

Past, Present, Future of Palliative Care: Part Two: Inpatient Palliative Care

Joshua Hauser, MD
Northwestern University
Ethical Issues in Palliative and Hospice Care Loyola
University Medical Center
January 9th, 2009

Why would Claire go to the hospital?

- The pain medications aren't working at home
- The family needs a break
- There needs to be more coordination of services than can be accomplished at home.

What would an inpatient palliative care unit look like?

- A part of the acute care hospital.
- A rounding team of physicians and a nurse practitioner.
- A daily interdisciplinary team meeting that includes physicians, nurses, social workers, chaplains and people from home hospice.

Outline

What is it?

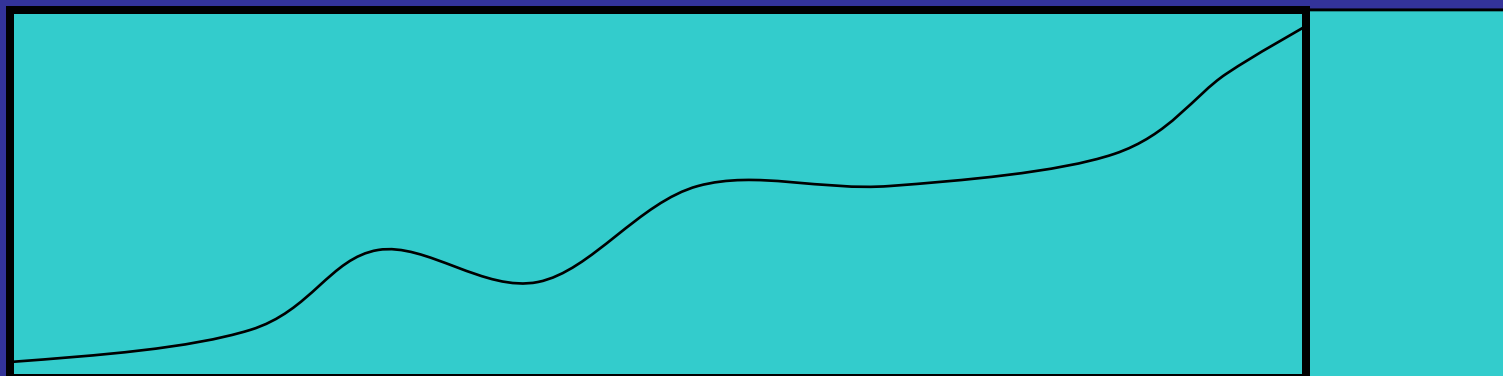
Why is it?

Who does it?

Does it make a difference?

What are some challenges?

Curative / remissive therapy



Presentation

Death



Palliative care

Hospice

What is inpatient palliative care?

Palliative care provided in a hospital, either on a physical unit or seen in consultation with other hospital services

What is inpatient palliative care?

- 1. Efficiency.** In-patient palliative care provides rapid, intensive and continuous interventions for patients in severe distress; whether physical, psychological or spiritual.
- 2. Access.** Hospitals are an important place for patients to access palliative care.
- 3. Influence.** The integration of in-patient palliative care service within a secondary/ tertiary hospital will significantly affect its philosophy, policy and care delivery towards terminally ill patients.

- IAHP

Why inpatient palliative care?, Part 1

1. **Symptoms:** out of control at home.
2. **Respite:** Family out of control at home.
3. **Goals changed:** Came in for “aggressive care” and things changed.

Why inpatient palliative care?, Part 2

The NMH story: reasons for consults

- A symptom issue
- A family problem
- My service is too big
- My patient's dying - expectedly
- My patient's dying – unexpectedly
- My attending made me call
- My attending forbid me from calling
- The nurse/social worker/other suggested
- Don't know what else to do
- Time to stop the vent
- A dispo issue
- Nothing left to do

Who does it?

