

Policy Implications and Clinical Care at Life's End



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Objectives



- ⌘ Discuss current end-of-life (EOL) care
- ⌘ Current state of pain management
 - ☑ Access
- ⌘ Professional education
- ⌘ Recommendations for Public Policy

The Case of Ms. C.



- AC is an 81 year old women with advanced dementia who was admitted to MSH with a Stage IV pressure ulcer and fever. Over the next 2 months, she underwent multiple debridements of her pressure ulcer and experienced multiple febrile episodes all treated with intravenous broad-spectrum antibiotics. Several planned discharges were aborted because of the development of a new fever and her pressure ulcer progressed to encompass her entire sacrum with extension to bone. Her albumin, despite tube feeding, was 1.2 mg/dl – a prognostic indicator consistent with high mortality rates.

Current state of End-of-Life Care



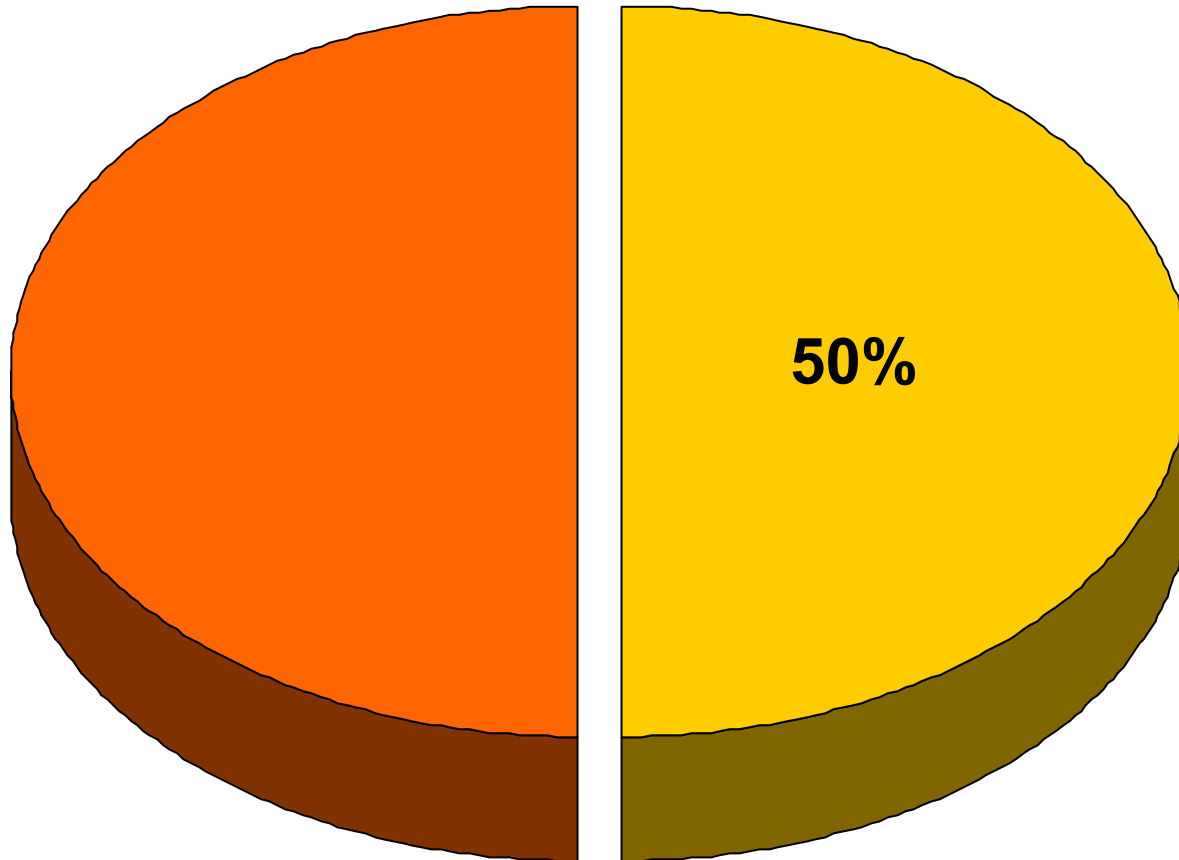
**The Study to Understand Prognoses
and Preferences for Outcomes
and Risks of Treatments
(SUPPORT)**

