Introduction To Palliative Medicine

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Hospice of the Bluegrass
Objectives

- Review Definitions and History
- Define Principles and Culture
- Discuss Future Challenges
Definitions: Palliative Care 2007

• Active interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness and their families.

• It is offered simultaneously with all other appropriate medical treatment.

WHO (November 2007)
Definitions: Palliative Care 2011

• Palliative Care is a specialized medical care for people with serious illness.

• This type of care is focused on providing patients with relief from the symptoms, pain, and stress of serious illness—whatever the diagnosis.

• The goal is to improve quality of life for both the patients and the family.

• Palliative Care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support.

• Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.
Co-evolution:
Organizations and their environments evolving simultaneously toward a better fit for each other.

William Starbuck, Organizational theorist.
Professor Emeritus, New York University
Definitions: Hospice Care
2011

Palliative Care at the end of life.
“Medicine is always the child of its time and cannot escape being influenced and shaped by contemporary ideas and social trends”

**Stephens G., The Intellectual Basis of Family Practice.** 1982
## Historical Perspective (Western)

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.C. pre-Christian</td>
<td>First recorded hospice, Rome</td>
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<td>475 CE</td>
<td>First recorded hospice, Rome</td>
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<tr>
<td>1400’s</td>
<td>Middle Ages Christian orders established networks of hospices across Europe (“Old “Hippocrates to” New” Christian)</td>
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<tr>
<td>1842</td>
<td>Mme Jeanne Garnier started “Calvaires” (hospices)</td>
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<tr>
<td>1859</td>
<td>Sister Mary Aikenhead founded Irish Sisters of Charity</td>
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<tr>
<td>1879</td>
<td>Sister Mary Aikenhead opened Our Lady’s Hospice for the Dying, Dublin.</td>
</tr>
<tr>
<td>1890</td>
<td>Dr Herbert Snow, Cancer Hospital, Brompton, London, The Palliative Treatment of Incurable Cancer, with an Appendix on the Use of the Opium Pipe, and “Opium and Cocaine in the Treatment of Cancerous Disease.” BMJ.</td>
</tr>
<tr>
<td>1899</td>
<td>Calvary Hospital for the Dying, New York City (after “Calvaires” concept)</td>
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<tr>
<td>1905</td>
<td>Irish Sisters of Charity open St Joseph’s Hospice for the Dying.</td>
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<tr>
<td>1909</td>
<td>Cancer Hospital, Brompton, London designates 19 beds to advanced disease cancer patients</td>
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<tr>
<td>1910</td>
<td>Our Lady’s Hospice for the Dying, Dublin.</td>
</tr>
<tr>
<td>1924</td>
<td>Dr Herbert Snow, Cancer Hospital, Brompton, London, The Palliative Treatment of Incurable Cancer, with an Appendix on the Use of the Opium Pipe, and “Opium and Cocaine in the Treatment of Cancerous Disease.” BMJ.</td>
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<td>1929</td>
<td>Calvary Hospital for the Dying, New York City (after “Calvaires” concept)</td>
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<tr>
<td>1930</td>
<td>Cancer Hospital, Brompton, London designates 19 beds to advanced disease cancer patients</td>
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<tr>
<td>1935</td>
<td>Brompton’s Cocktail used every 4 hours at St Lukes Home for the Dying</td>
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<tr>
<td>1952</td>
<td>Marie Curie Memorial Foundation: Cancer Care homes</td>
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<tr>
<td>1952</td>
<td>Marie Curie Memorial Foundation: Cancer Care homes</td>
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<tr>
<td>1957</td>
<td>Dr Cicely Saunders opens St Christopher’s Hospice, Sydenham, London.</td>
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<tr>
<td>1964</td>
<td>C.M. Parkes, psychiatrist: Bereavement Research</td>
</tr>
<tr>
<td>1965</td>
<td>The Institute, Yale University, Saunders, Ross, Wall: Care for the Dying.</td>
</tr>
<tr>
<td>1974</td>
<td>The Connecticut Hospice, New Haven Connecticut, started as Home Care service</td>
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<tr>
<td>1975</td>
<td>Balfour Mount started Palliative Care Service in The Royal Victoria Hospital, Montreal.</td>
</tr>
<tr>
<td>1978</td>
<td>The Connecticut Hospice opens nation’s first inpatient hospice unit (44 beds ...just like St Christopher’s Hospice)</td>
</tr>
<tr>
<td>1983</td>
<td>U.S. Congress: Medicare Hospice Benefit</td>
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<tr>
<td>1987</td>
<td>Royal College of Medicine (England) recognizes palliative medicine as a Specialty</td>
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<tr>
<td>1991</td>
<td>Cruzan v. Director, Missouri Department of Health,</td>
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<tr>
<td>1994</td>
<td>Dr. Jack Kevorkian, Oregon Death and Dignity Act</td>
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<tr>
<td>1995</td>
<td>SUPPORT study</td>
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<tr>
<td>1996</td>
<td>AHPM: Board Certification for Hospice/Palliative Medicine</td>
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<tr>
<td>1997</td>
<td>Institute of Medicine Report</td>
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<tr>
<td>2001</td>
<td>National Report: Transforming Death in America</td>
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<tr>
<td>2004</td>
<td>National Institute of Health: Consensus Report on End-of-Life Care in America</td>
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<tr>
<td>2005</td>
<td>The Terry Shiavo Case</td>
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<tr>
<td>2006</td>
<td>American Board of Medical Specialties (ABMS): Designation of Hospice/Palliative Medicine as a “Sub-Speciality”</td>
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<tr>
<td>2007</td>
<td>American Counsel of Graduate Medical Education (ACGME) begins accreditation for HPM Fellowships</td>
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<tr>
<td>2010</td>
<td>62 accredited HPM Fellowship Programs nationwide</td>
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</table>
Palliative Care and Hospice

