Hospice and Palliative Care

Overview of Hospice & Palliative Medicine

BUTH

Ogbomoso, Nigeria

17 June 2015

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WHO Definition of Palliative Care

- Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

WHO - Palliative Care

continued

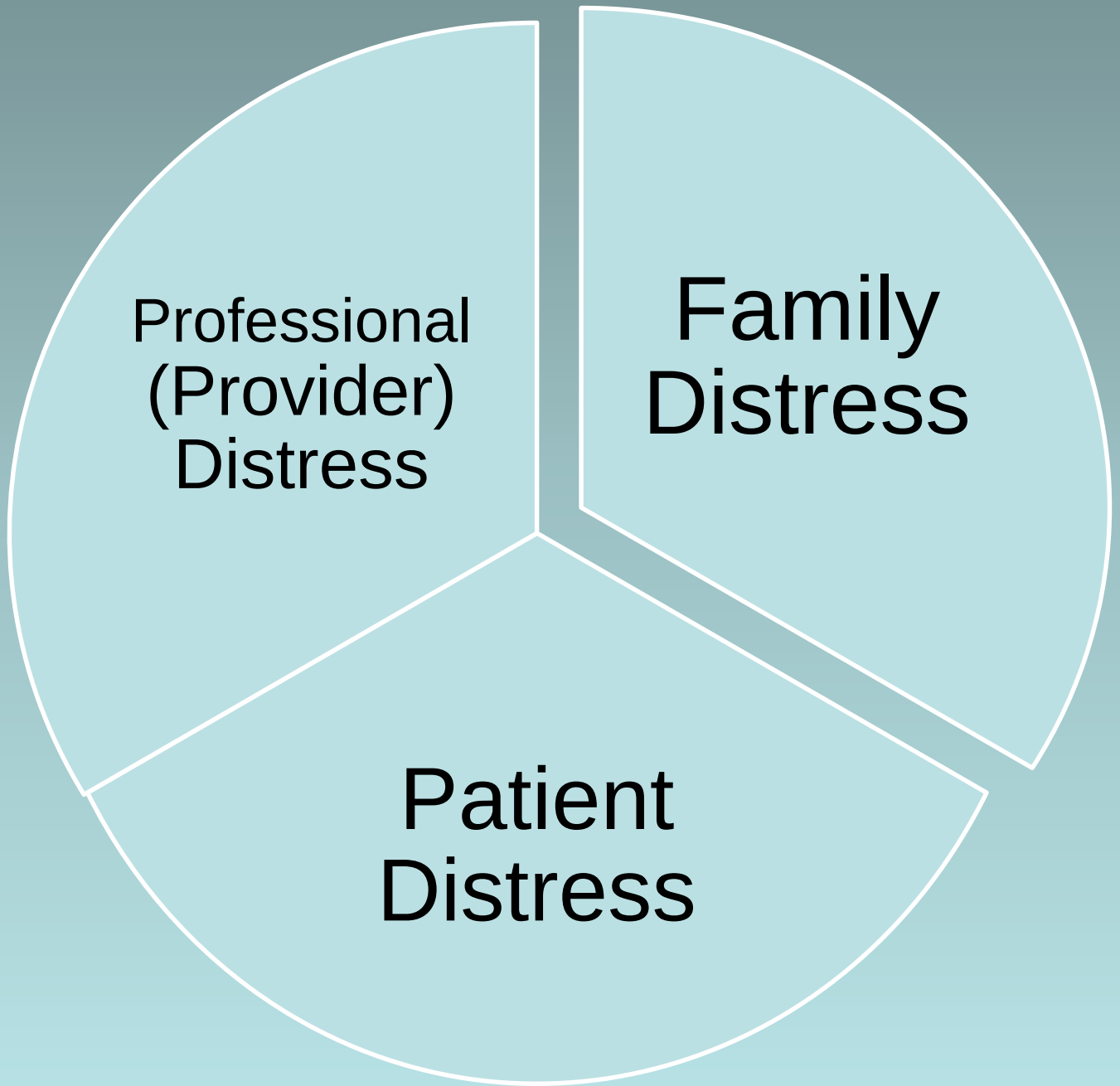
- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Hospice Definition

Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. The goal is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible. Aggressive methods of pain control may be used. Hospice programs generally are home-based, but they sometimes provide services away from home -- in freestanding facilities, in nursing homes, or within hospitals. The philosophy of hospice is to provide support for the patient's emotional, social, and spiritual needs as well as medical symptoms as part of treating the whole person.