SUPPORT: Background

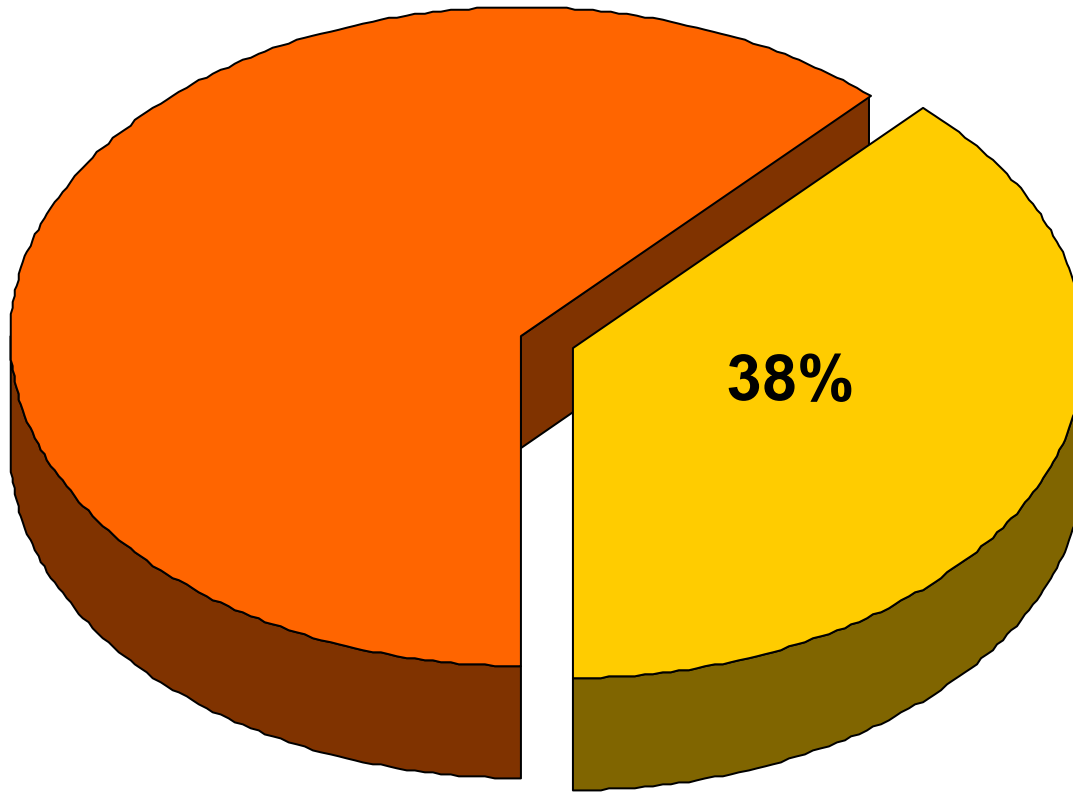


- ⌘ Controlled trial to improve care of seriously ill hospitalized patients
- ⌘ Multicenter study funded by RWJ
- ⌘ 9000 patients with life threatening illness
 - 1st phase- How people die in hospitals

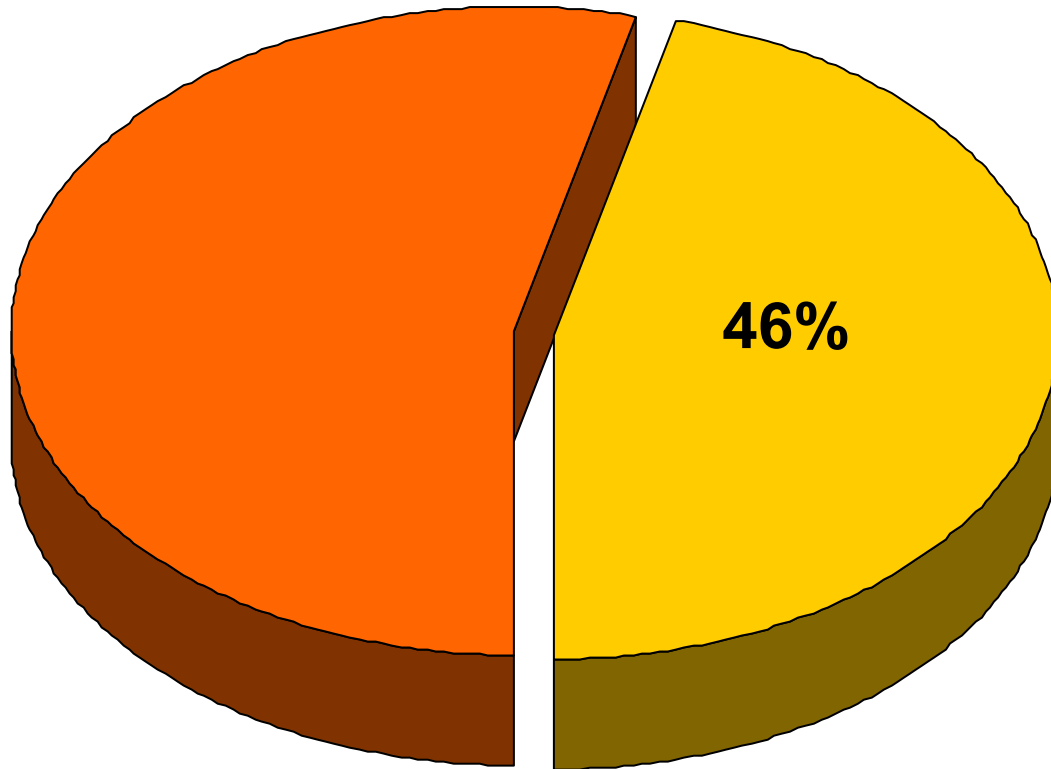
Experienced Moderate or Severe Pain at Least Half of the Time Within Their Last Few Days



