Aaron Leetch, MD (host):

Welcome to the latest installment of Paradigm Shifts, the official podcast of the National Foundation of Emergency Medicine. The purpose of this podcast is to create visibility for young and soon to be prolific academic emergency physicians by highlighting their research and their vision for their field. We hope to introduce these ideas to you the listener and to expand and maybe even redirect your thinking toward the forefront of both science and the philosophy of emergency medicine.

Aaron Leetch, MD (host):

So today, I'm joined by Dr. Justin Brooten. Dr. Brooten received his medical degree from the Medical College of Georgia, and he subsequently completed his residency in emergency medicine and a fellowship in palliative care medicine from Wake Forest Baptist Medical Center. He stayed on there as an assistant professor of emergency medicine. Dr. Brooten's research interests include telemedicine interventions for palliative care and the ED, prognostication of disease using AI and how prognosis of disease is communicated in the emergency department. Dr. Brooten welcome.

Justin Brooten, MD (guest):

Thank you. It's great to be here.

Aaron Leetch, MD (host):

So today, we'll be discussing a broad overview of your research in palliative care and the three paradigms that your research addresses are as follows. So number one, palliative care is not just an end of life care. Number two, some emergencies are actually palliative care and or end of life care opportunities. And number three, that specific communication strategies can help direct patients toward the routes of care that actually fit their hopes and expectations. So could you tell us a bit about how you became interested in this area of research?

Justin Brooten, MD (guest):

Well, palliative care was something that I had a little bit of exposure to before medical school. A lot of people in palliative care will talk about having relatives that were receiving end of life care. And I got to see that with a couple different relatives. And it just seemed very important to me, when you have somebody that's nearing the end of life, the way that they're taking care of, I feel, is just so crucial. And it's something we're all going to have to deal with at some point. And that was something that I just was really interested in it. And it was very profound, the way that you take care of someone near the end of their life, I feel like as a physician, and just as a human being, it's just a very profound experience.

Justin Brooten, MD (guest):

And a lot of people in palliative medicine will say that. At the same time, I really liked the challenges of emergency medicine and the variety of things you see in emergency medicine. So what happens is, when you take care of people with emergencies, you inevitably take care of people with end of life situations. Research has shown that 75% of older adults show up in the emergency room in the last six months of life. So we see these patients. And when you start looking at how we're trained, and it's improving, it's becoming more commonplace in emergency medicine to understand how to deal with end of life because these patients present. But from the research standpoint, I feel like when you see care for these patients, you think, "How could this be different? What could we do differently? How do we provide both really excellent emergency care that tries to extend life, while also recognizing situations where we probably can't extend life? Or when the attempt to extend life could actually lead to suffering?"

Justin Brooten, MD (guest):

And that's an important distinction to make. Because I feel like you want to give patients what they're looking for, if you can, most people want to live longer, but also most people don't want to suffer. So they need physicians who can help them navigate that. When they show up and it's actually end of life, they don't always know that. Sometimes patients do. sometimes they really know what's coming. And sometimes they don't. And sometimes they need someone who's not just clinically skilled to be able to handle the emergency but also understands the need to address that end of life concern and say, "what's important to you? What can we do for you that's going to suit you and is going to fit with your wishes and your wants, knowing how serious your condition is?"

Justin Brooten, MD (guest):

So I feel like that sort of naturally lead, and I was able to fulfill both desires through emergency medicine. Both the desire to be a great clinician that I can intervene in lots of situations, have a broad skill set, get to do critical care get to do primary care. Some people don't like that, but I like taking care of simple problems that can be fixed the emergency room and give people guidance, and all the way to end of life care. I mean in a shift I've seen an eight week old and I've seen 105 year old in the same shift and I mean there's just not a lot of places you can do that. So for me it's very rewarding, but it naturally progressed into the research aspect of it as I saw issues that needed to be addressed and I saw areas whereas many things as we need to know as emergency physicians there was some skills may be lacking or some education may be lacking that could help when we have these patients present to us.

Aaron Leetch, MD (host):

It's such a prime opportunity in the emergency department to intervene in doing what's best for patients. But I think that we, in the emergency department are often so focused on preventing life, limb sight, fertility threatening injuries, that the thought of making that decision that no, this is a non survivable injury or that this is an illness that I can't repair kind of leaves us helpless. And that response can sometimes be poor communication, maybe some paternal decision making, and some other things that really need to be trained out of us not just as physicians, but as people that are having our own emotional response to what's in front of us.

Aaron Leetch, MD (host):

This goes to the very first paradigm that palliative care is not just end of life care. And I feel like most of us when we've learned about palliative care and medical school learned of it as well, this is what you do for people at the end of life. And for us in the emergency department, the end of life is not something that we're viewing, we're trying to prolong life, that's what we're here for. And that's not necessarily where we should be aimed, depending on the patient. So could you speak to that a little more of how we maybe should be framing these patients when they come in and where palliative care may intervene. That's not just a patient who needs to have medical support withdrawn.

Justin Brooten, MD (guest):

Yes, thank you. That's an excellent point, because I think it's, like you said most people, for most physicians, palliative care is synonymous with end of life care. And I think it's important as an emergency physician and a palliative care physician, that there's a lot that can be provided even when patients are doing things that are life extending. We don't often consider certain conditions as terminal, but you take somebody with significant CHF, or significant COPD, we can do a really good job of extending life for these patients. But those diseases come with a symptom burden. And they come with a day to day just challenge that those patients face not just from multiple medications, but just symptoms they face and also emotional coping skills.