Care Continuum

Suffering


Professional (Provider) Distress
Family Distress
Patient Distress

Some Basic Assumptions:

- A bunch of young, smart professionals in training who are anxious to learn;
- Issues of hospice & palliative care are unfamiliar issues;
- We can not cover the whole, so will cover this topically;
- Characterize the field by practical application examples

“ I’m always ready to learn but I don’t like being taught”

Winston Churchill

Fundamentals of Medical Education

- Knowledge
- Skills
- Attitudes

  - *ALL* are essential

Fundamentals of Medical Practice

It is suggested that the purpose of health care is to serve the community by continually improving health, healthcare, and quality of life, for the individual and the population, by health promotion, prevention of illness, treatment and care, and the effective use of resources, all within the context of a team

Fundamentals of Medical Practice

1. What is wrong with me? (diagnosis)
2. What does this mean for me? (prognosis)
3. What can be done for me? (care & management)
4. What can I/we learn from this patient? (research & effect on others)
5. What can be taught to others from this? (education)

Attributes of Medical Professional

1. High Standard of ethical practice.
2. Professional development.
3. Work within a team.
4. Patient centered care.
5. Attention to standards and outcomes.
6. Interest to change, improve, research, & develop.
7. Ability to communicate.

“You can change without improving, but you can’t improve without changing”

Leo Damkroger

- Change is inevitable
- Hospice care is changing a great deal
- “Palliative Care” is being incorporated in practice and concept
- The paradigm shift from curative to palliative is often difficult

Core elements

1. Physical aspects of care – disease process; symptom control
2. Psychosocial aspects of care – communication skills, psychological responses, grief, sexuality, personal feelings
3. Cultural issues
4. Spiritual issues
5. Ethical issues
6. Importance of team work
7. Practical aspects – eg. laws, regulations, resources, etcetera

Palliation literally means “to cloak or to cover.”
In medical terms, palliation simply means the patient feels better.
Pain and symptom control pre-empt all other concerns.
Simply focusing on non-curative treatment does not equate with Palliation.
Attempted reduction of symptoms and suffering in patients with advanced, chronic, end-stage, or terminal illness

- Prolonging Life vs Enhancing Life:
  - When does the patient feel better?
  - How much better will they feel?
  - How long will they feel better?
  - What duress must be tolerated until the feeling better occurs?
- Often, the best treatment is no treatment

- Recognizing “Terminal Decline” - Progression toward the end of life care:
  - collect quantifiable clinical data
  - acknowledge cultural influences
  - attempt to engage patient and family to understand treatment “futility”

Illness/Death Trajectories - 4

1. Sudden death
2. Typical for cancer
3. Typical for end-organ failure
    1. COPD, CHF, ESRD
4. Typical for dementia

Topics Identified for improved learning

- Education in Pain and Rx of opioids
- Controlling Nausea and Vomiting
- Counseling and Communication Skills
- Symptom control of non-cancer patients
  - CHF, COPD, ESRD, Dementia, +

Approach to Patient and Problems

- Expression of warmth
- Caring
- Empathy
- Respect
- Humanity

Holistic Assessments & Management

- Communication and personal insight
- Physical, psychological, social, spiritual assessments
- Ability to engage and talk with patients with cancer, and their carers
- Display insight
- Identify patient issues, hopes and fears
- Critical analysis of care, both medical & patient perspective

