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A Story of Implementing Palliative Care in an Inner-City Trauma/Surgical Intensive Care Unit

Foundation of the University of Medicine and Dentistry of New Jersey Medical School (Newark, N.J.)

The Trauma/Surgical Intensive Care Unit (SICU) at University Hospital in Newark is the sort of place people land without warning: a gunshot wound late at night; a car accident on the way home from the movies. Many of the patients are young. Virtually no one comes in carrying an advance directive.

"As a trauma surgeon," says Anne Mosenthal, M.D., head of the unit, "I imagined saving everybody's life. But people come in and a lot of them die—or arrive dead. A big part of my life is going out to tell a family their son just died. Nobody ever taught us how to do that."

Dealing with the fallout of life and death traumas—with stunned, often angry families suddenly forced to make painful decisions, and with critically ill patients who may not be able to communicate their wishes, or signal their need for pain relief—is the focus of the interdisciplinary palliative care program designed by Mosenthal and co-principal investigator Pat Murphy, and it has changed the culture of the SICU.

"Traditionally," says Pat Murphy, who started the hospital's first bereavement program 20 years ago, "'going for broke' is the ethos on the SICU. Trauma surgeons tend to think, let me try one more thing, maybe it will work. Sometimes the most valuable service they can provide is witnessing a good death."

Within 24 hours of a patient's admission, Susan McVicker and Janet Harris Smith, who are family support and bereavement counselors, meet with the family to answer their questions. "The first thing we ask," says Smith, "is 'What do you need?'"

Within 72 hours, a second meeting brings the family together with a physician, nurse and one of the support counselors to make a comprehensive plan that addresses care goals, the patient's spiritual or religious needs, the family's emotional concerns, cultural preferences and any other issue of importance to the family.

Trauma patients make up roughly 60 percent of the patients on the unit; the remainder are liver transplant candidates hoping to get well enough to qualify for surgery, and a smaller number of post-transplant and other surgical patients in crisis. Most of these patients, says Dorian Wilson, M.D., head of UMDNJ's liver transplant unit, also come in without an advance directive (AD).

"During the admission process, we ask, have you got an AD? The next step is, what are we going to do about it? Even the families who look like they are going to pounce on you are often ready more than you think they are. I used to think, 'they won't be able to handle it,' but they can if you help them."

"People don't really know what predictions signify," says McVicker. "The physician will say, 'His eyes are open,' and they expect a great outcome. We tell them to ask the doctor what survival means. They hear from physicians that they won't do resuscitation. They see resuscitation on ER. You have to explain: 'Resuscitation won't bring your parent back from cancer.'"

"I had a 45-year-old die today at 3:30," Smith recalled at the end of a long day on the unit. "He had a very clear advance directive, but a nurse had put a face mask on him after extubation. Once you put it on, it's emotionally very hard to take it off. I was able to say to the family, 'You are honoring your father's wishes, making a gift to him, just as he gave a gift to you by telling you clearly what he wanted to have happen.' That helped, but the 15-year-old said, 'It's not fair.' And I thought, *you're damn straight*."

The same day, less than 24 hours after a 19-year-old man was brought in with a gunshot wound in the back of the head, SICU chief surgeon David Livingston, M.D., McVicker and Reverend George Blackwell, an ordained Baptist minister and director of pastoral care for the hospital, met with his angry, extended family crowded into a small conference room.

"His Mom and aunt were there," recalled Livingston, "and I basically said, 'I don't know what you know but I'm going to start from the beginning. He wasn't breathing, he wasn't moving, when the paramedics found him.' You don't say 'alive.' The mother asked me, Is he brain dead? And I said, not yet. But he probably will be in the next couple of hours."

From the medical professional's perspective, brain death is an incontrovertible matter. To families in shock, it is often just incomprehensible. "Almost no one gets it the first time," says Rev. Blackwell. "To hear that this young person who looks fine is dead—it just doesn't compute. What we've learned is that the earlier we start, the easier it is to make a difference. It's a process."

Recognizing when it's time to stop treatment is something most surgeons have to learn, says Livingston. "There's a difference between when you are doing something for a

patient, and when you are doing something to a patient, but that transition is subtle. Nurses take the brunt of this. They recognize when patients are being tortured. They also have seen patients come back from incredible situations."

The program's innovations have affected the unit's nursing staff. "I'm not saying that before we were not sensitive," said Shyla Joseph, a seven-year veteran on the unit, "but now they make more resources available."

Pain management is one big change. "If the patient is alert," says Ann Lopez, who has been in the SICU for three years, "we ask, 'Are you in pain right now—on a scale of 0–10.' We have a separate assessment for patients who cannot speak: we look for grimacing, and restlessness. Usually there are standing orders for morphine, or if they can swallow pills, Percoset. Before, if a patient asked for more painkiller, we used to have to say, 'It's not time yet.' Now we've been taught you have to address pain no matter what. Right then. If the first med doesn't work, you have to give them something that does, until their pain is relieved."

Another small change that has made a big difference is the shift to unrestricted visiting hours. Before, says Mosenthal, "We had lots of problems with families getting angry about visiting hours. Now there is open visiting 24 hours a day and it has been fantastic."

"Everybody can come now," says Joseph, "even small children. The family support team prepares them. Now families have more information, they know what each machine is doing. They ask us, 'Once you pull the plug, he's going to die?' They ask, 'Is he going to suffer?' We say, 'We'll bring medication for pain, and he'll slip into a deep sleep'. Here we bring patients back to life who are dead, but not all the time. I think this is a good place to die, too."

La Vern Allen, a nurse who has been on the unit two-and-a-half years, agrees. "The program has made our job easier. It's difficult when it's just you and the families and they are upset with you for breaking bad news. Now we can call the team to back us up. We've learned from them to be more conscientious in what you say—and you say it with more compassion. You keep it in the back of your mind: If that was you, how would you want bad news to be told?"