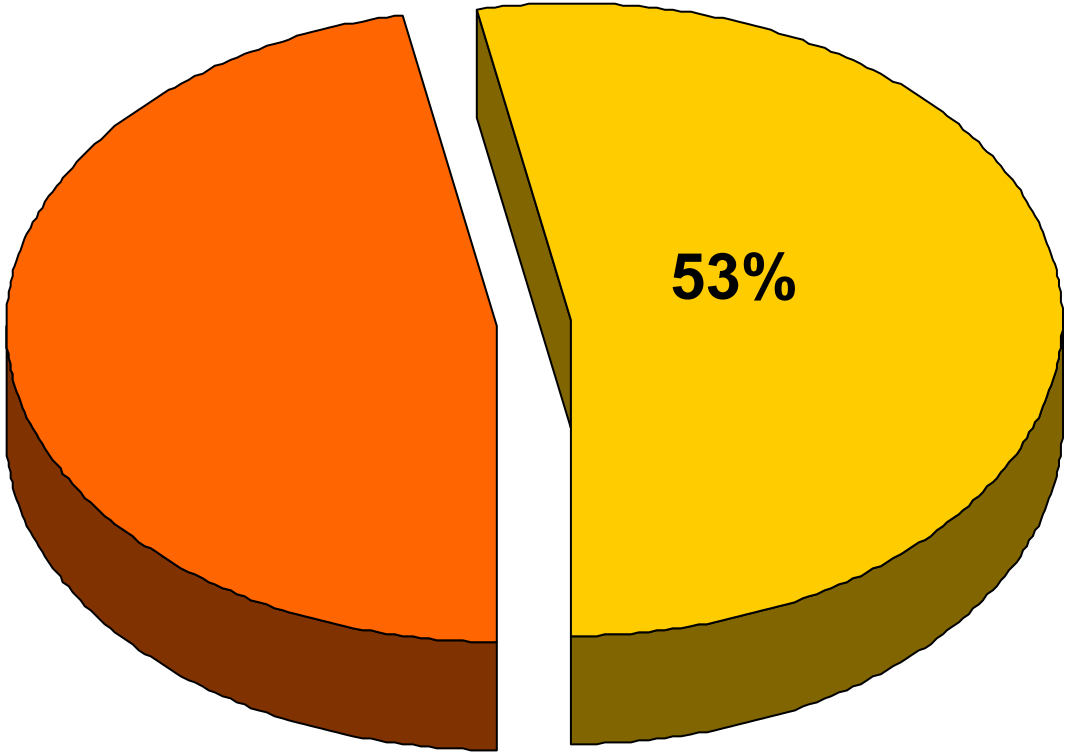
Prolonged Suffering: 10 or More Days in ICU, in Coma, or on Ventilator