End of Life

*Attitudes towards death and dying

*Communication w dying pts

*Communication w family

*Grief & bereavement

*Social contexts of dying

*Psychological aspects of dying

*Religious and cultural aspects of dying

*The experience of dying

*Analgesics for pain Cancer; Chronic

*Symptom relief for advanced terminal disease

*End of life hydration & nutrition

*Other physical therapy

*HIV/AIDS

*Pediatrics

*Euthanasia, PAS

*Death determination

*ACP

“Any idiot can face a crisis. It’s day-to-day living that wears you out”

Anton Chekhov

Palliation in Heart Failure

- HF is the most common reason for hospital admissions in the elderly
- HF equates to high mortality and morbidity
- Prevalence: 2.3% in >45; 10+% in >70 and increasing
- HF is progressive in both cardiac and systemic manifestations

Palliation in HF

- Improvements in dx and tx decrease short term case fatality rates ... = increased longevity
- Approximately 5% mortality with acute admissions
- Most long term deaths are due to pump failure
- ~1/3 die suddenly

Palliation in HF

- HF is 5% of total USA $$$ =38Billion +
- Uncertainty regarding death, both timing and mode, is an important feature
- HF patients experience slow decline clinically and functionally, punctuated by periods of decompensation
- HF symptoms, therefore, are non-linear

Palliation in HF

- Symptom burden in final week of life:
  - pain = 78%
  - dyspnea = 61%
  - low mood = 59%
  - insomnia = 45%
  - anxiety = 30%
  - anorexia = 37%
  - constipation = 32%

Palliation and HF

- Outpatient concerns in HF
  - reduced ambulation
  - psychological distress
  - pain
  - fatigue
  - dyspnea
  - cough
  - decreased libido

Palliation in HF

- Other major concerns:
  - depression is masked by other sx's
  - cachexia [^ TNF , cytokines]
    - correlated with ^ Rt filling pressure
  - cognitive impairment
  - advanced care planning is dismal
    - low rate of AD's and DNR/AND's

Palliation in HF

- Maximize medical management
  - ACE-I
  - ARB (investigational as add-on)
  - Beta Blockers
  - Digitalis
  - Diuretics
  - Aldosterone inhibitors
  - Hydralazine/nitrates

Palliation and HF

- Other precautions:
  - tricyclics [neg inotrope,proarrythmic]
  - phenothiazines [prolong QTc]
  - NSAID’s
- Tidbit for symptom improvement:
  - USE Opiates for symptoms
  - Attention to systemic nature of HF

“PAIN IS STANDARD BUT SUFFERING IS OPTIMAL”

Robert Mitchell

Pearls in EOL for Pain

- Chronic Pain not acute pain
- Chronic Pain may be without signs
- Chronic Pain associated with behavioral changes

Pearls in EOL for Pain

- Remember non-pharmacological tx's
  - heat, cold, massage, positioning, accupuncture/pressure, behavior mod.
- Avoid Meperidine !!
- Use dosage conversion charts

Pearls in EOL for Pain

- Delerium can mimic pain
  - Moaning does not necessarily mean pain
  - Constipation, urinary retention, infections, etc. can cause delerium
  - If unsure, rotate opioid & tx delirium [haloperidol or ‘atypical’ = d.o.c.]

Pearls in EOL for Pain

- Opiod Neurotoxicicty
  - myoclonus
  - hyperalgesia / ‘pulling away’
  - hypervigilence
  - bad dreams: nightmares,hallucinations
  - Rx singular opioids if possible

Pearls in EOL for Pain

- Fentanyl patches may require s.q. fat, & must be afebrile
- in elderly, could be “a very expensive band-aid”
- transmucosal fentanyl = very fast

Pearls in EOL for Pain

- Conversions
  - use charts, calculate TOTAL dose
  - eg, MS oral:parenteral = 3:1
  - Hydromorphone(Dilaudid) = 5:1
  - Morphine:Methadone dependent on length of time and on dosages
    - Low= 3:1 High=20:1