

# Palliative Care for the Vascular Patient

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# DISCLOSURES

## Kathryn Schlenker, DO

- No relevant financial relationship reported

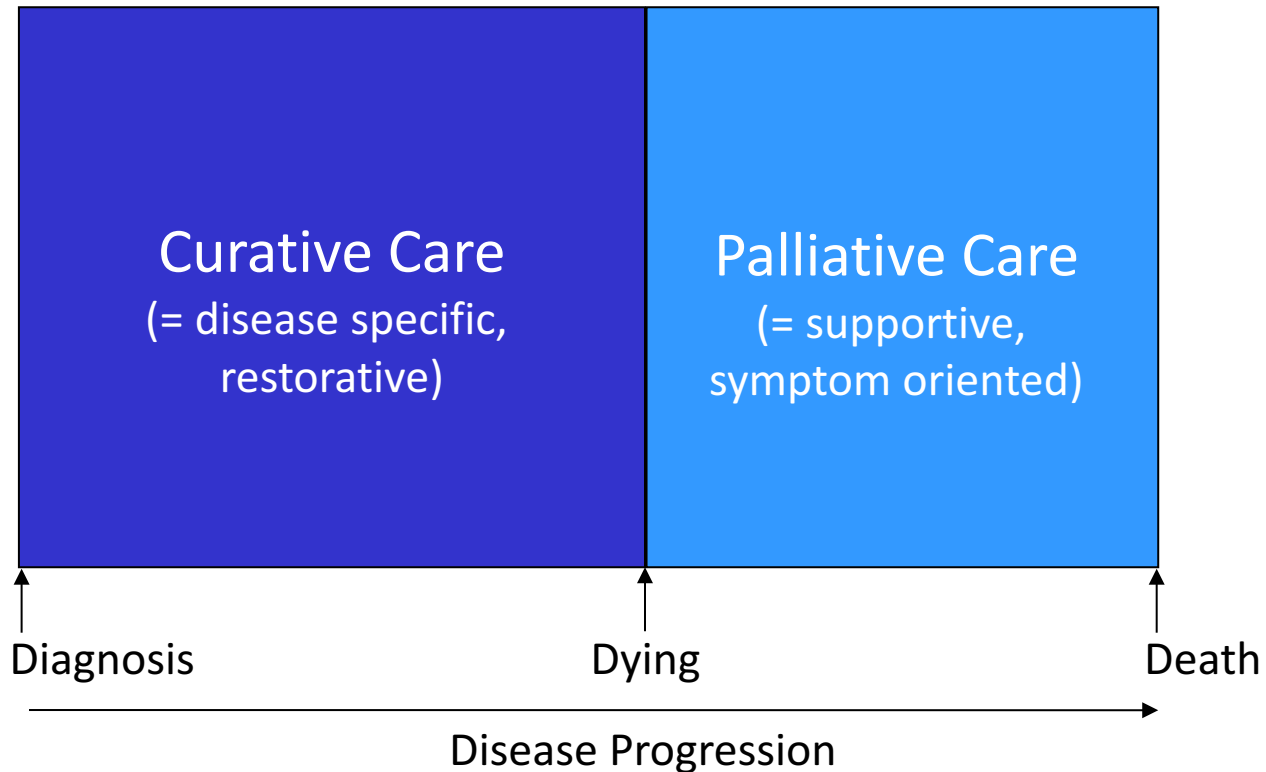
# Goals and Objectives

- Provide an overview of Palliative Care.
- Explore Advance Care Planning and it's role in caring for the vascular patient.
- Outline a basic goals of care discussion.
- Review available advance care planning resources.

# Definition of Palliative Care

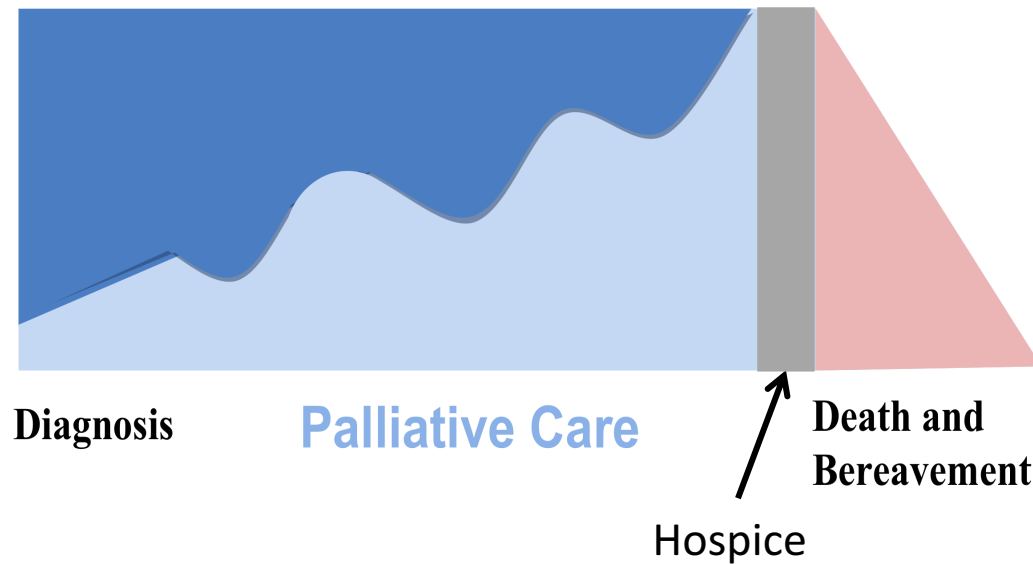
- Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with **relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis.**
- The goal is to improve quality of life for both the **patient and the family.** Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide **an extra layer of support.** Palliative care is appropriate at any age and at any stage in a serious illness, and **can be provided together with curative treatment.**