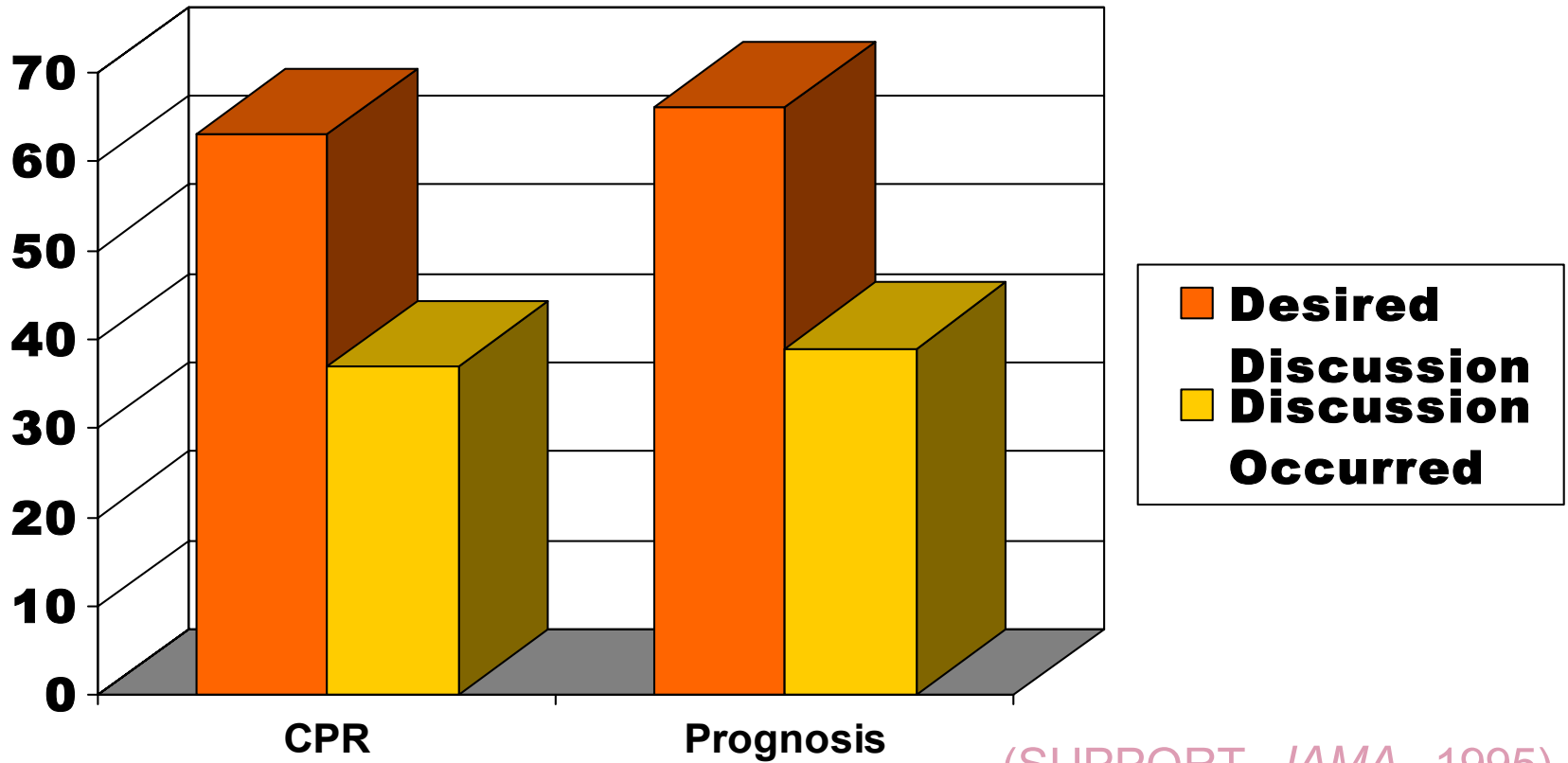
Late DNR Orders: Written Within 2 days of Death