**Palliative Care**
- any time in disease process
- acutely-ill hospitalized pts
- chronic-debilitated

**Hospice**
- 6 month expected survival

**Ongoing disease-modifying treatment**
Principles and Culture
“If you listen carefully to your patients they will tell you not only what is wrong with them but what is wrong with you.”

Walker Percy MD, Love in the Ruins 1971
Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments
Studies of patients with serious illness report increasing desire for aggressive therapies as health status declines.

Fried et al. Arch Intern Med 2006;166:890-895
Median Life Expectancy Over the Years

30,000 BC
1000 BC
1800
1900
1950
1970
2000

Modern Sanitation
Antibiotics/Immunizations
Modern Medicine

0
10
20
30
40
50
60
70
80
90
Dying Then and Now

Then (1901)

– Death typically followed a short period of rapid clinical deterioration in the setting of an acute unpredictable infection in an otherwise healthy adult or child.

Now (2010)

– Death typically occurs in adults following a long period of progressive functional decline and loss of organ reserve accompanied by specific disease processes.

“Rectangularization” of the Mortality Curve: Change in the proportion of a cohort to survive to a given age without experiencing morbidity, disability or mortality. (Manton, Soldo, 1992)

Compression of Morbidity Theory: The number of years that a group of older adults can expect to live with the debilitating effects of illness or disability may be reduced in future cohorts. (J.F. Fries, 1980, 1992)
Death in America

- Approx. 2.4 Million Deaths/ Year*
- Approx. 1.5 Million Medicare Hospice Benefit recipients / year**
  - Approx 1.8- 2.0 Million Individuals could benefit from Hospice/year
  - Eventual Hospice Penetration: Approx. 75%

*National Registrar (2002)
**NHPCO (2008 National Dataset)
Death in America

- Heart disease: 28.5%
- Malignant neoplasm: 22.8%
- Cerebrovascular disease: 6.7%
- COPD: 5.1%
- Accidents: 4.4%
- Diabetes: 3.0%
- Pneumonia: 2.7%

CDC (2002)
Death in America

• Consistently Americans, when asked prefer to die in their home. (85%-90%)

• Death in Institutions
  – 1949 : 50% of patients
  – 1958 : 61%
  – 1980 : 74%
  – 2001 : 77% (53% in acute care hospitals, 24% in nursing homes)
  – Estimation: 2010: 40% of Deaths in America will occur in a Nursing Home.
    - 1.6 million Americans live in Nursing Homes.
    - 90% of these people are over the age of 65.
    - 5.3 million SNF residents projected by 2030.
Site of Death
Kentucky (1989 – 2001)
Chronic Illness in the Elderly Typically Follows Three Trajectories

1. Mostly cancer
   - Short period of evident decline

2. Mostly heart and lung failure
   - Long-term limitations with intermittent serious episodes

3. Mostly frailty and dementia
   - Prolonged dwindling
An 81 y/o man with moderate-severe dementia (Fast 6e), prostate cancer, heart failure, and recurrent infections. His 78 y/o wife of 61 years feeds him at home with noted weight loss and decreased swallowing. He is treated with bisphosphonates, antipsychotic medications, an ACE inhibitor, a beta blocker, and judicious use of diuretics. He presents to the ER with septicemia, loss of consciousness, heart failure and dyspnea. He is admitted to the ICU with a “Full Code” order.

What are the important issues?
Is this patient terminally ill?
The Old Model: The Cure - Care Mode

Life Prolonging Care

Disease Progression

Palliative / Hospice Care

Do Everything

There is Nothing More We Can Do

Comfort Care Only

Death
A New Model: Integrating Palliative Care

Disease Modifying Therapy
Curative, or restorative intent

Diagnosis

Palliative Care

Hospice

Life Closure

Death & Bereavement

Do Everything AND Palliate

Curative, Palliative and Life-Extending Efforts

Comfort, Palliative Care and Dignity
The Nature of Suffering and the Goals of Medicine

The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians’ failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.