Justin Brooten, MD (guest):

So one of the things I think that gets neglected, is chronic disease affects your psyche, it affects your psychology, it affects everything else. Patients who have a better understanding of their disease and have supports in place to help them cope with their disease, they do better medically. So that's one point. The other thing is, patients with terminal illness need physicians who are saying to them, "we are going to do what we can to make sure you have as much quality life ahead of you. And at the same time, we also need to plan for that day when things get really bad." And I think that's one of the things that we neglect.

Justin Brooten, MD (guest):

And so palliative care for say patients with COPD, CHF, dementia, not just cancer, it's certainly cancer, because we can anticipate sometimes when patients have advanced cancer. That there's going to be an outcome down the road that could be poor. But they need somebody not who's not necessarily treating their disease process, who's saying, "Let's look at you as a person, what's important to you?" So I mean, that gets into advanced care planning, but also symptom management.

Justin Brooten, MD (guest):

So one of the things I've noticed is, we have... And this is where emergency physicians are actually really well equipped for this. we have to look at the whole patient and their disease processes, we interact with specialists on a regular basis. But on a given shift I'm going to talk to a cardiologist and neurologist and orthopedic surgeon, I'll talk to all these different physicians. But at the end of the day, I have to look at the patient holistically. So one of the things I think it's nice as an emergency physician is, when we see a patient, they're like they've got an infection. They're sick. But yeah, they've also got really bad CHF, and they've also got this wound that hasn't been healing and their diabetes is really out of control.

Justin Brooten, MD (guest):

And when they get going to the hospital, the hospital certainly is going to be looking at all those things. But we actually are in a good position to say "This patient doesn't just have one medical problem, they have a whole slew of medical problems." And sometimes the signals, I think, the information they get from their individual specialists can be well, "This problem is doing pretty well, you're doing pretty well here, and you're doing pretty well here." But sometimes they need somebody to say "Yeah, but on the whole scope, you've got several things that are all affecting your health."

Justin Brooten, MD (guest):

And when patients, when patients are presented with the idea that they may have a life limiting illness, you're actually empowering them to start making plans. And you're not saying "Hey, we're not going to try, we're not going to provide care for you." But you're saying "Yeah, this disease, you have this ALS that you have, this CHF that you have, it's going to have an endpoint. So while you're doing well, let's talk about what's important to you so that when you get to that point that you're so sick you can't communicate, or the interventions that we can do right now are not helpful anymore. It would be really great for us to know what's important to you. Because I want to make sure that the care we provide for you is in line with what's important to you."

Justin Brooten, MD (guest):

Now, you may not explore that in detail, certainly as an emergency physician, but when you have patients who have a terminal condition, it can be really helpful not only for their symptoms, but for those other things to get them referred to a palliative specialists. A lot of your specialists and a lot of primary care physicians because when they see them in the office, I suspect a lot of times that patients are not as sick. When we see them in the emergency room, they're sicker.

Justin Brooten, MD (guest):

So we have an opportunity to say, "Has anybody talked to you about this? You've got a pretty significant condition." Has anybody ever sat down with you and said, "Hey, what's important to you?" And most patients and families, they're not upset when you say, "Hey, what's important to you?" They're like, "well, wow, that's a great question. Thanks for asking me that." So I think that's one of the things that we can do early on is not just wait until these people are super sick and we're deciding whether or not they need to go on a ventilator. We need to go "Has anybody talked to you about this? Has anybody talked to you about your stage four cancer?"

Justin Brooten, MD (guest):

For example, there's been several studies in stage four lung cancer that patients who are getting treatment. So this isn't just patients who are not candidates for treatment, or not trying to get treatment, patients who are getting treatment for their cancer, do better and live longer when palliative care is involved earlier than when that's not. And I think the reason for that is cancer treatment's tough. When it's effective, even when it's just slowing the spread of the disease it's still tough on the patient. And when they have somebody else who's not just their treating physician, not just their oncologist, but somebody else who's saying, "How are you doing? What can we do to support your family? What can we do to make sure your mood... If you need to be on an antidepressant, that's understandable, that can happen in cancer treatment."

Justin Brooten, MD (guest):

When you address those other areas, and try to make their quality of life with that severe illness as good as it can be, they handled treatment better, and they live longer. So we've got some excellent oncologists here that have been really proactive about saying, "Hey, I've got a patient, I'm treating them for their cancer. But I think that your team can come alongside and help them as they go through that." But I think that's one of the things that we can start identifying more in the ED, not just the, this patient is going to die soon. And I probably need to help get them to hospice. But actually, this patient's not dying soon, but they're dying eventually. And they need to talk to somebody about it before they show up to the emergency room and we're having to decide all this stuff on the spot.

Aaron Leetch, MD (host):

So the example that we often think about, we think about somebody that comes in with terminal cancer. Somebody who comes in and is completely deconditioned, cachectic, that we're searching for the DNR order trying to figure out what's going on. Those are the ones we think of withholding interventions. But what you're suggesting is that we have some of these diseases that we know that we just can't fix this, we can't turn around congestive heart failure once your ejection fraction is reduced. We can't turn around end stage renal disease except for maybe a transplant or liver disease with bad cirrhosis. So what are some of these other conditions that should spring into our mind? Maybe we should consider some of these palliative care referrals or some of these conversations with patients besides just cancer?

Justin Brooten, MD (guest):

So that's an excellent question. And that's an area I've been really interested in is trying to look at the data with different disease groups so a physician can genuinely say... they don't have to have seen the patient for years, they can genuinely say "Looking at the data I'm looking at, this patient's prognosis is limited, there's something going on." So one general category would be neurologic disease. So to qualify that I would say degenerative neurodegenerative diseases, so I'm thinking Parkinson's disease, Lewy body dementia, Alzheimer's dementia.

