include delivering bad news, discussing care goals, and clarifying the plan of care and patient disposition (see also *Fast Facts #222 & 223*). Pre-meetings among relevant clinicians are helpful for family meetings to run smoothly (1). This *Fast Fact* provides practical guidance to holding a successful pre-family meeting ‘huddle.’

Basics of the ‘Huddle’ The huddle typically occurs just prior to family meeting, ideally in a private setting (and not right in front of the patient’s room). Along with the primary medical team, the huddle may include key specialists/consulting team members including members of the palliative interdisciplinary team, the bedside nurse and/or unit charge nurse, the unit care coordinator and/or social worker, spiritual care, and other professionals as relevant such as speech language pathology, physical therapy, etc. Huddles often take between 5-15 minutes. Goals of the huddle include: (1) achieving a common understanding of the medical situation and possible options and outcomes, (2) agreeing on the family meeting’s purpose, (3) sharing what is known about the family and their concerns, and (4) determining professionals’ roles during the family meeting.

Data There are no specific data on the effectiveness of huddles prior to family meetings. However, huddles have been used for improving care in different settings, ranging from facility safety huddles to perioperative settings. Evidence suggests huddles identify safety challenges (2), decrease laboratory and pharmacy costs (3), and improve family and provider satisfaction (4).

Facilitating a common understanding of the clinical situation The first task of the huddle is to ensure that everyone is on the same page about what is happening medically, what range of interventions/options are appropriate to offer the patient/family, and what range of likely outcomes should be outlined. The clinician leading the huddle might say, “I want to make sure we all have the same view about what is going on with the patient and what we think her future might be.” In cases where health care providers have divergent thoughts, it is helpful to discuss the best- and worst-case scenarios and the milestones that will help determine how the patient is doing (5). The goal is to generate a consensus and allow the meeting leader to present this information to the patient/family in a cohesive fashion.

Agreeing on the goals of the meeting Second, the huddle participants should come to an agreement regarding the meeting’s purpose, incorporating what is known about the patient’s/family’s hopes for the meeting. The patient or family is likely to be confused if some health care providers are asking about the patient’s values while others are viewing the meeting merely an opportunity to update the family or discuss disposition. It is always a goal to make sure the patient/family leave the meeting better informed about the situation/options, and feel heard and valued. Clarifying the meeting’s purpose further than that “*What’s the fundamental message we want to convey during this meeting?*” and “*What, from our point of view, are acceptable outcomes?*”, helps avoid mixed messages. It is also very important to clarify in advance if decisions about the plan of care need to be made urgently.

Sharing information & concerns Third, the huddle is the time for health care providers to share information about the family structure, who the legal decision-maker is (if not the patient), how the patient/family make decisions, and places where the meeting might go “off track.” Given not all huddle members have met all family members, the huddle can update everyone on family dynamics (e.g., “The children always defer to their mom,” or “The cousin is a nurse and asks of biomedical questions”). Bedside nurses, social workers, and chaplains are particularly important as they may have spent much time with the

patient/family and may have a different view and experience of the patient/family than other providers. Helpful questions include “What do we know about how this family makes decisions?” or “What are some specific concerns folks have about what might happen in the meeting?”

How to facilitate the family meeting Finally, it is important to decide who will lead the family meeting, taking into account who the patient/family may have the strongest therapeutic relationship with, and to name key roles in the meeting as relevant (e.g., the surgical consultant will be sharing the news that the patient is no longer a surgical candidate, or the oncologist will be reviewing chemotherapy options and outcomes). Often the leader is a physician or an advanced practice nurse, especially if biomedical facts are being shared, but this depends on institutional culture and the purpose of the family meeting.

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