Inpatient deaths

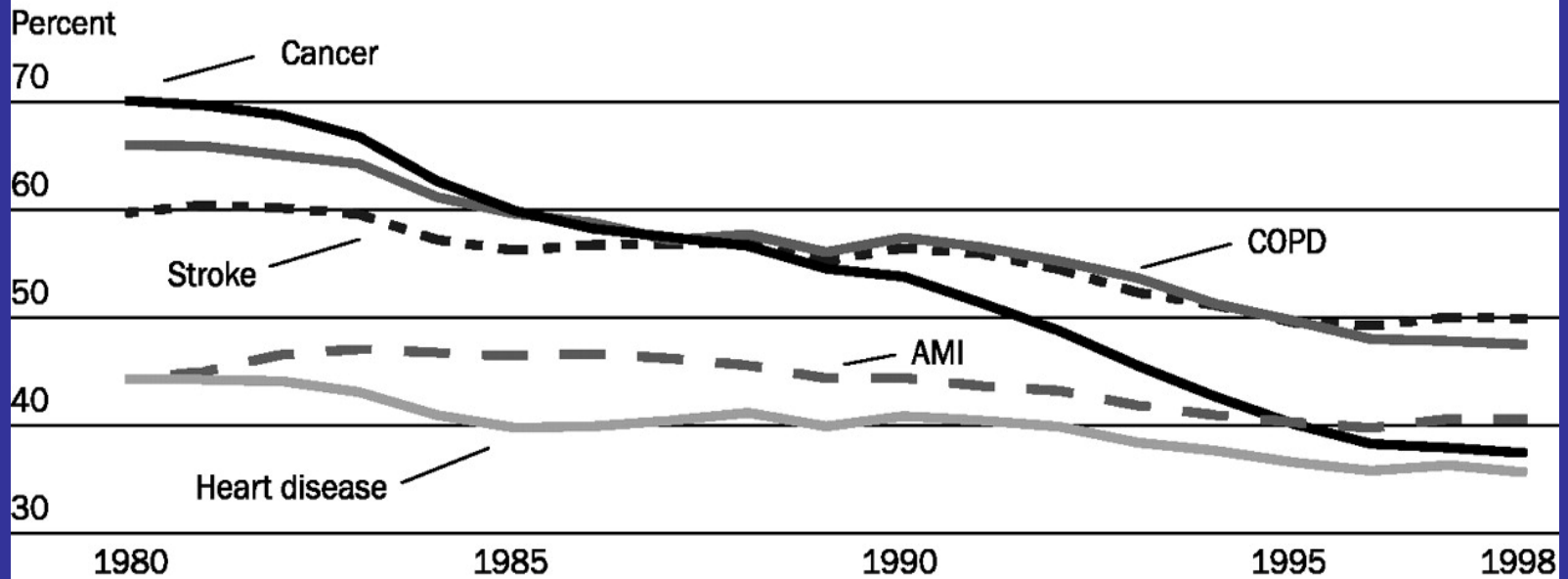
1993	Overall US	60%	(Weitzen, Medical Care, 2003)
1994	Connecticut	43%	(Gallo, JAGS, 2001)
1996	Massachusetts	40%	(Emanuel, 2002)
1996	California	36%	(Emanuel, 2002)

Inpatient palliative care

2000	632 hospitals
2003	1027 (25% of all hospitals)

EXHIBIT 3

Decline In Percentage Of Americans Dying As Inpatients, By Cause Of Death, 1980-1998



SOURCE: National Vital Statistics System Death Certificate Records.

NOTES: AMI is acute myocardial infarction. COPD is chronic obstructive pulmonary disease.

James Flory, Yinong Young-Xu, Ipek Gurol, Norman Levinsky, Arlene Ash, and Ezekiel Emanuel,
Place Of Death: U.S. Trends Since 1980,
Health Affairs, Vol 23, Issue 3, 194-200

HEALTH
AFFAIRS

Does palliative care make a difference?

- Outcomes:
 - Sx generally improve
physical > psychological
 - Prescriptions of pain medications increase
 - Length of stay decreases
 - Cost of care data equivocal

- Finlay, 2002; Higginson, 2003, Francke, 2000

Does palliative care make a difference?

- An automatic family meeting for all patients with:
 - Predicted LOS > 5 days
 - Predicted mortality > 25%
 - Change in functional status that was potentially irreversible and sufficient to preclude eventual return home

- Lilly, et al, Am J. Med, 2000

Does palliative care make a difference?