# Traditional Dichotomy of Curative and Palliative Care for Chronic Progressive Illness



# Conceptual Shift for Palliative Care

## Disease-Directed Therapies



| Primary Palliative Care   | Specialty Palliative Care  |
|---|--|
| Discuss prognosis for common illnesses  | Complex discussions of prognosis   |
| Basic assessment and communication of values, psychosocial/cultural/spiritual needs to create individualized plan of care | In depth assessment and care planning, especially in times of uncertainty or when significant distress present |
| Basic advance care planning   | Advance care planning with complex social context and complicated medical care                                 |
| Basic symptom management  | Treatment of severe/refractory symptoms  |
| Basic conflict resolution   | Complex conflict resolution within families and between families and providers                                 |
| Identify ethical and /or moral distress   | Advise when ethical/moral distress present   |
| Basic knowledge of hospice  | In depth knowledge of hospice  |

# Advance Care Planning

*A process of communication* between the patient, the family/health care proxy, and staff for the purpose of prospectively identifying a surrogate, clarifying treatment preferences, and developing individualized goals of care near the end of life.



# Goals of Advance Care Planning

- Enhance patient and family education about their illness, including prognosis and likely outcomes of alternative care plans.
- Define the key priorities in end-of-life care and develop a care plan that addresses these issues.
- Shape future clinical care to fit the patient's preferences

# Advance Directive

- Written instruction relating to the provision of future health care when an individual lacks decisional capacity
- Generally refers to 3 documents:
  - Living Will
  - DPOAHC
  - POLST

# Communication Strategies

- Normalize the conversation
  - “I talk with all of my patients about their healthcare preferences, especially before having a surgery.”

# Patient perspective and expectations

- Understanding

- How do you see things for yourself (your health) right now?
- What has the doctor told you about your health/condition?
- What have you been told about surgery?



# Prognosis & Complications

**Worst Case**

**Most Likely**

**Best Case**



# Patient perspective and expectations

- Understanding
- Hopes
  - What are you hoping for?
  - What are your goals and priorities?

# Patient perspective and expectations

- Understanding
- Hopes
- Concerns
  - Do you have any concerns or worries about your health? Your current situation?
  - Do you have any specific concerns about the surgery?

# Patient perspective and expectations

- Understanding
- Hopes
- Concerns
- Acceptable Quality of Life
  - Function: What abilities are so critical to your life that you can't imagine living without them?
  - Trade Offs: If you become sicker, how much are you willing to go through for the possibility of gaining more time?



# Be Specific

- Extended ICU stay with debility
- Dependence on others for care
- Living in a nursing facility
- Stroke
- Ventilator dependence
- Hemodialysis

# Patient perspective and expectations

- Understanding
- Hopes
- Concerns
- Acceptable Quality of Life
- Surrogate Decision Maker
  - If for some reason something unexpected happened, who would you want to make medical decisions on your behalf?

# Surrogate Decision Making in Washington State

- Appointed guardian
- DPOAHC
- Spouse
- Children of at least eighteen years of age—consensus
- Parents—consensus
- Adult siblings—consensus

# Advance Care Planning Resources

- Advance Directive/Living Will
  - Honoring Choices: [www.honoringchoicespnw.org/](http://www.honoringchoicespnw.org/)
  - The Conversation Project: [www.theconversationproject.org/](http://www.theconversationproject.org/)
  - End of Life Washington: [www.endoflifewa.org](http://www.endoflifewa.org)
  - WSMA: [www.wsma.org/advance-directives](http://www.wsma.org/advance-directives)
- DPOAHC
  - [www.wsma.org/advance-directives](http://www.wsma.org/advance-directives)
- POLST
  - [www.wsma.org/POLST](http://www.wsma.org/POLST)

# Thank You

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