The Last Years of Life: Death Is Not Predictable

Covinsky et al. JAGS 2003;
Typical Hospice Patient...

Patient with advanced cancer and/or end-stage system failure.

Primary caregiver in the home.

Length of stay with hospice is < 1 month.

Equipment needs:
- Hospital bed, oxygen, bed-side commode, walker, wheelchair, suction apparatus.

Medical supplies:
- Chucks, diapers, dressings, mouth/skin care, Palliative drugs.
Typical Hospital Patient
Patient Bob
What usually happens

- 82-year-old with hypertension, diabetes, renal failure, respiratory failure, vision loss.
- Cycle of health crises- falls, fractures, pneumonia
- Hospitalized two times in 9 months
- Home with Medicare-HH, discharged from homecare after 4 weeks- new crisis- repeat hospitalization
- In pain, symptoms not managed, stuck in ICU, intubate / extubate, long hospital stay, resulting in progressive deconditioning, weakness, functional decline
- Not ready for hospice but in need of more support in hospital and ongoing transition management and care coordination at home
Bob Jones:
What could happen (if survival)

- Palliative care consultation for:
  - Pain and symptom relief- facilitates success of rehabilitation, reduces hospital length of stay
  - Patient/family discussions re needs/goals, advance care planning
  - Placement needs assessment
  - Identification of on-going support services at home/NH
  - Plan for coordination and monitoring after home care ‘skilled need’ terminates
  - Support for gradual/or rapid transition to hospice when illness progresses to terminal stage
Everybody with serious illness spends at least some time in a hospital...

- 98% of Medicare decedents spent at least some time in a hospital in the year before death.

- 15-55% of decedents had at least one stay in an ICU in the 6 months before death.

Dartmouth Atlas of Health Care 1999
Palliative Care

- The patient’s perspective
- The clinician’s perspective
- The hospital’s perspective
The patient perspective

For patients, palliative care is a key tool to:
- relieve symptom distress:
  - pain, nausea, dyspnea, anxiety, depression, fatigue, weakness
- navigate a complex and confusing medical system
  • understand the plan of care
  • help coordinate and control care options
  • “Goals of Care”
- provide practical, emotional and spiritual support for exhausted family caregivers.
- allow simultaneous palliation of suffering along with continued disease modifying treatments (no requirement to give up curative care).
The clinician perspective

For clinicians, palliative care is a key tool to:

- manage day-to-day pain and distress of highly symptomatic and complex cases, 24/7, thus supporting the treatment plan of the primary physician
- handle repeated, intensive patient-family communications, coordination of care across settings, comprehensive discharge planning
- promote patient and family satisfaction with the quality of the care provided.
The hospital perspective

For hospitals, palliative care is a key tool to:

– effectively treat the growing number of people with complex advanced illness
– provide service excellence, patient-centered care
– increase patient and family satisfaction
– improve staff satisfaction and retention
– meet JCAHO quality standards
– rationalize the use of hospital resources
  • increase capacity, reduce costs.
Burden of Care

Growth in Medicare enrollment and spending

- Enrollment, in millions (left scale)
- Spending, in billions (right scale)

Sources: Centers for Medicare and Medicaid Services;
Final Days

Unlikely Way to Cut Hospital Costs: Comfort the Dying

Palliative-Care Unit Offers Painkillers and Support, Fewer Tests, Treatments
“Well, it’s not a good sign, that’s for sure ...”
Theory for Prognostic Model

- Pathological Findings
- Clinical Findings
- Psychosocial Factors
- Diagnosis
- General Prognosis
- Individual Prognosis
- Therapy
- Co-morbidities

Adapted from Vigano 2000
# Hospice Top 10 Admission Diagnoses

<table>
<thead>
<tr>
<th>Diagnoses in 1993</th>
<th>1995</th>
<th>2000</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung cancer</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>3</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>4</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>COPD</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Colon Cancer</td>
<td>6</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Pancreatic Cancer</td>
<td>7</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>CVA</td>
<td>8</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Recto-Sigmoid Cancer</td>
<td>9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>10</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Debility Unspecified</td>
<td>-</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Failure to Thrive</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Senile Dementia</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
</tbody>
</table>
US Hospice Patient Growth 1982 - 2006
US Hospice Provider Growth 1990 - 2006
Growth in **Hospital-Based Palliative Care Programs**

( AHA Annual Survey, 2000-2004)
U.S. Hospital-Based Palliative Care Programs
(AHA Survey 2004)
“I don’t want to achieve immortality through my work. I’d rather achieve it by not dying.”

Wood Allen
The Big Question for US!

