

Palliative Care and Older Persons

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The Case of Mrs. L

- Mrs. L, an 85 yo woman who lives at home with husband, has a 5 yr hx of Alzheimer's disease. Over last year has lost thirty pounds and is eating irregularly. Behavior is quiet but will get agitated if attempts are made to force her to eat.

Mrs. L goes to the hospital

- She has been admitted four times to the hospital over the last year, each time for a fever, caused by a urinary tract infection
- She was discharged from the hospital two weeks ago and now is lethargic at home, has a temperature of 101, is not eating
- Her husband calls their doctor who tells him to bring Mrs. L to the hospital

Hospital Stay

- Mrs. L is admitted to the hospital through the emergency room and found to have another urinary tract infection and dehydration in the setting of Alzheimer's disease and weight loss.
- The physician does not address code status, asks for a swallowing study and a GI consult for a PEG tube, orders a full body CT to work up the weight loss, and asks for social work to assist in nursing home placement.

Husband's concerns

- The next day, Mr. L speaks with the social worker and admits he is finding it difficult to care for his wife but would like to keep her at home and is concerned about the talk of a feeding tube and other testing...he says "But the doctor knows best and I should do what he recommends"
- What other options are available?

Objectives

- Define and differentiate palliative care and hospice care
- Understand what is meant by the “trajectory of dying” and how it can influence choices for the best care
- Consider common issues in caring for older persons with life limiting illnesses

Reference

- Slides 7-24 from the EPEC Curriculum

End of life in America today

- Modern health care
 - only a few cures
 - live much longer with chronic illness
 - dying process also prolonged

(from EPEC, "Gaps in End of Life Care")

Protracted life-threatening illness

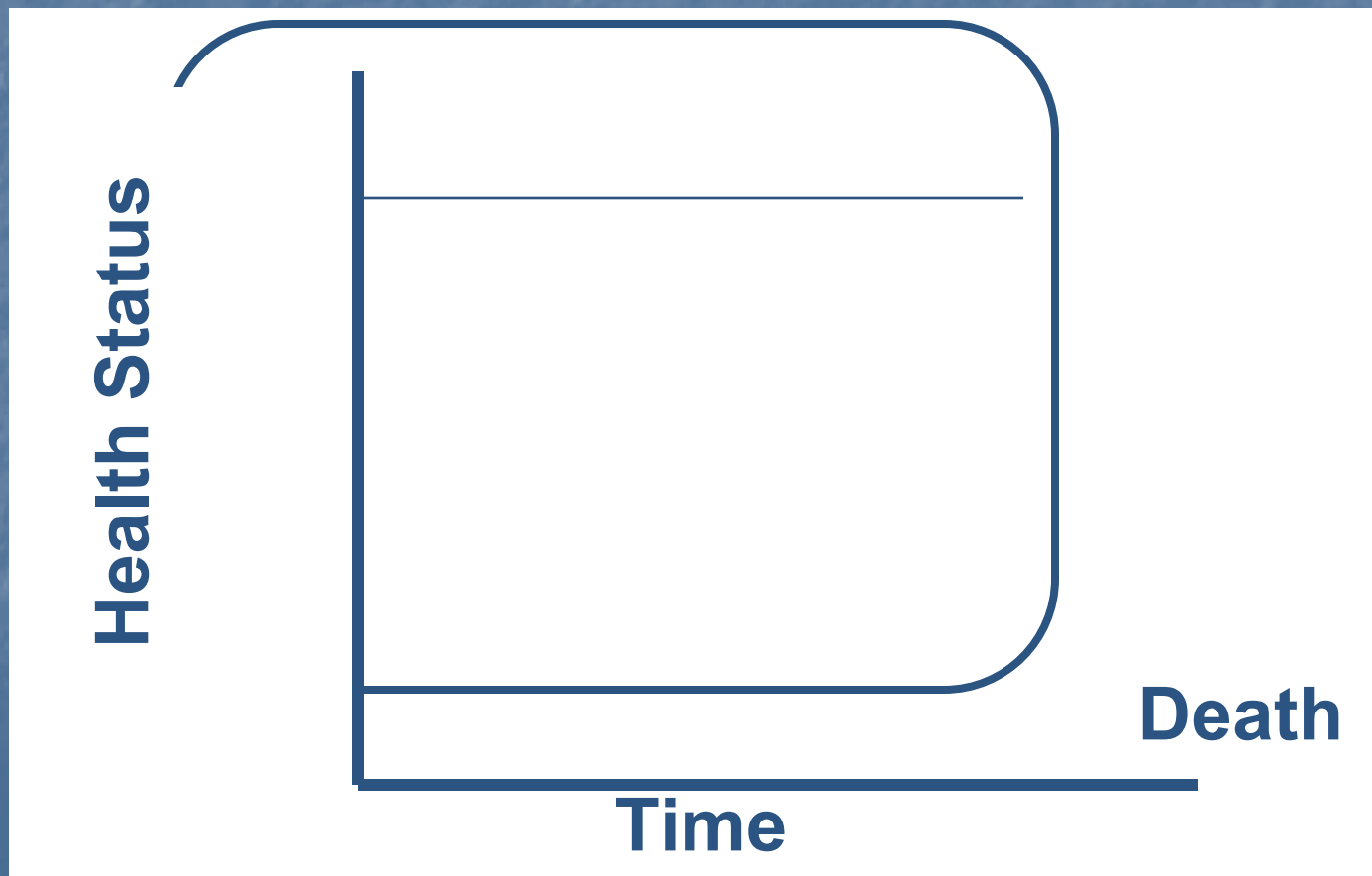
- > 90%
 - predictable steady decline with a relatively short “terminal” phase
 - cancer
 - slow decline punctuated by periodic crises
 - CHF, emphysema, Alzheimer’s-type dementia