Justin Brooten, MD (guest):

And there's great things. This doesn't discount what our neurological colleagues can do. We just know that those conditions continue to progress. And a lot of times when you see multi-system issues, so you've got somebody with dementia, that's cachectic, that's getting aspiration pneumonia, that's getting UTIs. So that's a natural progression of that disease process. And that's the time when they come in before they're in florid sepsis or they're in florid respiratory failure that's the time to talk with family and say, "Has anybody talked to you about what the point of dementia is?" That these patients eventually die from infection. Because a lot of families are really surprised when you tell them that.

Justin Brooten, MD (guest):

Oftentimes, it's not treated with how families perceive it, as a terminal condition. So I would say neurologic conditions, any progressive multi system condition, so you mentioned liver failure. Cirrhosis. So when somebody is not a good candidate for aggressive treatments, so they're not a good candidate for transplantation. Those kinds of things. I will often encourage residents, when I have a patient with something like live disease, say, "Let's check a MELD score. Let's look at it." Because sometimes they're surprised. I mean, you look at the patient, you go, "They don't look so great." But then you run the numbers, you're like, "Here's an estimate for the prognosis."

Justin Brooten, MD (guest):

And they're really surprised. And I'll take that information to the family and the patient, depending on how open they are to talk about and I'll say, "Has anybody ever talked about this with you?" And sometimes they're surprised. sometimes they're not. Sometimes the families are surprisingly aware, even though they haven't been informed, they can look at the big picture and see that the person is getting worse. So your diseases that qualify people for hospice in the milder forms that should be thought of as a precursor for something's going to happen. So neurodegenerative. I know some of this repetition.

Justin Brooten, MD (guest):

So your neurodegenerative conditions, so Parkinson's, ALS, severe MS, I would say. Advanced dementia, advanced Parkinson's. So those are broad categories to consider. Another thing would be severe liver disease, is one of the categories, severe kidney disease when the patient's considering stopping dialysis. Or there's other things that preclude them from continuing dialysis. So you got somebody who's EF is so poor that now when they get dialysis, they just get hypotensive. And they can't tolerate it anymore. So that happens. Sometimes you have patients who they possibly could live longer if they could continue dialysis, but if they just hit a wall with it, then now you're talking to that could be a care transition point.

Justin Brooten, MD (guest):

Advanced cardiac or pulmonary conditions. So advanced CHF, so [NHY 00:15:42] class four or more would be hospice criteria. But really, if they've got significant symptom burden from CHF, that's still a candidate for palliative care. Pulmonary, so pulmonary fibrosis, COPD, any kind of progressive lung condition where you know that they're going to continue to get worse. The other thing, it's kind of a broad category, and it would definitely qualify for people for palliative care doesn't always qualify them for hospice unless it's associated with other things, its failure to thrive.

Justin Brooten, MD (guest):

So when you see failure to thrive, that's coming from something else, that's a good indication. So they've got dimension, they got failure to thrive, they've got severe COPD or CHF, and they've got muscle wasting. So those are good indications that's not a sustainable state. So once you've got a metabolic mismatch, where they're just not going to continue in that course, that's a good example of somebody that you need to start having a conversation while that patient is conscious and with it, so that they can talk about with their family, and they can navigate that and start making plans. By the way, they're not showing up to the emergency room without advanced directives, they may show up to the emergency room. But some of it's been addressed before they ever show up.

Aaron Leetch, MD (host):

I think that's an excellent point. Because one of the reasons that I usually hear of why people don't want to have this conversation is "well it's uncomfortable. And I'm just the emergency doctor, I've just met this patient for all of 5, 10 minutes." What's even more uncomfortable is when that patient comes in a state of extremists. And you're trying to figure this out, when an intervention either needs to happen right now or needs to be withheld right now, that's a far more difficult situation. And some of these minor inconveniences or uncomfortable interactions can actually prevent something that would be absolutely devastating for either the patient or their families.

Justin Brooten, MD (guest):

And that is so true. And it's amazing how often, when you explore it, you find families who are like, "Well, no, they said they would never want this." But nobody ever asked them. And families don't realize, I call it a permission slip, people don't realize you need a permission slip to die in this country. And we understand because we oftentimes don't have the information. So we're going to give the benefit of the doubt and people want life sustaining treatment. But I've had situations where patients came in with advanced conditions in extremis. They had said to their family, "I want to die at home, or I'm done with treatment." But they never did paperwork.

Justin Brooten, MD (guest):

So now they show up at our doorstep and we're behooved to do things that after the fact the family's like, "Oh, no, they wouldn't have wanted any of this." And it is, it's devastating. And there's ways to have a conversation that are not confrontational, and that actually really invite people to feel empowered I would say. Studies have actually shown that physicians that know the patient less are actually better at prognosticating.

Aaron Leetch, MD (host):

Really?

Justin Brooten, MD (guest):

Yes. And it makes sense. Because when we look at a patient, it comes in and they're really sick, and we don't know them we're looking at the data objectively. And as human beings, our psychology does not like to accept things that are negative. When you have an investment in that patient's care, and you've been taking care of them it's impossible not to on some level psychologically block out the inevitability that they're getting worse. Even if you can rationalize it, there's part of our brain that protects our psyche and says, "Oh, no, they're going to be okay, I've talked to this person, we have had so many conversations." Actually, when you just see a patient and you don't know them, and you're just looking at the objective data, you're actually better at assessing what their prognosis is than if you know them.

Aaron Leetch, MD (host):

That's really interesting.

