

PALLIATIVE CARE

INTRODUCTION TO THE SPECIALTY

Richard E Butin MD
William H Jennings MD, FACP

UMKC- School of Medicine
Truman Medical Center

Objectives:

By the end of this session, you will be able to:

- Define Palliative Care
- Know when Palliative Care is appropriate
- Understand the evolution of Palliative Care as a specialty
- Differentiate between Hospice Care and Palliative Care

Definition of Palliative Care

- the active, total care of patients whose disease is not responsive to curative treatment. (WHO)
- For over 2000 years this was known by another term- “Doctoring”
 - Robert Buckmann MD PhD, AAHPM 2008

Who is dying in the U.S.?

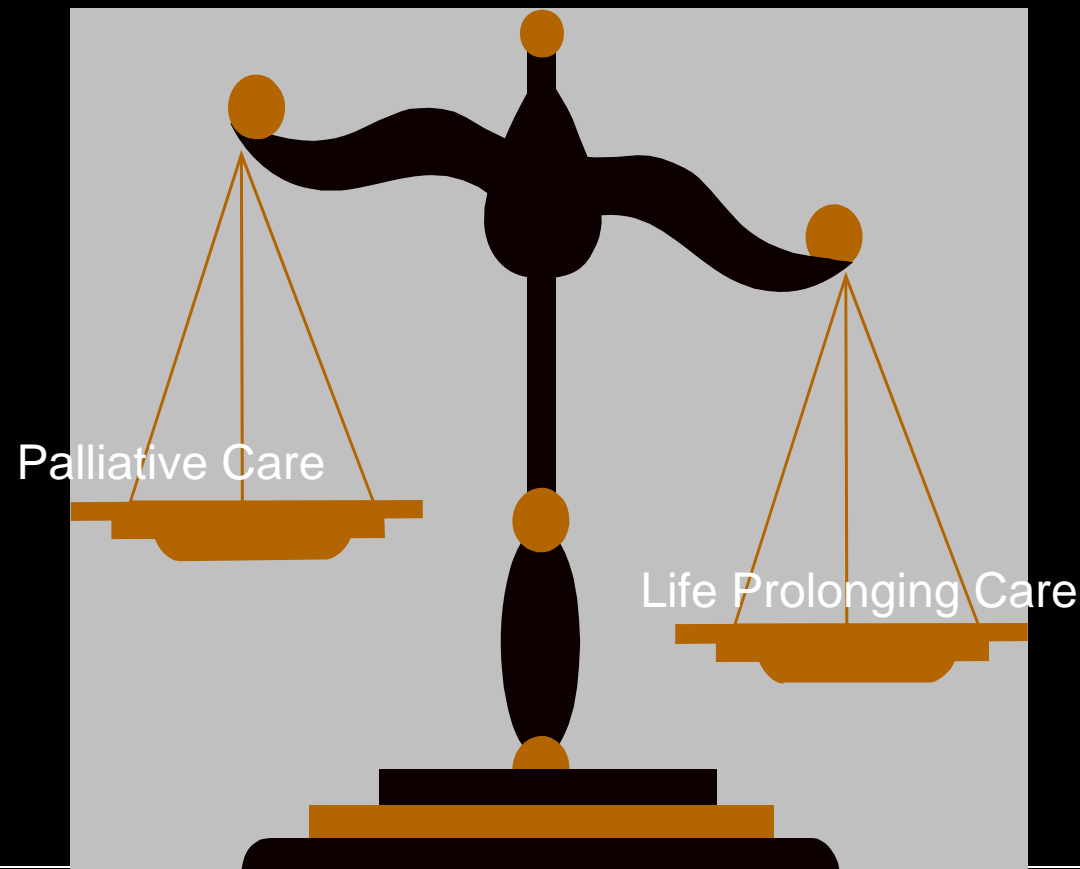
- Median age of death is 77 years.
- Among survivors to age 65, median age at death is 84 for women, and 80 for men.
- In the frail elderly death follows a long period of progressive functional decline and loss of organ reserve accompanied by specific disease processes.