(from EPEC, “Gaps in End of Life Care”)

Sudden death, unexpected Cause

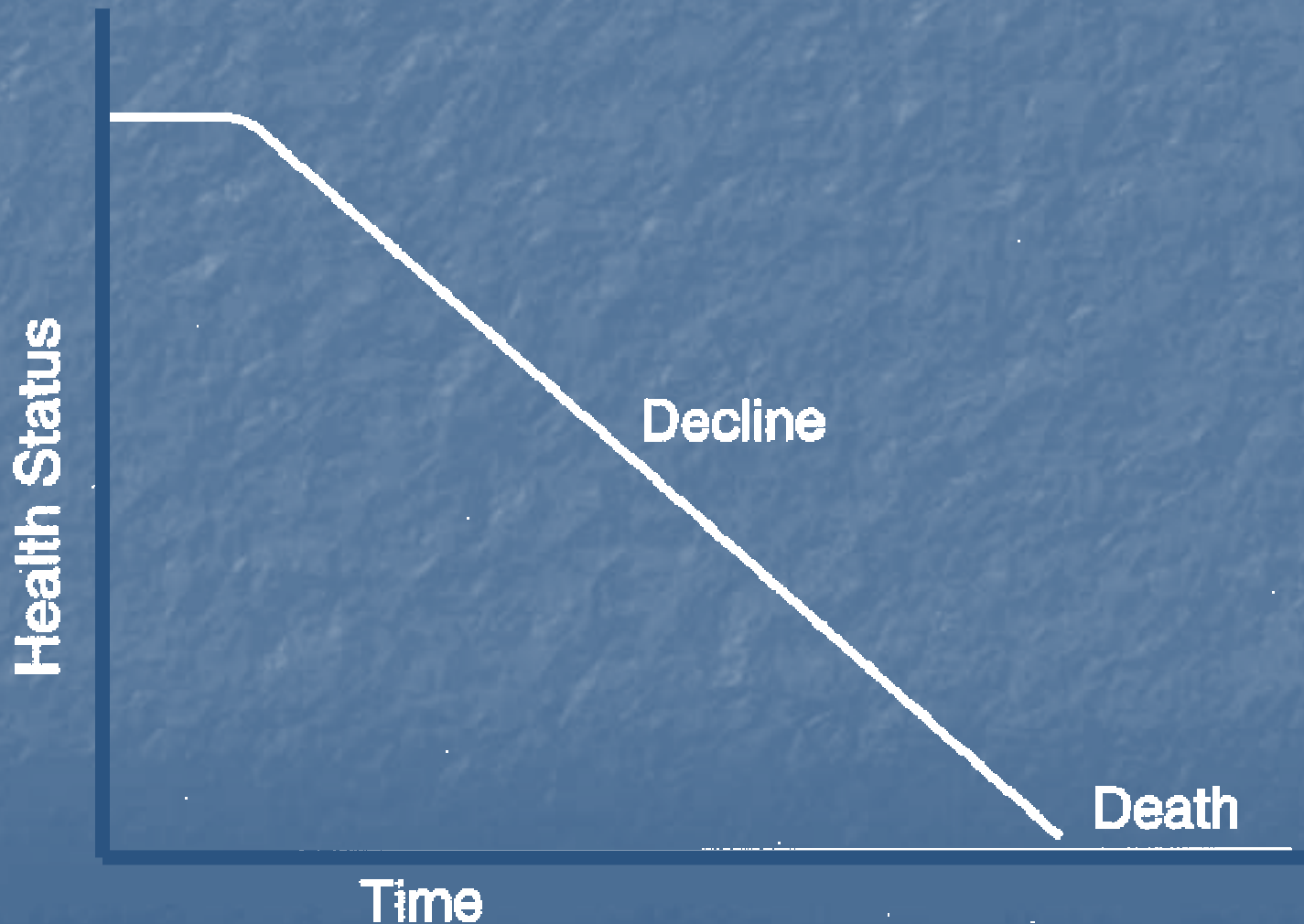
(From EPEC, "Gaps in End of Life Care")