Justin Brooten, MD (guest):

So that's one of the things I like to tell ER doctors. And when they've actually done studies on anticipating when people are going to die. There's a couple studies out of Harvard, a doctor by the name of Keeichi who's written a couple studies on this, and they've looked at several things. He's done several studies. One of the things that they looked at was when physicians anticipate mortality, so ER physicians, when they're asked, "Would you be surprised if this patient dies in the next month?" We're actually pretty good at guessing that question. Because we're just looking at the objective data.

Justin Brooten, MD (guest):

So that's one of the things that sometimes we're actually going to anticipate that the patient may be doing worse before their primary doc does. Because when they make it to the primary care appointment, they're doing better than when they have to come to the emergency room.

Aaron Leetch, MD (host):

That's a really good observation.

Justin Brooten, MD (guest):

And we can get data in our hands right away. That's the other thing, we can get the tests back right away, we can see the changes very quickly in real time. So it's funny because it's kind of the opposite of what you'd expect. The person who knows them should... Well, yes, the person who knows them should address this stuff. But sometimes actually, you've got your hand on the pulse of how well they're doing. Because we're used to do that all the time.

Aaron Leetch, MD (host):

Well, that kind of leads into your second paradigm that some emergencies are actually palliative care or end of life opportunities. And it's kind of up to us to be able to differentiate those. Is this really the reason why is because when they're well enough to go to their primary doctor, they're hoping everything is going well, they're seeing the very best of this patient, but we're seeing them when they're at their worst.

Justin Brooten, MD (guest):

Yes, because I mean, if you think about it, and I have a tremendous amount respect for primary care doctors, this is not meant to disparage them at all.

Aaron Leetch, MD (host):

Oh, certainly not.

Justin Brooten, MD (guest):

But people just can't make it to the office, when they're at a certain level of sick. If they call into the office, and they got unstable vitals or other things, they're not going to come to the primary care office. So we are seeing them in a worse condition. And the data does show people that are sick enough to have lots of symptoms, or are progressing towards the end of life transition point, they are going to show up the emergency room for that. If they're short of breath, if they're having chest pain, if they're having severe abdominal pain from some progressive process, they're going to show up to the emergency room. So we're seeing a subset of patients that's sicker for one.

Justin Brooten, MD (guest):

And then the other thing is there's three categories that I kind of mentally think about, and that I try to communicate with the residents and I think about when I'm thinking about what is ED palliative care from the emergent transition standpoint. And there's patients that have problems that are relatively easily fixed with relatively predictable outcomes. pretty healthy person that comes in with an appendicitis that's kind of a no brainer. It's going to get taken out, they're going to do fine. And it's going to make complete sense.

Justin Brooten, MD (guest):

And then you have a subset of patients where there's something that could be fixed, maybe, but maybe the outcome is really variable, or it could be an outcome that's really undesirable. So for example, and I'm sure you've encountered us, you get an elderly patient with multiple comorbidities, that's got ischemic bowel. And maybe they could get through the surgery, maybe they could, but they're going to be really debilitated, their ADLs are going to go down, they're going to be requiring nursing care or long term acute care. And maybe the best outcome that they could get is not great.

Justin Brooten, MD (guest):

So that can change. Some people would say, "I want to take that risk, I'm okay if the outcome is not ideal, I'm okay with that potential for extending life, even though there's a risk that I may end up in a state that's not ideal." And then different people will decide differently, how to address that situation. And then there's the situations like you were talking about the not-fixable. So this is the person on blood who has already had advanced dementia, that was having frequent falls, hopefully they weren't on blood thinners at the time. But now they've all they have a massive head injury, a massive head bleed, and they're not an operative candidate. And we know that they're going to pass away.

Justin Brooten, MD (guest):

So those are pretty straightforward. they're not going to get offered an intervention because it's not going to be helpful, and the family is going to go "Well at that point, then we know that really the only appropriate thing is probably to make them comfortable." In most situations. But that gray area in between. And that's where I think it's really important that we take the data, and we take the communication and we try to merge them together.

Justin Brooten, MD (guest):

Because one of the things that I hear a lot is we ask people about what interventions they want without qualifying what the effect of those interventions are. So CPR is a good example. somebody who's very frail, and already has multiple medical problems, or they're there for something that's pretty significant like sepsis, with multi-organ dysfunction, when I talk about code status with them, I'm not just asking them what they want me to do. I'm going to say, "This is what I could do. But this would be the outcome of that." and I'll make a recommendation. That's the other thing where some doctors may not be comfortable is saying "You know what, we could do this. But honestly, in your condition, it probably wouldn't be helpful, it likely would be harmful, and it likely would be ineffective."

Justin Brooten, MD (guest):

And people assume that when we offer interventions as physicians, that they're all uniformly beneficial. And I think when we have things that are under the heading of it could be done but it probably won't be helpful. We need to be really clear about that. And I think that changes the decisions people make.

Aaron Leetch, MD (host):

I can't even tell you how many times I've been in a room and had a resident use the phrase "So everything." And the patient says, "Well of course." And the resident walks out of the room, shaking their head rolling their eyes saying, "Oh, gosh, this patient's not going to do well." Well, I've been just as guilty. Maybe we should tell them that do everything is not necessarily in their best interest. And instead of saying "So everything," saying, "Here are the interventions that we have, is this something that you would want even if this means you never get off the ventilator, then you end up with a trach and g-tube."

Aaron Leetch, MD (host):

And some of it may just be time crunch that we have in the emergency department. Some of it is discomfort with these conversations. But it's funny, I was thinking that many of us as the stereotypical emergency doctors, myself included, sometimes, we can easily think cynically about a patient's prognosis, but we're not willing to actually tell them that. Because it's tough to transition what we are thinking in our minds to a compassionate and a good means of communication of that this is what we feel to be the truth in the matter.

