TWO WORLDS COLLIDE VAD AND PALLIATIVE CARE CO-EXISTING

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KEYWORDS

VAD

Palliative Care

Rural Setting

GP

EXECUTIVE SUMMARY (100 words maximum)

In NSW Voluntary assisted Dying (VAD) became legal on 28TH November 2023. This case study highlights a collaborative approach between specialist palliative care and a rural generalist hospital as we navigated the VAD process with our patients and their families..

Palliative care can be seen by some as the opposite of the VAD process. It does not affirm life but is about patient choice and autonomy in decision making. Many of us working in the palliative care space have somewhat struggled with our patients desire to pursue the process feeling we should be able to provide supportive care and symptom management for our patients until the end of their lives. The case study will highlight the opportunities encountered to learn from our patients, to advocate and support them in their choices.

INTRODUCTION

The case study will follow a patient MS through his palliative care journey until his death by the VAD process. We will discuss the challenges he faced with symptoms and his decision to pursue VAD along with our own difficulties as we navigated the journey of a community patient admitted and then referred for VAD in a rural generalist hospital.

HIGHLIGHTS

- Symptoms can be very difficult to manage and as palliative care clinicians we would be naïve to think we could fix or manage every patient's distress.
- Learning to adapt to VAD and the need for advocacy for our patients has been a steep learning curve.
- Navigating a new normal has meant adapting to change and focusing on a very different way of looking at patient centred care.

Case study presentation:

MS was a 73 yr old male referred to our service in September 2023.

He lived with his wife D. MS was a retired truss draughtsman living in a small coastal hamlet and was a member of a supportive small community. His adult children (2 sons) were very involved in decision making and supportive of care –they did not live locally. His wife was active in the small community where they had resided for an extended period of time after retirement.

Diagnosis:

R Temporal Glioblastoma Multiforme 09/2022

Gross resection 09/22 with radiotherapy and oral therapy he transitioned to further systemic therapy with disease progression and then had 3rd line treatment and was referred to our service as his disease was progressive and incurable.

PMH

OCD

Depression and anxiety

Speech Impediment

HTN

MS was referred to our service as a result of his disease progression. At the time of his referral his symptoms were well managed and he was very functional at home. He was linked to our community team and had regular nursing visits and was well supported at home. We had arranged reviews by our multi discipline team over the months he was in our care. He had slight functional deterioration but was independent in his care and still able to enjoy a good quality of life with his family and community.

We had discussed his Advanced Care Directive (ACD) at the time of his admission and he had articulated that he never wanted to be a burden for his wife and family. He expressed the concerns that he would have if he was not self-caring and always focused on wanting to maintain his dignity and relationships until he died. He did not ever mention VAD in these conversations.

He remained stable until the New Year (2024) when he had his first seizure and was admitted and reviewed in the inpatient setting. He was discharged on steroids and commenced on antiseizure medications.

Unfortunately, after this episode his function continued to be impacted and most things became increasingly difficult. He relied heavily on his wife for support, and this led to distress around his loss of fucntion.

His mobility deteriorated and he developed worsening L sided hemiparesis and had multiple falls at home. Most activity became very difficult, and his distress was heightened. He was reviewed at home and expressed his deep distress and increased anxiety around his loss of function and expressed an interest in pursuing the VAD process on 24/1/24 during a home visit.

We have a collaborative arrangement with our local hospital that allows for us to often be fortunate to directly admit to the ward and we were able to do this for this deeply distressed patient.

On admission his function had significantly deteriorated he was unable to ambulate or self-care in any capacity and his existential distress was obvious. He again requested VAD. The GP VMO made the referral and we worked collaboratively to manage his symptoms during the process and visited at very regular intervals. The initial VAD assessment was on 31/1/24 and his second review was 7/2/24.

During his time as an inpatient we witnessed the transition of a deeply distressed patient to one who found peace and autonomy in his decision making and spent his last 2 weeks happily supported in his care in the inpatient setting. The transition was in many ways remarkable. Social work provided support on the ward and this resulted in many discussions with his family. Multiple discussions with nursing staff also enabled open and honest discussion around the process and we were able to support all members of the team. MS continually thanked us for our involvement and support during his admission.

His final VAD appointment was on 14/2/24 he had opted for Intravenous administration of medications which ended his life.

RESULTS/ OUTCOMES

Working in a collaborative manner is always beneficial to patients and families. With this being one of the first cases in our small hospital we learnt to support each other through the process and learnt many lessons.

MS was one of our first patients to receive VAD on the ward and since staff have been incredibly supportive of the process and of each other as we navigate the new landscape that is emerging.

CONCLUSION

VAD and palliative care can co-exist well. The focus much be on patient centred care and collaboration with all treating teams. We cannot and never will be able to manage all patients distress. We need to be able to focus on patient choice and advocate for them regardless of our own beliefs and step back if this creates distress but acknowledging the patient needing autonomy and support in their decision making.