Physician Did Not Understand That a Patient Wanted to Avoid CPR



Communication about End-of-Life Care



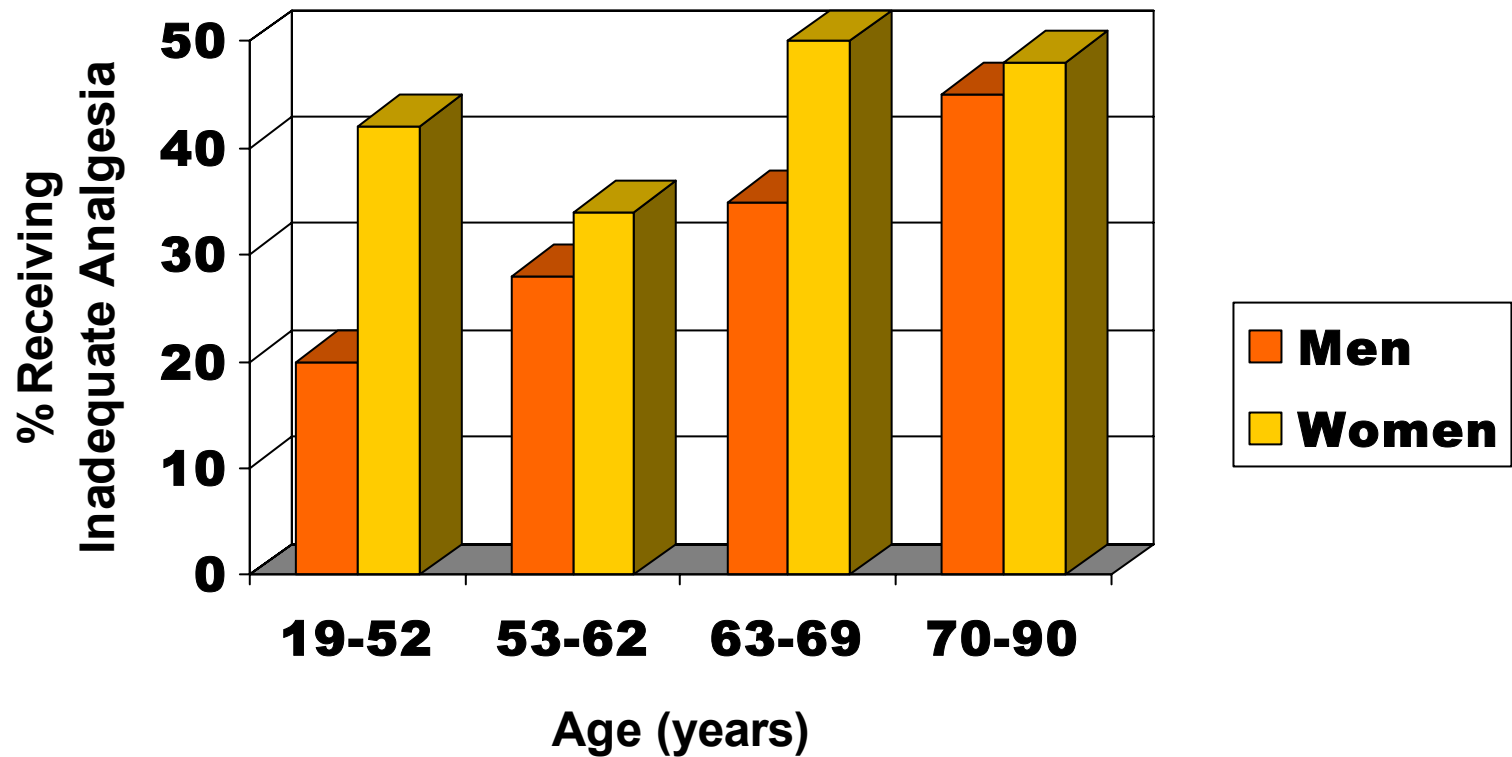
(SUPPORT, JAMA, 1995)

Current Science of Pain Management



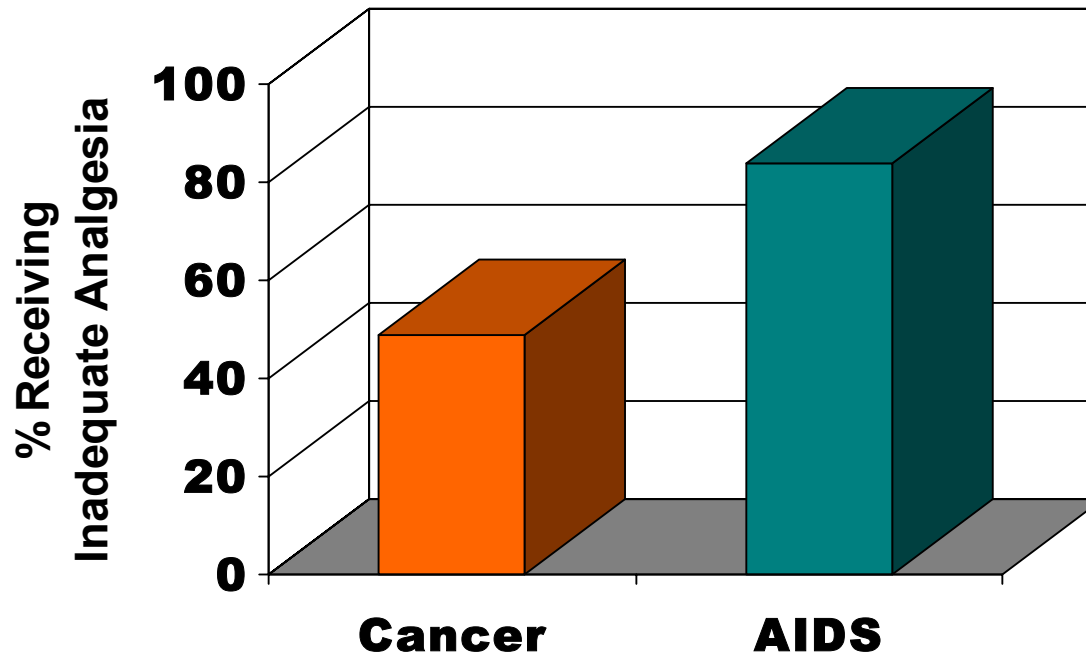
- ⌘ World Health Organization Analgesic Ladder validated in numerous studies and multiple settings
- ⌘ 70-90% of patients can achieve satisfactory pain relief following these guidelines
- ⌘ Alternative strategies are available for the remaining 10-30% with intractable pain