Justin Brooten, MD (guest):

Yeah, I like the way you put that. And it's true. And I've done the same thing. We're pushed with the time crunch, I think one of the things that we forget to ask is, I try to paint a picture for the patient. I try to say, "If you were in a state where we looked like you were nearing the end of life." Because that's the thing, if we got a patient who's really sick, and they code, that's an end of life situation. So I often will tell them, "If you ever got so sick that we thought you're nearing the end of life, would your focus at that point be things to maintain your comfort, or would it be things to maintain your existence, even if that just meant you had a pulse. Maintain your pulse and keep you alive even if that existence meant you were in a bed and you couldn't move and couldn't communicate?" Or would you say "If I'm actually going to pass away, I would really prefer to just be made comfortable."

Justin Brooten, MD (guest):

It's amazing how many patients will actually say they'd agree to the second option. And I think, because when we say everything, everything to the patient, and everything to the doctor are two completely different things. I think, inherently the patient means everything that's helpful. I'm making a big assumption there. But in my experience, that's what they're actually saying is I want everything that's going to be helpful.

Justin Brooten, MD (guest):

Most patients don't want care, that's not going to help them and not going to change their outcome. So what I'll say is I'll say, "Here's the different..." And one of the ways I've heard my colleagues in palliative care say this is some people want to stay alive, even if that's just, I have a pulse, and I'm in a bed, and they're okay with that. And some patients say, "Well, no, I would really only want to be kept alive, if I could still communicate with my family, and I could still do things and I could still function somewhat independently." And that way, you're kind of giving them the option to say what outcome is okay for you.

Justin Brooten, MD (guest):

Because as physicians, it's our job to say, "I think I can get the patient to this outcome." Because the patient most of the time, they're not interested in the interventions. they don't know enough to know what those individual interventions are going to look like, or what they're going to result in. What they're interested in most of the time is what is my life going to look like? So when we ask them that question, then I can say, "Well, rather than me get to the nitty gritty about all the single... Like, oh, what about plasmapheresis? Are you okay with that?" You just go down to minutiae.

Justin Brooten, MD (guest):

We say, "Well, what's really important to you?" Because now as a doctor, I can say, "Well, now that I know this is important to you, I can actually tell you what interventions kind of fit with that. And I can tell you which don't." And the funny thing is, I've had patients who, their quality of life from my standpoint is not that great, their life expectancy is not that great. But once they have a pretty good understanding of what interventions are and the burdens of those interventions, if they're still wanting those interventions, I don't really have a big objection to it. Because I know that it's still consistent with what they really, truly want. Where I have a problem is when I think that the interventions that are being provided are not going to really obtain the outcome the patient wants, and they just don't understand that and they don't know that. That really bothers me.

Aaron Leetch, MD (host):

It's probably one of the times where we do the most good. We'll often leave a shift and think, "Oh, man, I intubated and lined and put chest tubes in on this patient. Now they're in critical care on three pressors, I really did something good today." Because we're doers a lot in emergency medicine. And some of the times that I felt I've actually done the best is when I spent 30 minutes at the bedside, which is very difficult to do in the ER and actually was able to translate medicine into English so that my patient could understand it.

Aaron Leetch, MD (host):

And I've discharged 101 year old lower GI bleed, because it didn't fit with what they wanted. And that this kind of gets into your third paradigm, which is really the crux of everything. We've talked about how emergency doctors as much as we don't want to say it, we actually do have a pretty good ability to prognosticate how patients will do over a given period of time. We actually are pretty good at kind of determining what interventions will work or not. But it's the communication issue that's a big deal.

Aaron Leetch, MD (host):

So as EM physicians, we can play a significant role in guiding these patients toward the goals that are concordant with the options they want. But it's hard for us sometimes to really be able to communicate that well. We're trying to multitask and do so much. And this is a conversation that really warrants a good amount of time, dedicated to this patient, we would have no problem spending that time with a patient, if they were hypotensive and we were troubleshooting their event. But to spend that time talking to them about these end of life decisions, when they're awake and talking to us seems like it's just out of our frame of reference. So what are some of the communication strategies we can do to ascertain what a patient's hopes and what their outcome should be? What are some things that we can do at the bedside?

Justin Brooten, MD (guest):

It's a great question. And it's not easily addressed. This is tough. And this is something that I tell the residents, "I'm a better palliative care doc, when I'm on palliative medicine than when I'm in the ER, sometimes. Because it is. you've got to be attentive to the flow the emergency room, and you can't commit too much time to one room, or you're going to lose the department. So it's difficult. A few things that I have found to be helpful. I will start very open ended. And this is one of the things that I think is important is you've got to figure out who are the people that I'm likely going to change what we do down here?

Justin Brooten, MD (guest):

Because there's going to be folks that are so blindsided, and they're so surprised and they have so little information about what's going on, that you're just probably not going to move the needle downstairs, even with a long conversation. So part of what I triage is, how open are they to this? If they're pretty open, sometimes they volunteer a lot up front. So one of the things I'll do depending on the mental. If the patient's pretty alert and with it, then obviously I'm going to talk to them, if they're not, I'll talk to their family, but one of the things I'll start with is, "I'm concerned, you're pretty sick, how have things been going? What's been going on?" And that will give you a lot of information.

Justin Brooten, MD (guest):

People will start saying, "Oh, yeah. Dad's been doing really poorly. He's been going downhill, he's not eating. He's having more hallucinations. You'll get a whole list of things." And then I'll ask them another thing. And this really surprises them, because they're used to the doctor just telling him how they're doing. I'll say, "Well, how do you think they're doing?" And then they'll tell you, "Oh, yeah, I'm concerned he's not doing so great." I know I have an in. this conversation doesn't have to be long and it's going to be productive.