“Should Public Policy separate Palliative Care from Hospice Care?”
Future Challenges and Perspectives
The Big Changes

- **Hospice**
  - Medicare Hospice Benefit payment changes
  - F2F
  - Hospice Medical Director “Certification”
  - AIMS
  - More Regulation
  - PA’s as physician extenders

- **Palliative**
  - Joint Commission “Certification “ of hospital programs
  - 2012: End of “grandfathering” for Board certification
On the Horizon

• **New/Added Models of Care**
  – Concurrent care (Wyden legislation)
  – Disease Management
  – The Medical Home
  – Hospice / Palliative Care consult services
• Preserving Hospice in the Nursing Home?
• Rural issues
• Pediatric Palliative Care Initiatives
• How does a Hospice afford a Hospice Physician?
How Do We as Physicians/NP’s/PA’s Continue to Develop the Field?
Evidence-Based Science

Research \hspace{1.5cm} \textbf{Evidence-Based Practice}

Clinical Experience
Five Practical Steps to **BUILDING** Clinical Excellence

1) Develop Evidence–Based Standards.

2) Apply the Standards.

3) Measure the Standards.

4) Change the “Culture”.

5) Go back to step one and continue to build Clinical Excellence.
Lessons in Building

• Be proud of what you are building.
• It takes a Team.
• Use materials that are “enduring” and easy to use.
• Easy instructions for all to follow.
• Lead and mentor the builders.
HPM Essential Needs

- Modern, “Old-fashioned” Clinician
- “Artful”, Scientific Communication
- “Empathetic” Bedside Care
- “Humble” Assertive Leadership
- “Strong” Community Advocacy
Who will be our patients?

Who will provide the care?
- Labor availability
- Family Caregivers
- New roles
- Healthcare Reform
- Nursing Care Centers

How will care be different?
A Health Care Paradigm

ARE YOU READY TO LEAP INTO 21ST CENTURY HEALTH CARE?

“Pull the Plug.”
or
“Plug in.”
or
“Which Plug?”
or
“When, Where, and How?”
<table>
<thead>
<tr>
<th><strong>BOL and EOL National Statistics</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong># of Live Births in U.S. (2003)</strong></td>
</tr>
<tr>
<td>NVSR, Vol 54, No 2</td>
</tr>
<tr>
<td><strong># of Deaths in U.S. (2003)</strong></td>
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<tr>
<td>NVSR, Vol. 54, No 13</td>
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</tbody>
</table>
# Human Resource Statistics (MD/DO)

## # of Ob/Gyns (2003)

| # of Ob/Gyns (2003) | 41,916*  
|                    | (8383 Non- Obstetrical Care)** |
|                    | *AMA Physician Characteristics and Distribution the US.Chicago. 2004  
|                    | **2003 Profile of Ob/Gyn Practice. ACOG |

## # of Hospice /Palliative Doctors (2003)

| # of Hospice /Palliative Doctors (2003) | ~4000-6000 Hospice Doctors*  
|                                          | ~120 Palliative Medicine Graduates?**  
|                                          | 2145 ABHPM Diplomats*** |

*NHPCO/AAHPM approximations  
**AAHPM approximation  
***ABHPM (7-2-2006)
# US History of Hospice Medicine and Family Medicine

<table>
<thead>
<tr>
<th>Hospice Medicine</th>
<th>Family Medicine</th>
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<tbody>
<tr>
<td>Counterculture Movement of the 1960’s</td>
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</tr>
<tr>
<td>“Whole person “ concept (Yale, 1965)</td>
<td>“Focuses upon the whole man, who lives in a complex setting” (Millis Commission, 1966)</td>
</tr>
<tr>
<td>Patient–Family Centered Care (Connecticut Hospice, 1971)</td>
<td>“Physician aware of social, emotional, environmental factors of patient and family” (Folsom Report, 1966)</td>
</tr>
</tbody>
</table>
Why Doctors Practice Hospice Care

• Positive Motivations
  – Very rewarding
  – Positive post graduate training experience
  – Had a supportive hospice doctor during residency
  – Decreased malpractice risk

• Negative Motivations
  – Not enough time.
  – Not enough training.
  – Difficult emotionally.

VistaCare Internal Survey, 2006, n=124, employed / contracted Hospice doctors, 62% FP, 25% IM, 13% other (4 ONC, 3 ANESTH, 1 CARDS, 1 GI, 1 ER). *11 Certified Geriatric Sub-specialist, ** 42 Certified Hospice /Palliative Sub-specialists.
Amazon.com

Mission Statement:
“To constantly strive for customer ecstasy by providing an online store with the ability to obtain anything for them at the touch of a button.”

A Hospice Mission Statement: (Fictitious)

“To constantly strive for patient/family ecstasy through comfort by providing expert medical teams with the ability to obtain anything for them at the touch of a button.”
Thank you!