Site of Death

- Hospitals: 56%
- Nursing homes: 19%
- Home: 21%
- Other 4%

(1993 National Mortality Follow back Survey)

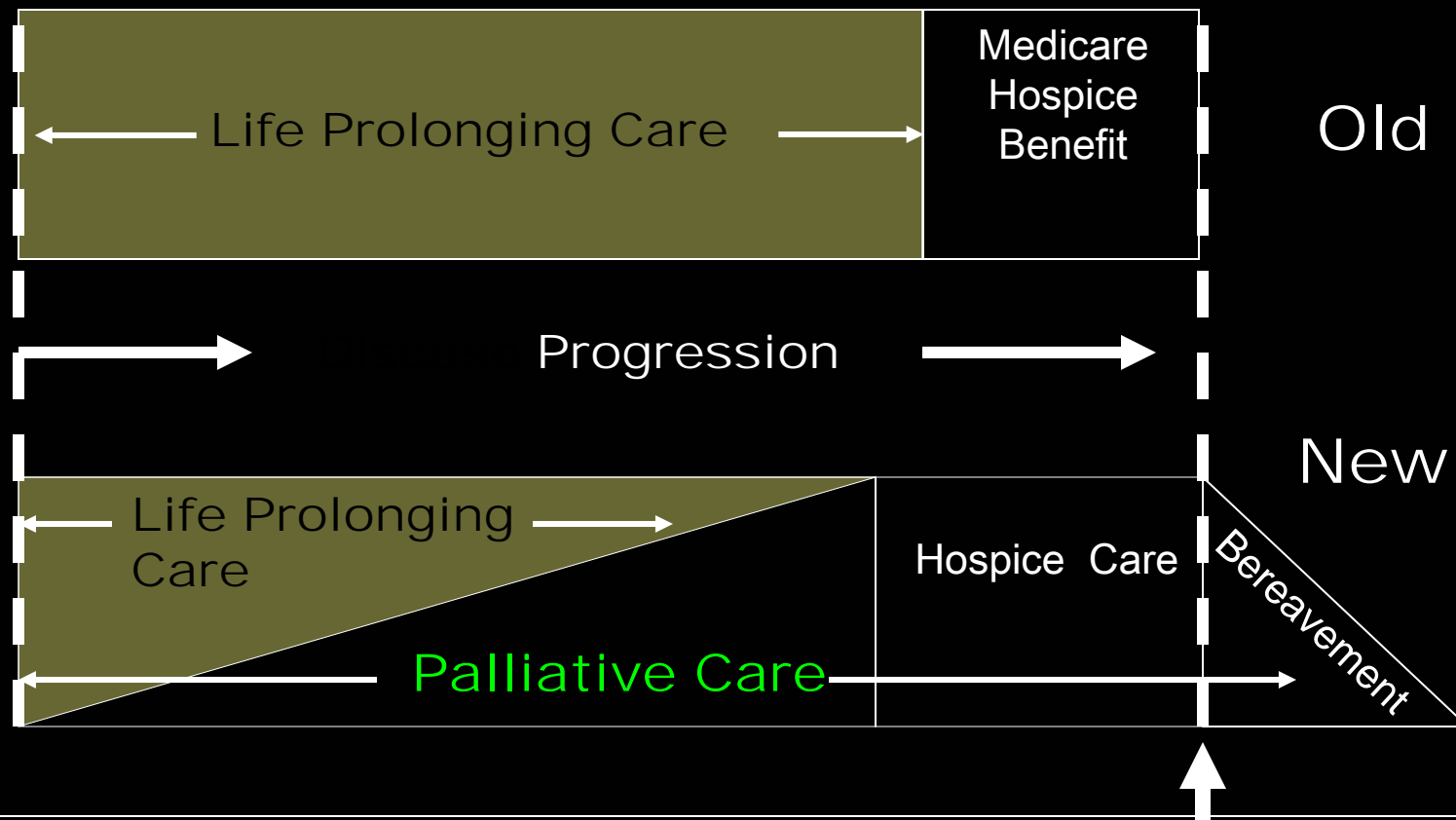
Restoring the Balance



Palliative Care