Justin Brooten, MD (guest):

When I've got somebody who it's very obvious from the get go, that there's a huge disconnect in how sick the patient is and what the perception of the patient of the family is, we're probably not going to move the needle downstairs. So that's one thing, because I think you have to pick your conversations. The other thing that I'll do when I need to start with prognosis, because you do have to be open ended, because sometimes patients surprise me. And the worst thing, not the worst thing, but one of the worst things you can do is say, "Well, you've got X amount of time." People will fixate that on that, and I've heard people get estimates from other physicians that I'll hear later. And I'm like, "That's very inaccurate." So you want to be careful about like, "This is how much time you have."

Justin Brooten, MD (guest):

For one, it's a range. And even the best estimates, it's usually a range. So even end of life, we're usually saying like, you have weeks to months, months to years, weeks to months, days to weeks, hours to days. Because there's a huge range in which things happen. So sometimes I'll tell families, I'll say, "I'm really concerned, your loved one has a limited amount of time." And that is super open ended. But it sends a message that says, "Oh, well, if it's a limited amount of time, we probably need to talk about it." I'm not I'm not defining it super strict. Sometimes I need to, sometimes I really need to define it. But I oftentimes I don't.

Justin Brooten, MD (guest):

So I'll say I'm concerned, "They've got a limited amount of time. And I think it's really important that we focus on what's important to them right now." And then they'll start telling you what's important to them. And also too it's hard, when you tell a family or a patient, "I'm really concerned about you." It's really hard to get upset with somebody. And they're like, "Wow." "You look like you've been having a really rough time. I'm really concerned about you. Tell me what's been going on." That's not confrontational.

Aaron Leetch, MD (host):

Right. Yeah.

Justin Brooten, MD (guest):

Well, sometimes you will. Sometimes you'll have people, like oh, no, they're in denial. And they're like, "Oh, no, they're doing great. They're doing fine." And you're like, "Okay, well, clearly, we're not going to fix this down here." But sometimes they need that permission. And I had some relatives several years ago, when I was sort of at the beginning of this journey. They ended up becoming caregivers of another relative. And she was diagnosed with ALS. And they were just asking me what I thought about it, what that was going to look like.

Justin Brooten, MD (guest):

So we talked through a little bit, it sounded like they were managing, but they were pretty sick. And we talked about what the future could look like. And fortunately, the patient had a very good neurologist involved that had been very, very upfront with the family about how things were going and what to anticipate. But they were really stuck with the burden of making a lot of decisions for this patient because I think her understanding of her disease was still a little unrealistic.

Justin Brooten, MD (guest):

So they told me several months later, had a life situation with this person where they went to the emergency room. And they had developed, I suspect, I believe, if I'm remembering the story correctly, renal failure and sepsis. And the ER physician said to them "This patient's got ALS, they got renal failure, they got sepsis, they're dying." And at this point, you're not doing them a disservice if you don't continue a bunch of aggressive efforts because they're going to die from the ALS anyways. And that's what they needed.

Justin Brooten, MD (guest):

They felt like they wanted to respect her wishes to live as long as she could. But knowing that other interventions were really not going to be helpful, and she already had a terminal illness, that's what they needed. So that ER doc, I don't know who it was. It was in Tallahassee, Florida. That ER doc gave them what they needed, I gave them the primer, I told them," okay, this is what it's going to look like down the road." But at that moment, they needed that ER doc to say, "Now is probably the time." And they were prepared for it. so when you are willing to go out on a limb, and run the risk of getting stuck in the room for a little bit, or open up a can of worms, that could be a little bit scary or a little bit dangerous, you'll find that people will sometimes say, that's all they needed. They just needed somebody to say, now's the time, I need the transition point. And that's where we can help.

Aaron Leetch, MD (host):

When I have a lot of elderly patients that come in with dementia, and something's changed, now maybe they're more aggressive, maybe they're less interactive, maybe they can't do their ADLs the way that they normally could, they're not speaking as much. I've had a conversation with families about the new normal, the new baseline, that this is a progressive thing, we're going to check in the emergency department and make sure it's not a urinary tract infection. To make sure they're not having another stroke are having something else.

Aaron Leetch, MD (host):

But this is something that they will eventually progress. And this will be the new normal for them. And they're not going to necessarily be able to gain back what they had. So maybe it's time that we talk about this and those new normals are times to say, "So we can keep your loved one in the hospital. But if we do, we're not going to be able to restore them back. We can send them home with you, do you feel like this is something that you'd be able to do or should we start talking about placement, palliative care." Some of these other, even hospice, depending on what their wishes are and what they're able to do with insurance and such. It leads to some difficult issues in the ED where we have people that can't be placed, or it leads to some issues where they have to get lots of other family involved. But ultimately, if we're trying to do what's best for the patient, it's hard when it's not a quick fix, it's not an appendicitis. Where it's not a [stemy 00:37:08], where it will just open you up, and then everything will be fine.

Justin Brooten, MD (guest):

Absolutely. And I think what you highlight there is so important is that they need... sometimes I think families need somebody to say, "These are all fairly reasonable options, like here are your options." Different families are going to choose this route differently. But this is what it's going to look like and these are the different routes. And that gives them the ability to say, "Well, yeah it has been really rough. Maybe this is the time." Or they'll may say, "we hear what you're saying, but let's hospitalize them this time. And let's do some IV antibiotics."

