

Case Report

The Use of Patient to Clinician Video to Improve Patients Safety with End-of-Life Documents

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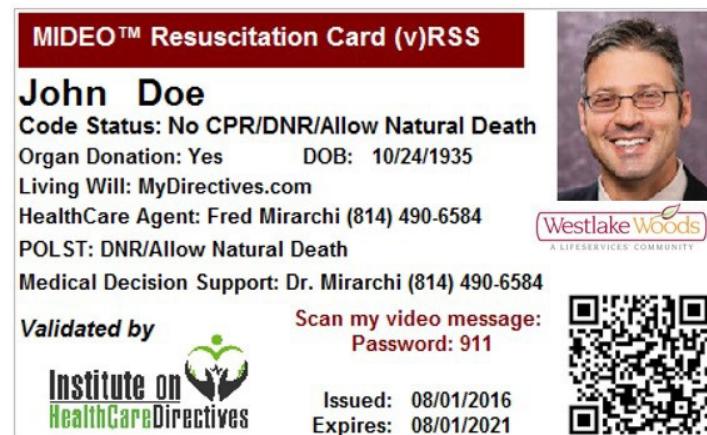
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Case A

55-year-old male with a past medical history of hypertension presented to an emergency room with Chest Pain. As part of his intake history he was asked if he had a living will. He stated yes. During his evaluation, he was found to have evidence of a Non-ST segment myocardial infarction. He was admitted to the hospital with a plan to undergo cardiac catheterization. During his stay on the telemetry floor he developed increase pain, was clammy and went into cardiac arrest from ventricular fibrillation. Upon Code Blue Team arrival, the physician was advised that he had a living will. The Code Blue activation was terminated, and the patient was pronounced deceased.

She cried and replied, 'I don't know'. At that time the crew began CPR and transported the patient to the emergency room.



MIDEO Resuscitation Card (v)RSS

Michael Gallagher

Code Status: FULL CODE, BAD AIRWAY

Organ Donation: Yes DOB: 02/09/1963

Living Will: Sisinni Law Firm (814) 864-5841

HealthCare Agent: Sean Gallagher (814) 555-5555

POLST: Requires Decision Support Approval

24/7 Decision Support: Dr. Mirarchi (814) 490-6584

Validated by



Scan my video message:
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Discussion

As we are educated on the ethical & financial concerns surrounding end-of-life care, we are informed by Institute of Medicine that end-of-life care is broken and accounts for \$170 billion in annual spending and is projected to be \$350 billion by 2019 [1]. While medical expense is an issue, we must be mindful of the patient safety concerns. Providers attempt to better align patient wishes with living wills & POLST (Physicians Orders for Life-Sustaining Treatment). However, the scientific research generated by the **TRIAD** (The Realistic Interpretation of Advance Directives) raises the awareness that medical errors exist [2,3]. The above cases represent two common medical errors. Case A represents "under-resuscitation" & case B represent over resuscitation². The financial benefits of both living wills & POLST are very much proven [4,5]. Additionally, they are very much required to help patients have a say in their end of life care. However, this is a process that has very little quality oversight and to date there is no good standardized process to share the discussion that is had between the patient and physician (often the Family Medicine Physician) accurately transfers with the next physician (often the

Case B

62-year-old male, who was admitted and discharged from a Cancer medical center, was diagnosed with an end stage Sarcoma. He was discharged with a POLST form stating DNR with Comfort Measures Only. He was to be enrolled in Hospice care. The next morning developed nausea. He very quickly passed out. His wife activated 911 to call for an ambulance. Upon the ambulance arrival, he was in cardiac arrest. The ambulance crew was handed the POLST form by the wife. They asked her what should they do?

Emergency Medicine Physician) or medical provider who may come in contact with the patient.

For clarification living wills require interpretation whereas POLST does not and is an immediately activated medical order set. The patient safety question therefore is, can we correctly interpret living wills, and can we trust the POLST to be an accurate reflection of the patient's wishes? The TRIAD research suggests that there is much opportunity for improvement to ensure safe and accurate medical care [6,7,8]. Most living wills are created by attorney's years in advance prior to the onset of medical conditions. The POLST are completed by other providers (ex. Social Workers or admission nurses) & signed by physicians who may or may not have been involved in the conversation [9]. With the approval of the advance care planning codes by Medicare in 2016, there has been an increase in the POLST form completion during the annual wellness exam. This has resulted in a broader use of POLST rather than the indications supported by the POLST Task force. The reported indication is a frail elderly patient who is not expected to live more than 1 year [10].

Patient handoff is problematic, and we must safely connect frontline physicians (such as Pre-hospital, Emergency Medicine, Trauma and Hospitalist physicians) with the patient's wishes determined in the primary care physician's office. If we review Case A & B again but this time they also had a form of patient to clinician video (Figure 1 for Case A and Figure 2 for Case B), would the outcome have been different? The TRIAD VIII (Multicenter Evaluation to Determine If Patient Video Testimonials Can Safely Help to Ensure Appropriate Critical vs. End of Life Care) study has shown that patient to clinician video can improve code status understanding to minimize interpretation errors. In addition, patient to clinician video can minimize both under & overtreatment medical errors that result from document interpretation errors [11].

Video is not new to patient care. Volandes, Wilson & El-Jawahri have performed pioneering work with clinician to patient video. It has been shown that clinician to patient educational videos can help patients make informed decisions about CPR [12,13,14]. To improve upon the principals of shared decision making and patient informed consent, patient to clinician video clarification can now allow the medical profession to become informed providers of the patient's actual wishes. Patient to clinician video provides benefits to providers to hear from patients, in their voice and expressions, when they are critically ill & receive their guidance. Whereas traditionally providers, with these new patient encounters, would be making interpretations after reviewing a form that may or may not have been completed correctly. POLST& POLST-like forms, when not fully completed lead to errors in treatment [15] and can be discordant with patient wishes [16]. Resuscitations are already extremely complex & physicians need to know what to do initially in the first seconds to include the golden hour of resuscitation. Furthermore, the physicians comfort in the process to trust and act on what is documented is of paramount importance. Paper forms at present do not do this well or provide the necessary level of assurance to Physicians. The current process has already

resulted in patient safety concerns and now litigation related to both wrongful death & now the creation of wrongful prolongation of life litigation.

POLST & living wills are very necessary tools to ensure patient autonomy and to control medical expenditures related to over-utilization of resources. However, it is a process that requires safe guards to ensure patient decisions and accurate medical care. To relate an analogy, the use of IV pain pumps was fraught with complications and did result in patient harm. Guard rails were created, and the practice was implemented to prevent accidental administration and death. Patient to clinician video represents an opportunity to become that safe guard to ensure accurate lifesaving or the provision of end of life medical care. Emerging technologies will allow us to hear and see patients to clarify their wishes. Combining technology and Medicare reimbursement for physician involvement should facilitate patient to clinician video in a safe & cost-effective manner. In conclusion, we have a patient safety problem with living wills & POLST documents. TRIAD VIII presents an opportunity to revolutionize advance care planning. It also has the ability to be an effective hand off communication tool linking the primary care office where advance care planning is often begun and hospital where acute care medical services are often provided. The traditional treat first and ask questions later approach is aggressively being challenged by the development of malpractice litigation and medical expense control. To ensure patient care and safety for when critically ill vs. when at end of life requires the continued recommendation to complete living wills and when appropriate POLST. However, the process must have quality standards for their completion & understanding. Patient to clinician video should be further investigated and developed to allow the clinician to hear from the patient to accurately guide their care.

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