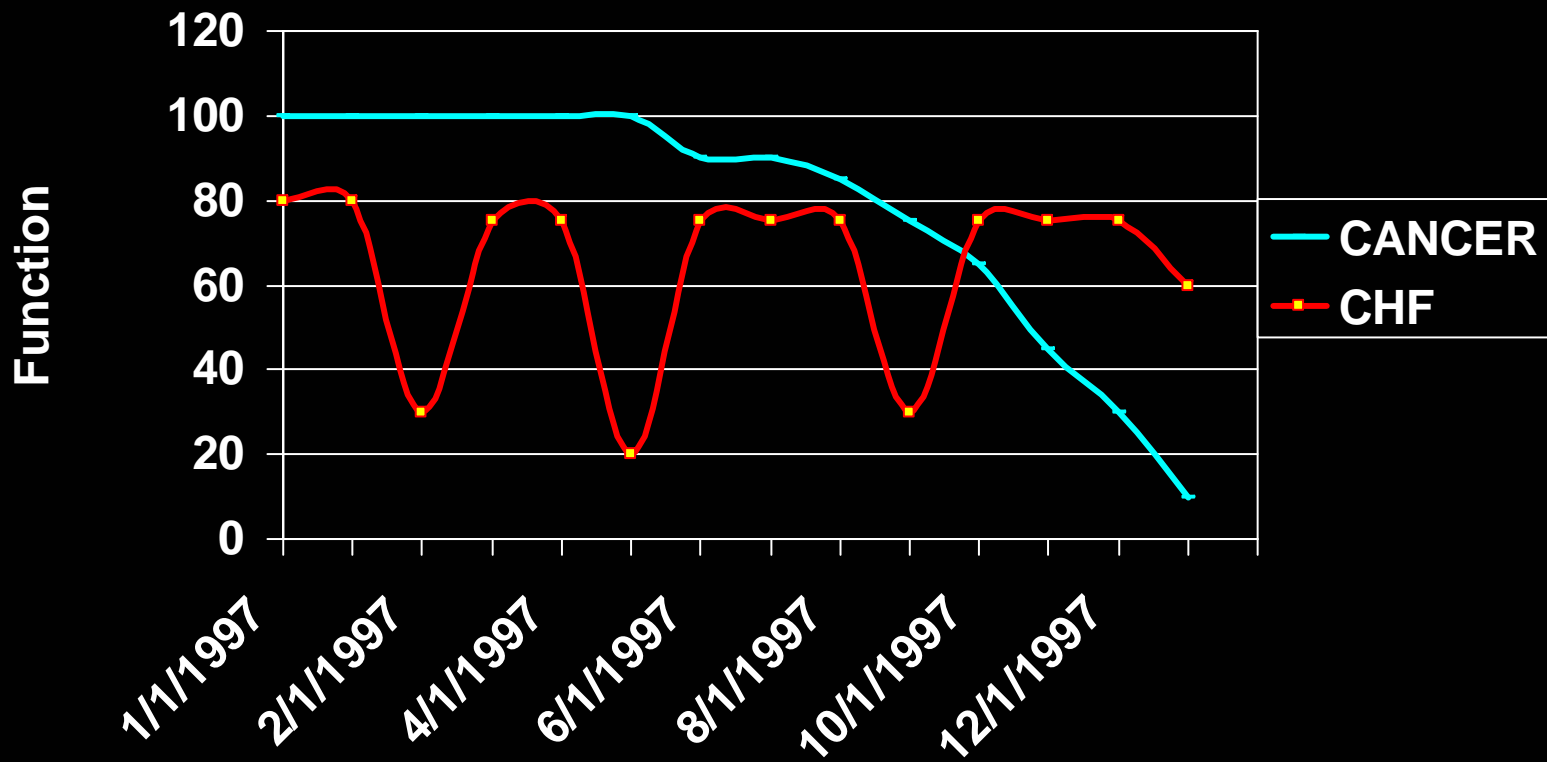
- Palliative Care
 - is not just pain therapy
 - is not just for cancer
 - is not just end-of-life care
- Palliative Care
 - is care **for** the end of life
 - not just **at** the end of life.