Justin Brooten, MD (guest):

And that's okay, because you've at least given them an understanding. You've given them that idea that yeah, this is a terminal condition, it's going to get worse, like you said, they're going to lose function, they're not going to get that function back. And then by giving them rounds, it helps them go, "So that's okay." If the patient's really advanced, they're like, "So it's okay to not give them antibiotics." And like, it's okay, not giving them antibiotics. If their quality of life is really poor, and you think it's poor. And you think that if they could tell us they think they would say it was poor, it's okay to let nature take its course.

Justin Brooten, MD (guest):

And that's one of the things that I'll use, is I'll talk about the dying process. And I'll say "People die differently. And this can be part of their dying process. And when it looks like it's getting to that we can either sort of we can try to slow it down, or we can kind of allow for a natural dying process and make sure that they're comfortable through that." In the advanced cases, in the less advanced cases, hearing that there's options they can pick from, I think is reassuring. Because then they know, "well, the doctor doesn't think I'm doing a bad job by not deciding to do all these other things. Like the doctor said, it's okay, you can pick this other route. That's all right." And that's reasonable for the state of their condition. And I think that people appreciate that, because they need that permission, sometimes set aside to de-escalate.

Aaron Leetch, MD (host):

I feel like as emergency doctors, we're usually pretty good with diagnostic uncertainty. "Well, we couldn't really find this, this is probably what it is." We certainly like to have an answer and to say definitively you have a stroke, you have an pneumonia, your loved one has died. Even those conversations, we don't like them, but they're definitive, and we can be definitive with them. With cases like this, what are examples or maybe times that you see that emergency doctors will kind of stick their foot in their mouth, over promise under report that will muddy the situation.

Justin Brooten, MD (guest):

So that's a great question. And it kind of goes back to the prognostication. I've been surprised. It's not super common, but it's not completely uncommon. You'll have somebody that comes in and they look like they're just clearly going to die in the next couple days. Like it's pretty apparent and they do better than expected. And that can really make families go, "what the heck, what were they telling us?"

Justin Brooten, MD (guest):

And they can really dial back and be like, "Oh, they're full code again." Because clearly that what we were told before was wrong. So I would say that goes back to the not delivering things with completely definite, sometimes the prognosis is really obvious, like the devastating brain hemorrhage. Where we know what that's going to happen it we don't know, maybe the minute or the hour, but we know where things are headed. But for example, I saw a patient who had a subdural that apparently had a pretty low GCS went to hospice. A couple days later, she is eating pudding, and laughing at my jokes. Like not laughing, laughing. She's mumbling, but she's clearly understanding what I'm saying.

Aaron Leetch, MD (host):

I worked on Sunday, I had two significant brain hemorrhages with midline shift, on blood thinners elderly people with comorbidities, non-surgical candidates, and we withdrew support on both of them. My social worker, correct me because I said withdraw care. She goes, "Aaron, we always care. We never withdraw care." I go, "All right, we withdrew intervention." We ex-tubated both of them, one died in about 30 minutes, and one died about 18 hours later. And they seem to be pretty much the same. So yeah, I think that definitive timeframe is not as important as soon, very soon.

Justin Brooten, MD (guest):

Yes. And I also try to let the family know... Because you mentioned diagnostic uncertainty and you're very right in that. I try to let the family know, hey we can check the vent, we can see if the patient's making effort on the vent. But there's still variability and what that's going to look like. So I try to be very clear to prepare them to say, "we know what the endpoint is going to be. But how that's going to look can fluctuate." And I'll tell them that. I don't want to tell you something that's incorrect. So the main thing is we just ensure whatever... And I'll use the term. We want to ensure whatever time they have left fits with what they would want.

Aaron Leetch, MD (host):

That's well said.

Justin Brooten, MD (guest):

And people like that sounds good. And I'm not committing to a timeframe. That also helps us know what setting they want. If we think that they're going to survive long enough. And I'll leave that open. Sometimes I'll say if it looks like they're making some respiratory effort, and they're going to linger, I like the word linger, then maybe we'll look at an inpatient hospice facility. If it looks like we discontinue these efforts, and it seems like the respiratory status changes very abruptly, and they're going to pass away fairly soon, then we'll leave them in place. And that way, they kind of know, they're not shocked when they linger, and we don't want them lingering or having an unnecessary admission to the hospital, we can get them to a more comfortable setting. Then it's they're not shocked when I say "Actually, they're kind of lingering. And that's not a bad thing. That means you have more time with them. But maybe we need to get them to an inpatient hospice facility so that your family has more room and it's a little more comfortable, and it's not as noisy and everything else."

Justin Brooten, MD (guest):

And that way people feel like "wow, we feel really taken care of." But you've not painted yourself into a corner as far as the prognostic time. And likewise, I had patients with pneumonia before that I saw on the hospice end, where they were given an awful prognosis like, oh, this is a bad pneumonia, they're septic and they're just going to do terrible. And they get the hospice, I had a lady that we discharged to rehab. And it was almost challenging for the family, they had gotten so prepared for the patient to just pass away in hospice. That we're like "You know what, she's actually doing pretty good."

Justin Brooten, MD (guest):

Our goal is not that everybody dies in inpatient hospice, when they're actually clearly going to survive, we need to come up with a disposition that's appropriate. And the family's like, "well, she's actually doing a little bit better." She's still not doing great. But maybe we switch to rehab so that they can use their Medicare and get a rehab stay and actually see if she can do some ADLs. And then at some point, when she's appropriate for hospice, again, we'll take her back.

Justin Brooten, MD (guest):

I've had people that came into hospice at times with such poor prognosis that actually did have some life left to live. And it just surprised us. So leave yourself some wiggle room, kind of give them an idea to know what the trajectory is expected to be. But also say "People do surprise us. And sometimes they live longer than we expect. Sometimes they rally." That's another term that I think is good, because it's vague, but it's true. Sometimes people rally a little bit and they have more time than we expect. And that way the family doesn't feel pushed and pulled in so many directions. And it feels like a more consistent message.