- < 10%, MI, accident, etc



Steady decline, short terminal phase

(From EPEC, "Gaps in End of Life Care")



Slow decline, periodic crises, sudden death

(From EPEC, "Gaps in End of Life Care")



Conceptions of suffering

- Fragmentation of personhood – Cassell
- Broken stories – Brody
- Challenge to meaning – Byock
- Total pain – Saunders

The broad perspective

- A narrow focus will miss the target
 - depression affects experience of pain
 - medication useless if can't get it
 - spiritual strength may enhance tolerance
 - feeling abandoned may be expressed as physical suffering

Elements of end-of-life experience

- Fixed characteristics of the patient
- Modifiable dimensions of the patient's experience
- Care-system interventions
- Outcomes – overall experience of the dying process

**Fixed
characteristics
of the patient**

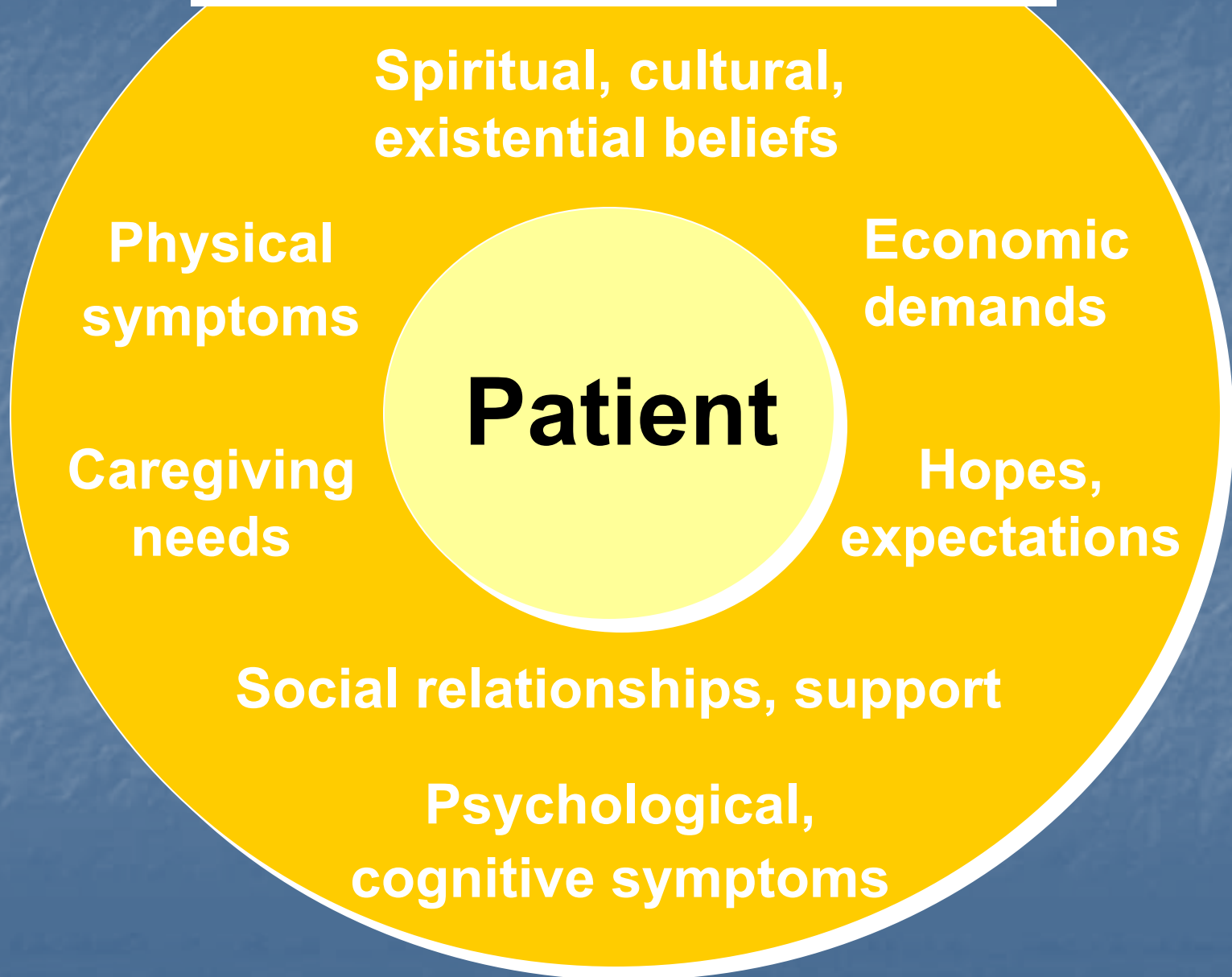
Diagnosis, prognosis

**Race, ethnicity
and culture**

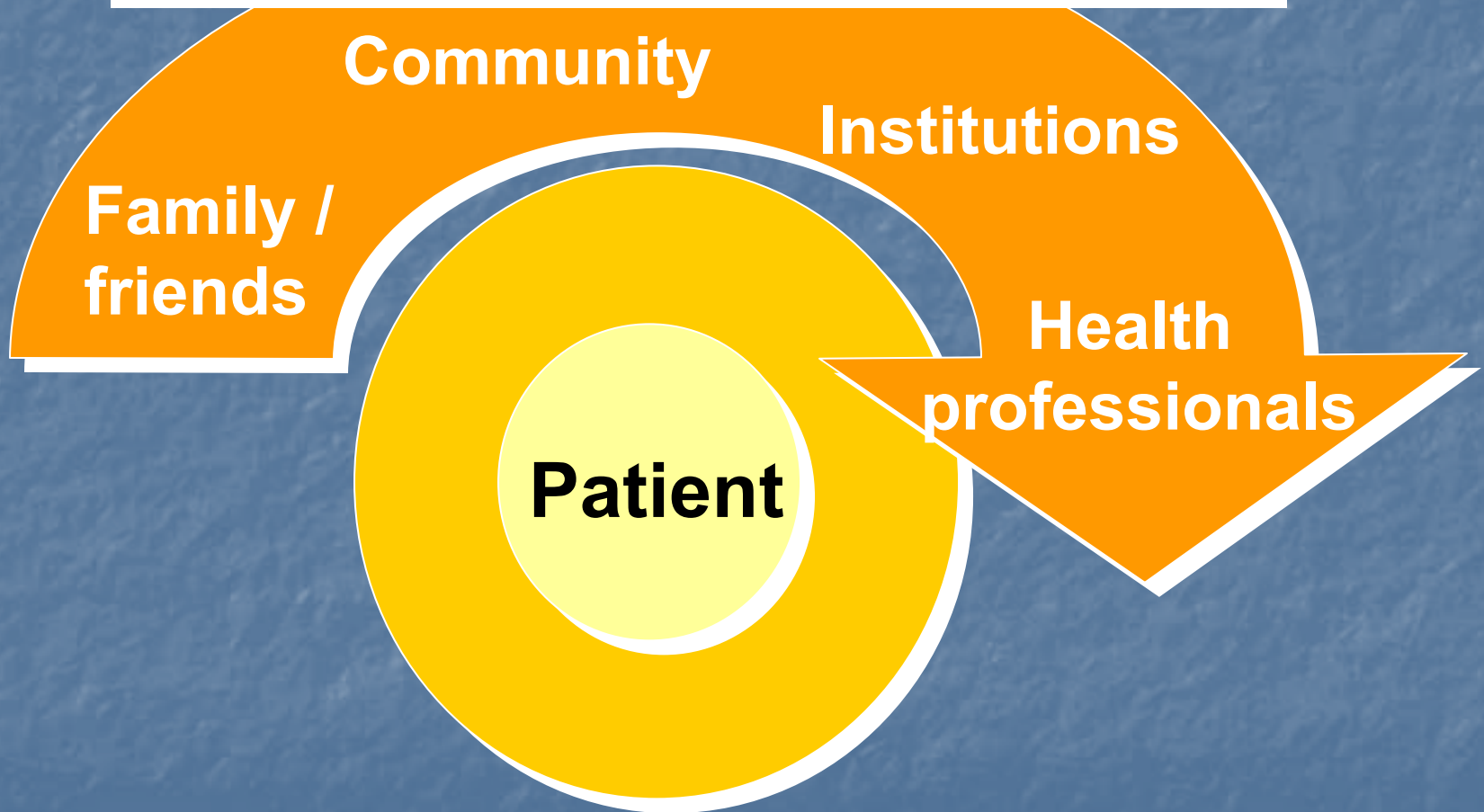
Religion

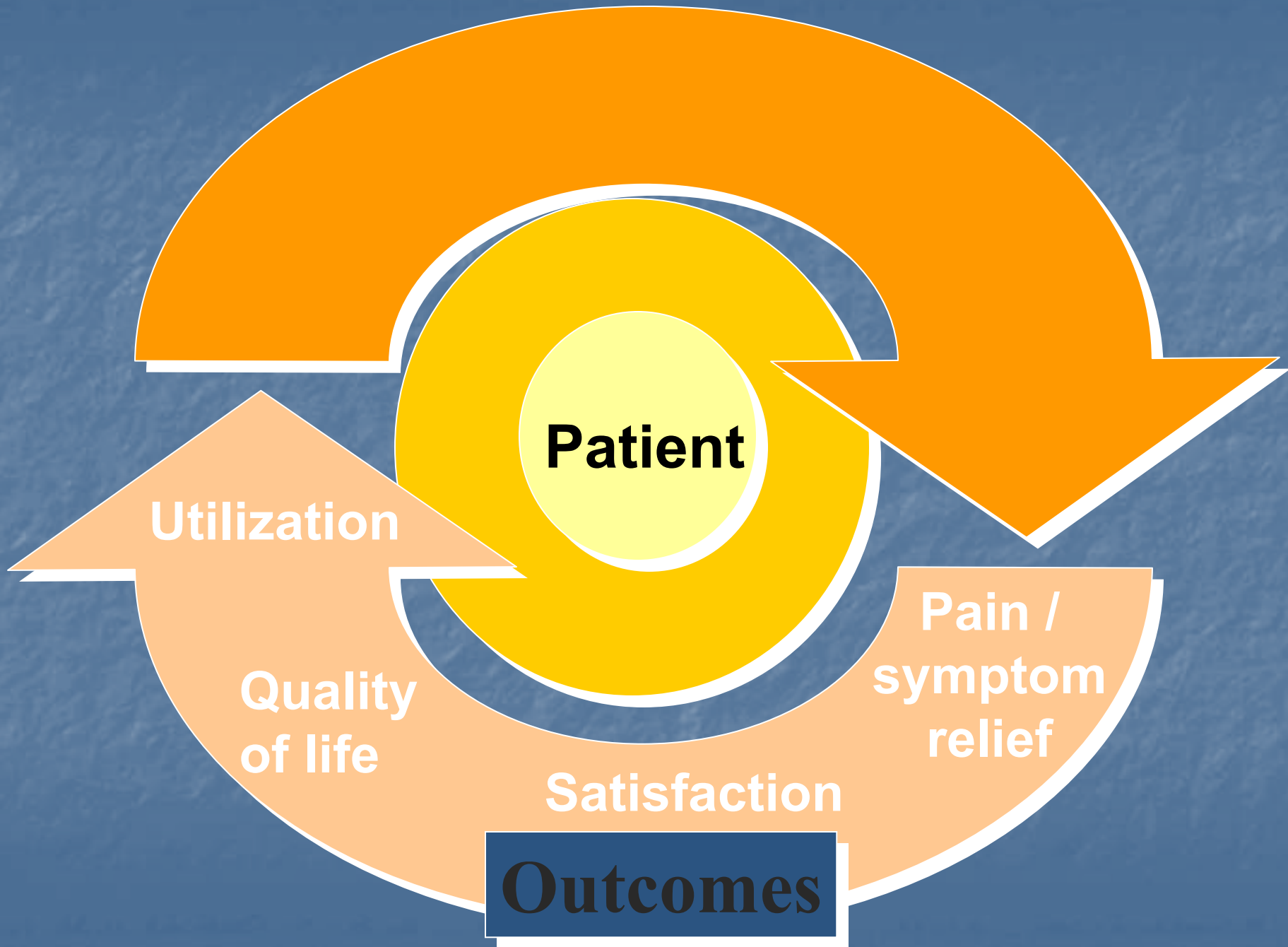
**Socioeconomic
class**

Modifiable dimensions



Health system interventions





Patient

Utilization

**Quality
of life**

Satisfaction

Outcomes

**Pain /
symptom
relief**

Hospice in the U.S.