Dying Trajectory- the Concept of Palliative Care



Death

Disease Trajectory



The Patients Served

Patients most commonly treated include:

- People with pain or other unrelieved symptoms related to cancer or cancer-related treatment
- Individuals with AIDS, ALS or cardiac failure
- People in all stages of life-limiting illness
- Patients with nutritional problems caused by progressive disease
- Patients and families with psychological distress related to life-threatening disease

Palliative medicine

- Incorporates seven major skills:
 - communication
 - decision making (prognosis)
 - management of disease-related complications
 - symptom control
 - psychosocial and spiritual care
 - care of the dying
 - coordination of care or continuity

Symptom management

- Pain
- Fatigue
- Nausea
- Depression
- Anxiety
- Drowsiness
- Anorexia
- Dyspnea
- Constipation
- Secretions
- Delirium

Comparing Hospice vs. Palliative Care

Hospice

- Prognosis 6 months or less
- Focus on comfort care
- Medicare hospice benefit
- Out of hospital

Palliative Care

- Life limiting illness
- May be combined with curative care
- Independent of payer
- Inpatient emphasis currently

The Need for Palliative Care *Now*

Why doesn't Hospice Suffice?

- Hospice is typically post-hospital care, identified in very late stages of illness.
- Only 20% of those eligible for hospice care receive it.
- Average length of stay from referral to death is 25 days
- 1/3 of these pts die within 7 days

Benefits of Palliative Care

Patient/Family/Significant Others

- Treats the whole person, physically, psychologically, spiritually, emotionally not just as a diagnosis
- Involves the patient, family, and significant other
- Supports patient, family and significant other
- Increases patient and family satisfaction
Identifies and coordinates resources
- Dramatically reduces symptoms

Benefits of Palliative Care

Nursing/Caregivers

- Demonstrated reduction in staff burn-out and turnover.
- Increased competency in caring for chronically or seriously ill and end-of-life conditions.
- Enhanced recognition and understanding of the needs of these patients and their families.
- Improved communication skills with patients and families at the most sensitive and critical time of the patient's life.

Benefits of Palliative Care

For Physicians

- Improves pain management of seriously ill patients with end-of-life conditions.
- Improves management of symptoms in patients
- Improves physician recognition of cultural considerations, grief, loss, and bereavement.
- Lends support for time-intensive management issues such as consultation and coordination of care
- Improves physician's skills

Benefits of Palliative Care

Community

- Reduction in length of stay and ICU stays (fewer days of ambulance diversion in the community, increase in ICU bed availability)
- Placement of patients in the most appropriate care setting
- Increase in quality of care for terminally ill and dying patients through improvement in symptom management
- Increase in primary caregiver certification in palliative care
- Increase utilization of advance directives

Our Experience at UMKC/ Truman Medical Center

- 2002 ethics committee plan development using CAPC template
- 2005 Aetna grant- \$150,000 over 3 years
- 2006 hired APN
- 2007 187 consults seen with 853 visits

Need for Palliative Care

TMC Patients Experience without a Palliative Care Program?*

National experience for facilities with Palliative Care Programs

29% of patients nationally die with hospice

Nationally, 78% of patients who die are over 73 years old

TMC Experience without a Palliative Care Program

- 34% died in ICU at TMC
- Only 6% at TMC had hospice involved
- 68% of patients at TMC who died could have benefited from palliative care
- Only 17% had an Advance Directive
- 50% had the need for palliative care identified very late in their stays
- 42% of TMC patients who died (*who could have benefited from Palliative Care*) were 46-64 years old
- Male/female ratio was 50/50

