



PALLIATIVE CARE CASE OF THE MONTH

“The Support Consult: Coping Skills in Real Time” by Mamta Bhatnagar, MD

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Case: Mike is 67yo man with severe COPD who was referred to the outpatient palliative care clinic for evaluation for medical marijuana. Mike and his wife, who is his main source of support, talked about many topics other than interest in medical marijuana. Topics ranged from Mike’s anxiety from past traumatic experiences, his current shortness of breath, Mike’s worry about taking too many medications, and fears about opiates. Mike wants to be able to return to a productive life where he can do chores around the house and feel like more of a contributory to his wife.

Palliative Care clinicians are asked to see patients for three primary reasons: to manage symptoms, discuss goals of care and for support. Support consults are generated when clinicians sense the patient or family struggling with serious illness or bad news. Palliative care clinicians have unique skills to support patients: improving patient’s understanding of their illness, building rapport, exploring current coping strategies and promoting positive ones. In this case of the month we will discuss how these skills are used by palliative care clinicians to help patients/families cope with their illness as part of the support consult.

Building a rapport: In the first part of a support consult, the clinician often asks the patients about themselves, specifically their work, hobbies, family structure. Clinicians allow time for the patients to share their story- both how they have been challenged by their illness and how they have coped. For example, patients will talk about how building new things, being creative or having a church family have been important sources of support for them. Having this information allows the palliative care clinicians to review how patients can continue to use those supports for themselves in the future.

Coping strategies: An assessment of coping involves finding out what brings the patient hope and joy, who they rely on for support and how they typically make their medical decisions. Questions such as “how have you coped with hard times in the past or “how well do you feel you are coping with this situation?” help improve the palliative care team’s understanding of the patient’s coping style. Two structured therapeutic interventions have been shown to decrease fears and improve well-being at the end of life. Dignity Therapy focuses on creating a legacy document that requires 4 sessions and is led by trained therapists. The “legacy” document contains information from the patient about their accomplishments, life lessons, hopes, and dreams for their loved ones.

Another psychotherapy technique is Meaning Centered Psychotherapy, which involves direct discussions with the patient regarding death related anxieties, fears, and includes facilitating a personal legacy project.

Cognitive Behavioral Therapy (CBT) helps patient’s challenge unhelpful cognitive thoughts and behaviors, allowing people new ways to deal with their fears and worries. Elements of CBT can be incorporated in any clinician’s visit. One CBT skill is cognitive reframing. For example, when patients worry about being a burden, one might help them reframe it as “while illness creates extra work, the extra work is a way for your family to show that they love you”. Pointing out positive coping strategies that patients have used in the past such as humor, distraction, problem solving also helps patients feel more control over their circumstances. Another helpful bedside counseling skill is called Acceptance and Commitment Therapy (ACT) which uses behavioral techniques where clinicians encourage patients to accept and mindfully observe negative thoughts rather than to avoid or change them. Once patients start noticing their thoughts, they can focus on alternative behaviors directed toward life goals.

Improve illness understanding;

Palliative care clinicians gauge a patient’s understanding of their illness through open-ended questions such as “What have the doctors told you about your disease?” This allows identification of gaps in the patient’s knowledge. If there is a significant gap in the patient’s knowledge of their illness, palliative care clinicians will reach out to the primary team to discuss prognosis with patients. At first, improved prognostic understanding can decrease the patient’s quality of life. However, when accompanied by positive coping skills such as positive reframing, accurate prognostic awareness improves patient’s ability to plan for the future and allows them to redirect hope, toward achievable goals.

Spiritual coping:

Spiritual pain is common among patients approaching death. Palliative care clinicians assess patients for unmet spiritual needs, often by asking, “How is your spirituality/religion important to you in daily life?” or by listening to phrases such as “Why is this happening to me?” or “What God would allow this?” The palliative care social workers and spiritual counselors are the best trained to provide spiritual support to patients. Spiritual support involves empathic listening to the patient’s story, learning their religious or spiritual belief systems and considering how these might impact their lives and medical decisions. The palliative care team is able to support specific rituals that might be important to patients and educate staff about the patient’s beliefs.

Personal details in the case published have been altered to protect patient privacy.

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 412-647-7243, pager # 8511, Shadyside, 412-647-7243, pager # 8513, Perioperative/ Trauma Pain, 412-647-7243, pager # 7246, UPCI Cancer Pain Service, pager 412-644-1724, Magee Women’s Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 412-688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s pager 412-456-1518

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Communication with primary team:

After doing an assessment, the communication between the palliative care team and the primary team is key. In this communication, the palliative care team members are able to clarify misunderstandings such as “patient or family being unreasonable,” which could result from a patient using denial as a coping mechanism and to talk about patient’s available resources. Palliative care can develop a plan for continual support and/or referral to other groups such as behavioral health services or wellness and integrative oncology.

Case conclusion:

Over the course several visits with the palliative care physician and social worker, Mike realized that he had created several barriers to effective symptom control. On his first visit, we spent some time finding out about Mike’s interests, how his past traumatic experiences and losses impacted his medical decision making. We asked Mike what was most important to him given his limited function and frequent setbacks with COPD exacerbations. With this knowledge, in subsequent visits we celebrated small improvements in functions such as a successful completion of a chore. To the couple we pointed out how his wife took on the chores around the house willingly and how they could work together. We also improved Mike and his wife’s illness understanding and talked about prognosis openly with a discussion of options for care in the future. While it made Mike sad, it also helped him to decide on what was most important to do in the time ahead and for that he was grateful.

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