Aaron Leetch, MD (host):

So kind of the last question I have for you, as we wrap up is as an emergency Doctor, how do we deal with the concept of palliative care as giving up. I think a lot of people are hesitant to do that because either they're worried they appear to the family that they're giving up. They worry they appear to the patient that they're giving up or in their own mind they say, "Well, we can't do this. This is giving up." How do we reframe this in our mind so that it's not giving up? It's actually doing what's best for the patient?

Justin Brooten, MD (guest):

That is a great question. And it is really tough. And it's difficult when you both have the ability to do things that sometimes extend life when you also have to accept that the patient's on a course that we're not going to change. And the way I look at it and the way avoid the whole getting up thing, and I've heard multiple people say this to me. rather than focus on what we can't do, let's focus on what we can do.

Justin Brooten, MD (guest):

The other thing is, everything we do comes with an associated risk and benefit. So if we've got a patient who's very sick, and we choose to put them on a ventilator, we choose to do certain things that comes with a cost to the patient, that comes with a physical cost. If they're vital, if their blood pressure is low, and they're in and out of consciousness, and they can still feel what we're doing, and they're going to probably die anyway, then is that added suffering, really giving a benefit to it.

Justin Brooten, MD (guest):

So some of these situations where we're talking about maybe we don't need to focus on curative treatment. And that's what I would say is rather than focus on curative treatment, let's focus on what we can do to make them comfortable. We're accepting the fact that a curative approach is actually going to now add suffering. And that's where I think the distinction is made. It's not giving up on the patient, it's not giving up on their existence. It's saying, "Let's honor the time they have left by trying to make it less uncomfortable, rather than doing things that aren't going to benefit them. That also could be uncomfortable."

Justin Brooten, MD (guest):

And I think that most families I've dealt with, if it's fairly inevitable that somebody is going to pass away, their goal is generally to say, "Well, what can we do to make that less uncomfortable for the patient?" And then my goal as a doctor, I'm providing something, it's a different goal, but I'm still providing something. And I think that's the way I look at it mentally. Because it is. There's times where there's been things in front of me, I'm like, "Well, I could kind of fix this. At least for a little bit, I could kind of fix this." But is that really the right thing for them? And is that what they want?

Aaron Leetch, MD (host):

I really like the idea of thinking of it as a risk or benefit thing. Because we do that all the time of here's the risk or benefit of keeping you in the hospital, here's the risk and benefit of TPA for stroke. Here's the risk and benefit of doing this intervention. And so for someone who has a terminal illness, the risk of withholding This is that you might die. But the risk of doing this is that you might survive, but with significant suffering, significant decrease in quality of life. So now I'll present this to you in as plain of English as I can, or whatever the patient's primary language is and say, "What is it that you would want because neither of these options are great options, but we're going to try to pick the best out of these options."

Aaron Leetch, MD (host):

I usually say to my patients in the ER, I say, "Hi, I'm Dr. Leetch, it's very nice to meet you. I'm very sorry that you're here. Very sorry to have to meet you like this." And I say, "This is a tough situation, nobody really wants to come to the emergency department. But since you're here, I want to try to make the best of a terrible situation. So let's see how we can choose the best outcome for you."

Justin Brooten, MD (guest):

Oh, and I can tell you, it's some of the situations, I've definitely had those. You know those intensive care situations where you get somebody through ARDS innovation and something really hairy and it feels like a triumph. But honestly, some of the most exciting situations I've ever had is when you deliver good end of life care. And the family afterwards just says "Thank you, thank you for telling us what we needed to... Helping us figure out what we need to decide." And you feel like you really made a difference.

Justin Brooten, MD (guest):

And it is and you're right, you're leveraging the fact that person is there for a reason they don't want to be there for. And saying, "But hey, I'm here to provide the best care under this situation. And knowing what's important to you is going to help me provide you the best care." It empowers patients and empowers families. And it really, as a physician, it's super rewarding when you can kind of take that awful situation and you're not going to make it better. But you could make it less bad.

Aaron Leetch, MD (host):

Yeah.

Justin Brooten, MD (guest):

Sometimes you will make it better. But you could definitely make it less bad. It's great to hear your experiences, because I think it's impossible to do emergency medicine and not encounter these patients and not have it impact how you want to practice. So I appreciate hearing how you practice and hearing your experiences there. Because it's universal. We all see people in the states and we all have to figure out how to navigate that the best we can with the resources we have.

Aaron Leetch, MD (host):

Yeah, and I think we have to be prepared for it. It's not something that you're necessarily looking forward to on your shift. If I really hope I get to walk somebody through an end of life event today, per se, we really kind of revel in the high highs. But the low lows are important, just the same. And if we're not prepared for it, it'd be like saying, "Man, I really hope I don't get an upper GI bleed today. I'm just going to put it out of my mind and ignore it, not learn about it and not get prepared for it because I just don't want to see it." We have to be prepared for things like this. And the more prepared we are, the easier it is to deal with.

Aaron Leetch, MD (host):

Well, we appreciate your time with us today. And we're really happy to get to highlight your research and what you're doing and just for summary your paradigms were that Palliative care is not just end of life care, that some emergencies are actually palliative care and or end of life opportunities, and that there are specific communication strategies that can help direct our patients toward the routes of care that really fit their hopes and expectations. So again, Dr. Brooten is one of the scholars supported by the National Foundation of Emergency Medicine. To hear more from him and others go to www.nfm.com. Thanks for listening.