* Based on TMC qualitative study of 62 patients who died at TMC in 2001

Palliative Care Team Composition

- Advanced Nurse Practitioner (ANP)
- Physician
 - Medical co-Directors
 - Residents
- Spiritual Health Services (Pastoral Care)
- Social work services
- Medical students
- Administration

TMC model

- Inpatient Consult service
 - Attending physician and admitting team continue with main management
 - An actual consult is written for in chart
 - ANP evaluates
 - Physician performs official consult and note generated in electronic record
 - PC team begins to help with issues of relevance
 - Daily visits
 - Frequent team meetings

Appropriate Referral

- Before the terminal phase of their illness
- Before
 - alternatives have been exhausted
 - patient is highly symptomatic
 - social disarray and family crisis

Appropriate Referral

- "Would you be surprised if such a patient were to die in the next year?"

Service Provided

- Symptom management
- Communication
 - Between caregivers
 - Family meetings
- Plan of care clarification
 - Goals of care
 - Discharge planning
- Emotional/ psychological support
- Family and social issues
- Spiritual support

The Case for Palliative Care

"The right thing to do"

- **ACP Guidelines 2008**

- **Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life: A Clinical Practice Guideline from the American College of Physicians** A. Qaseem, et al *Ann Intern Med* 2008

- **IOM priority 2003**

- **Educational imperative- LCME, AGME**

- **Accreditation imperative- JCAHO**

The Educational Imperative

- LCME requires, ACGME residency training recommendation, JCAHO recommends for staff
- Teaching hospitals are the site of training of most clinicians
- Medical school and residency curricula offer little to no teaching in palliative care
 - 74% of residencies in US offer none
 - 83% of residencies offer no hospice rotation
 - 41% of medical students never witnessed a physician talking with a dying person or their family, and 35% never discussed the care of a dying patient with an attending

Educational services

- Internal medicine elective- curriculum development ongoing
 - Resident
 - Medical student
- Educational sessions
 - Noon conferences
 - Morning reports
 - In-service
 - Nursing
 - Chaplains, social workers, pharmacy
 - Community/ family

Case discussion Ms. W.

- 68 y/o female
- Progressive dyspnea 2ndary to mult PE
- Mult skin nodules
- Biopsy- metast poorly differentiated adenoCA
- Mets to liver and bone
- Functional status ECOG 3+

Obligation to communicate treatment options

- Frequent educational (resident) dilemma
- Communication style-
 - what would you like me to do?
versus
 - here's what I recommend
- Prognosis
 - Physicians are overly optimistic ?
- Can physicians refuse to give "futile" treatment

Case discussion Ms X

- 40's Cauc female
- Homeless with mental health issues
- Began volunteering at church food pantry
- Failed to show for work, found down
- Prolonged resuscitation, ICU with anoxic encephalopathy, vent dependant/ unweanable
- Withhold/ withdrawal issues
- Surrogacy- no family

Summary

Palliative Care is:

- Patients with life-limiting illness
 - care **for** the end of life
 - not just **at** the end of life.

Palliative Care References

- <http://www.aahpm.org/> American Association of Hospice and Palliative Medicine
- http://www.eperc.mcw.edu/ff_index.htm End of Life/Palliative Care Resource Center- this is the link to **Fast Facts**, several hundred 1-2 page excellent summaries of aspects of diagnosis and treatment of issues in Palliative Care. Sponsored by Medical College of Wisconsin
- <http://www.capc.org/> Center for Advancement of Palliative Care- national organization
- <http://www.epec.net/EPEC/webpages/index.cfm> Education in Palliative and End-of-Life Care (EPEC), this is listing of educational materials to purchase and conferences to attend, from Northwestern University's Feinberg School of Medicine, supported by AMA, Robert Wood Johnson, and NIH
- <http://www.pallimed.org/> Blog of local Palliative Care consultant and national expert Christian Sinclair