PALLIATIVE CARE

AGS

THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
Leading change. Improving care for older adults.
Why do we need palliative care?
HOW AMERICANS DIED IN THE PAST (1 of 2)

• 1900
  - Average life expectancy: 47.3 years
  - Childhood mortality high
  - Adults typically lived into their 60s

• Prior to antibiotics, many people died quickly
  - Infectious disease
  - Accidents
HOW AMERICANS DIED IN THE PAST (2 of 2)

- Medicine focused on caring, comfort
- The sick were usually cared for at home

*The Doctor*, 1891

Sir Luke Fildes
MEDICINE’S SHIFT IN FOCUS (1 of 2)

- Science and technology

- Marked shift in values and focus of North American society
  - “Death-denying” or less experience with death
  - Value productivity, youth, independence
  - Devalue age, family, interdependent caring

- Improved sanitation, public health, antibiotics, other new therapies
  - Increasing life expectancy (in 2005: 78 years)
MEDICINE’S SHIFT IN FOCUS (2 of 2)

• Greater faith put in potential of medical therapies
  ➢ “Fight aggressively” against illness, death
  ➢ Prolong life at all cost
  ➢ Media heroics (eg, TV presents unrealistic CPR results):¹
    • *ER, Chicago Hope*, and *Rescue 911* in 1994–95: 75% immediate survival; 67% survive to D/C
    • Real life: 0%–30% survival depending on location (in or out of hospital) and age

• Death is “the enemy”
  ➢ Sense of failure if patient not saved

Where Do People Die?

- Hospital — 50%
- Nursing Home — 30%
- Home — 20%

Where Do People Want to Die?

- Home — #1
- Hospital — #2
- Nursing Home — Never
Palliative care arose because of a need
“Palliative care seeks to prevent, relieve, reduce or soothe the symptoms of disease or disorder without effecting a cure . . . Palliative care in this broad sense is not restricted to those who are dying or those enrolled in hospice programs . . . It attends closely to the emotional, spiritual, and practical needs and goals of patients and those close to them.”

Institute of Medicine, 1998
"The active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems, is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with anti-cancer treatment."

WHO, 1990
Suffering - Pain - Nausea - Diarrhea - Constipation - Agitation - SOB - Itching

Physical

Social

Spiritual

Psychological
THE ROLE OF PALLIATIVE CARE

The course of a life-limiting illness

Therapies to prolong life

Therapies to relieve suffering and/or improve quality of life

Hospice

Bereavement Care

Palliative Care

6 months

Death

Slide 12
HOSPICE VS. PALLIATIVE CARE

Hospice

• Focus is on pain and symptom management
• Patient has a terminal diagnosis with life expectancy of less than 6 months
• Not seeking curative treatment

Palliative Care

• Focus is on pain symptom management
• Diagnosis does not have to be terminal
• May still be seeking aggressive treatment
• Is not linked to reimbursement
Hospice is defined by the Medicare hospice benefit

- Eligibility:
  - 6-month prognosis (as determined by 2 physicians)
  - Goals of care must align with those of hospice

- 343 doctors provided survival estimates for 468 terminally ill patients at the time of hospice referral; physicians overestimated prognosis by a factor of 5.3

The hospice team – RNs, social worker, chaplain, supervision by a hospice physician, nurse’s aides up to 1–2 hours daily, volunteers (usually 3 hours/week), and bereavement support for up to 13 months after.

- Medications/therapies for the sole purpose of palliation of symptoms related to the primary diagnosis.
- Medical equipment for safety/symptom relief.
- Dressings/other care needs related to the diagnosis.
- 24-hour coverage.

THE MEDICARE HOSPICE BENEFIT
COMMON MISCONCEPTIONS ABOUT HOSPICE (1 of 2)

• The patient must be bedridden in order to be eligible for hospice care
  ➢ Hospice promotes quality of life and function!

• The patient must have cancer

• Being on hospice means giving up hope
  ➢ Help patients and families re-frame their hope

• I need to be “DNR” to sign up for hospice
COMMON MISCONCEPTIONS ABOUT HOSPICE (2 of 2)

• I lose control or access to medical care if I sign up for hospice
• I cannot dis-enroll from hospice if I change my mind or get better (hospice survivor)
• It’s “too early” for me to sign up for hospice
  ➢ If patient is medically appropriate for hospice, focus on the extra support they will receive at home, and improved quality of life because of symptom control
THE PRACTICE OF PALLIATIVE CARE

- Pain and symptom management
- Prognostication
- Communication skills
- Application of bioethics/law
- Community resources/hospice
- Psychosocial and family care
- After-death care

Ideally, palliative care is provided by an interdisciplinary team: physician, nurses, social worker, chaplain, psychologist
SOCIAL & SPIRITUAL SUPPORT (1 of 2)

Nursing
Assist with hygiene, dignity, and privacy; maintain open communication with individual and family; encourage family involvement in care

Social services
Coordinate family support; engage community services; ensure wishes are congruent with advance directives and resolve any conflicts

Dietary
Liberalize diet; provide extra fluids for person
SOCIAL & SPIRITUAL SUPPORT (2 of 2)

Activities

Pets, reminiscence, aromatherapy, music, visits from children

Physical Therapy/Occupational Therapy

Assist in maintenance of independence and comfort; consult on positioning, safety issues, and pressure ulcer care

Community

Involve hospice, local clergy
BEREAVEMENT SUPPORT FOR SURVIVORS

- Sympathy cards
- Pamphlets on grief and loss; referral to community services
- Memorial services
- Bedside services
- Follow-up call or letter to family
- Children — art therapy
PROFESSIONALIZATION OF PALLIATIVE CARE

• Faculty at ~50% of US medical schools
• Requirements for training: LCME/ACGME
  ➢ IM, Neuro, Surgery, XRT, Hem-Onc, Geriatrics
• 55 fellowships: 1–2 years
• Board certification: >2100 MDs
• Subspecialty status: September 2006
PALLIATIVE CARE AT THE UNIVERSITY OF COLORADO

- Paid by the hospital
  - MD 50%
  - 2 full-time nurse practitioners
- Approximately 40 consults/month
- 24-hour service
- Not coercive!
Dr. Cox: Well, if she refuses dialysis, then there really is no ethical dilemma, is there?

J.D.: But what about our duty as doctors?

Dr. Cox: But what about our duty as doctors? Look. This is not about Mrs. Tanner's dialysis; this is about you. You're scared of death, and you can't be; you're in medicine. Sooner or later, you're going to realize that everything we do around here, everything, is a stall. We're just trying to keep the game going, that's all. But, ultimately, it always ends up the same way.
THANK YOU FOR YOUR TIME!

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