- A place
- An organization or program
- An approach to or philosophy of care
- A system of reimbursement

Palliative care

- Relieving suffering
- Improving quality of life

Palliative care – definition 1

“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

Palliative care – definition 2

“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

Palliative care – expanded definition

- Affirms life, regards dying as a normal process
- Neither hastens nor postpones death
- Provides relief from pain, other symptoms
- Integrates psychological and spiritual care
- Interdisciplinary team
- Support system for the family

WHO 1990

Curative / remissive therapy



Presentation

Presentation

Death

Palliative care

Hospice

Trajectory of dying

- Pay attention to the inexorable downward slope, punctuated by acute crises with partial improvement
- Think about your frail older patients who are gradually losing function
- Consider what you can and cannot do to help them
- Think a bit more about frailty...

Frailty

- Easy to recognize, hard to define
- Not a diagnosis, but a description: Caused by multiple conditions
- Characterized by some or all of the following
 - weight loss
 - functional decline with assistance in ADL's
 - frequent falls
 - decline in cognitive status
 - development or non-healing of pressure sores, *et alia*
- What do you do?

Getting the paradigm right

- A paradigm is an example that serves to provide insight and guidance in similar situations
- As physicians, we learn a paradigm of acute care, mainly with hospitalized patients, that emphasizes aggressive therapy, brief interactions, and aims at cure

Caring for older persons...

- Age in and of itself may not be a helpful guide
- For some active old people, the acute care, cure oriented paradigm is appropriate
- For the frail older person, a palliative approach is likely more appropriate

Palliative care

- From the Latin *pallium*, meaning a cloak or a shelter
- Palliative care is NOT equivalent to hospice care
- One can combine palliative care with curative cure
- Palliative care addresses suffering in all its dimensions

Suffering and pain

- **Physical:** pain and symptom control
- **Social:** isolation, loss of relationships, decreased ability to care for self
- **Psychological:** loneliness, anxiety, depression
- **Spiritual:** uncertainty, why me?, guilt, fear

Back to Mrs. L

- What would you recommend?
- Hospice Referral?
- Proceed with g-tube and other studies
- Palliative care consult?

Another approach...

- Meet with Mr. L
- Assess Mrs. L
- Treat UTI and rehydrate with IV
- Arrange for PT consult
- Ask for home care involvement
- SW to assist in getting homemaker and home healthcare aide
- Chaplain/Pastoral Care to talk to Mr. L

Possible outcomes...

- Mrs. L home with homemaker and home health aide to assist with cleaning, bathing, feeding
- Mr. L gets some respite time
- Next UTI treated at home
- Church visits to home
- Home PT, walker from Mrs. L, improved functional status...etc.

Ethics and Palliative Care

- Ethics is not about dilemmas
- Ethics is about trying to do the right action
- Right action is determined in reference to the goals...limit suffering and not abandon
- Alzheimer's disease is a fatal illness
- Palliative care aims to assist person with the illness, improve environment, care for the family

Key points

- Hospitalization likely worsens Mrs. L
- A feeding tube may not prolong life and could result in an adverse outcome
- Attempts to improve function likely have more benefit than attempts to diagnose and treat specific medical conditions.

Acute vs. Palliative Approaches

- An acute care paradigm would look to rapid assessment and resolution of problems: CT, Peg tube, placement
- A palliative care paradigm looks at assessment more broadly, recognizes some things are broken that can't be fixed, but that excellent care is still possible: increased home services, respite care, avoiding hospitalization, minimizing invasive treatments

Mrs. L and Hospice

- Criteria for hospice admission for Alzheimer's require a higher degree of acuity than Mrs. L demonstrates
- Bed bound, non-communicative, total care
- A palliative approach provides a bridge between acute care and the end of life care given by hospice

Conclusions

- Palliative care provides care directed broadly at multiple dimensions
- It seeks to intervene to improve function
- Ethical concerns over care of older persons often ignore some of the medical reality---can't cure, can help, aggressive efforts may cause more harm than good