- **Four objectives of the meeting**
 - Review medical facts
 - Discuss patients perspective on death and dying, chronic dependency, loss of function and the acceptability of risks and discomforts of critical care
 - Agree on a care plan
 - Agree on criteria by which the success or failure would be judged.

Does palliative care make a difference?

- **Results**

- 1.5 meetings per patient
- Decreased length of stay: 3 days to 4 days
- Decreased mortality: 31% to 18%
 - Improved mortality of other patients
 - Transfer of patients who were dying

Does palliative care make a difference?

- **Prospective, RCT of ethics/pall. care consultation on “Nonbeneficial Life-Sustaining Treatments” in 7 US hospitals**
 - >500 patients
 - No difference in mortality between control and intervention
 - 2.95 hospital day reduction; 1.44 day ICU reduction
 - 87% of physicians, nurses, patients/ surrogates found consultation helpful in addressing treatments

- Schneiderman, JAMA, 2003

Does palliative care make a difference?

396 reports of randomized controlled trials, 22 met our inclusion criteria.

Improved outcomes:

Family satisfaction with care: 7 of 10 studies.

Quality of life: 4 of 13 studies

Symptoms: 1 of 14 studies

Cost savings: 1 of 7 studies

-Zimmerman, JAMA, 4/08

Outline

What is it?

Why is it?

Who does it?

Does it make a difference?

What are some challenges?

Challenges

- We like to win
- We don't like to be limited in our choices
- We have hard time communicating

Winning: hospice is for losers

“I’ve heard of hospice; it’s where you go when everything else hasn’t worked....like you throw in the towel.”

- Husband of a patient with pancreatic cancer, 2002

Winning on TV

60 occurrences of CPR in 97 episodes:

31 on *ER*; 11 on *Chicago Hope*; 18 on *Rescue 911*

Most arrests traumatic: 28 percent (apparently) due to “primary cardiac causes.”

65% of cardiac arrests occurred in children, teenagers, or young adults.

75% of patients survived immediate arrest

67% appeared to survive to hospital discharge

- Diem, et al, NEJM, 1996

Winning in the hospital

Survival

<i>Author</i>	<u>Event</u>	<u>24 hrs</u>	<u>D/C</u>
Bedell	-	33%	14%
Taffet	40	-	5.5
Murphy	22	-	3.8
Blackhall	-	20	3.1
Rosenberg	54	-	23
Ballew	39	-	16

We don't like to be limited

What is “comfort care”?

Transfusions

Antibiotics

Radiation

Chemotherapy

Hospice limitations

All California Hospices	%
Patient must have a willing caregiver in the home	26
Patient must be willing to forgo future hospital admission	29
Patient cannot be receiving TPN	38
Patient cannot be receiving tube feedings (NG, other enteral feeding)	3
Patient cannot be receiving radiotherapy	36
Patient cannot be receiving chemotherapy	48
Patient cannot be receiving transfusions	25

We don't like to be limited

Why might a hospice limit certain treatments?

1. Ideology
2. Training/Education
3. Money

We have a hard time communicating (1)

A 55 yo with diabetes, congestive heart failure, seizures and anoxic encephalopathy is about to be extubated. The palliative care service is called and see the patient and her family. Their decision to extubate her is consistent with her wishes, and multiple discussions they had together in the past.

Over that morning and the day earlier, several nurses had also discussed this with them, their primary care physician had discussed this with them and the intensivist had discussed this with them.

Two questions

1. How many discussions have there been?
2. How'd they go?

We have a hard time communicating (2)

When it comes time to extubate the patient, the pulmonary fellow asks to go in with the nurse to perform the extubation.

The nurse looks at him and shrugs her shoulders. As he walks into the patient's room, the nurse looks down the hall, catches the eye of her manager, raises her eyebrows and mouths some words that can't be made out.

They both go in to extubate the patient.

What Happened?

What Happened?

Multiple discussions, no coordination

Multiple discussions with wrong people

Nurse doesn't agree with plan

Nurse doesn't like fellow

Fellow doesn't like nurse

No protocol for who does what

Other....

Future Challenges

Transitions of care: hospital to home, home to hospital, etc.

Team communication and accountability

Integration with other hospital services