Undertreatment of Pain in 597 Ambulatory Cancer Patients



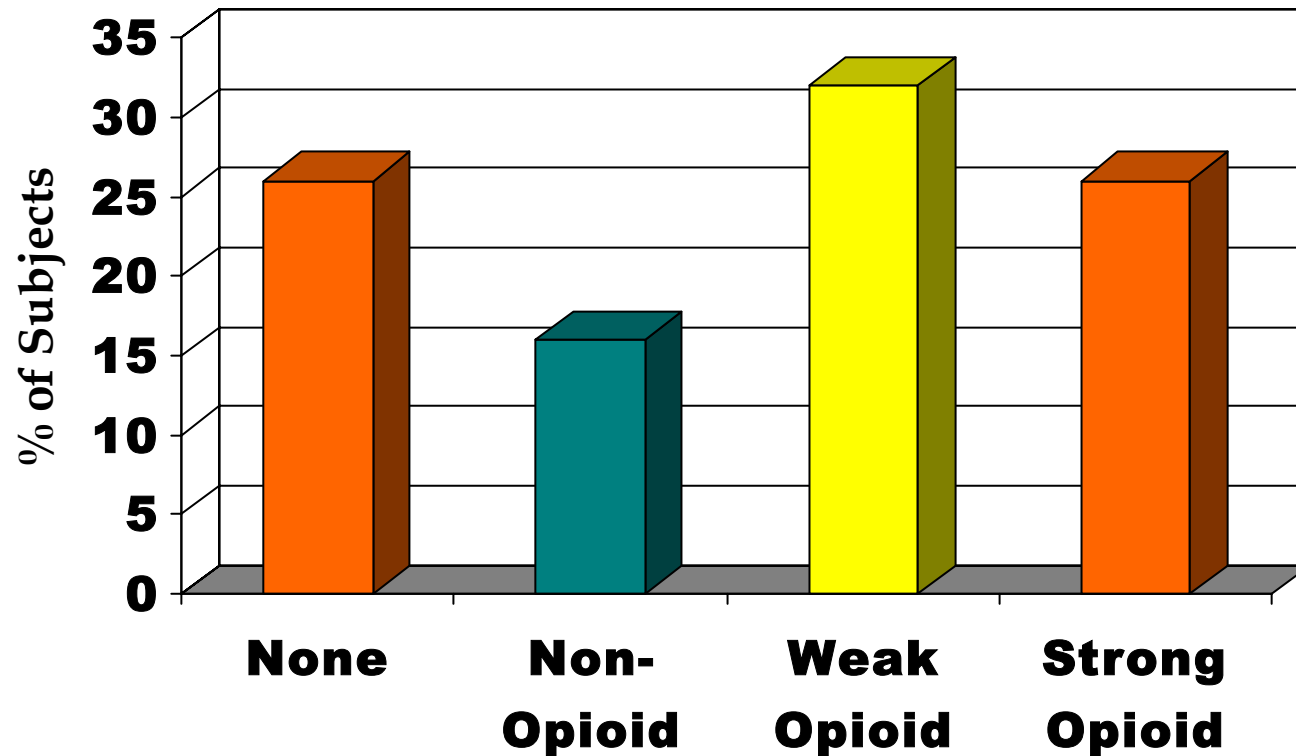
Cleeland et al., NEJM, 1994

Undertreatment of Pain in Ambulatory AIDS Patients



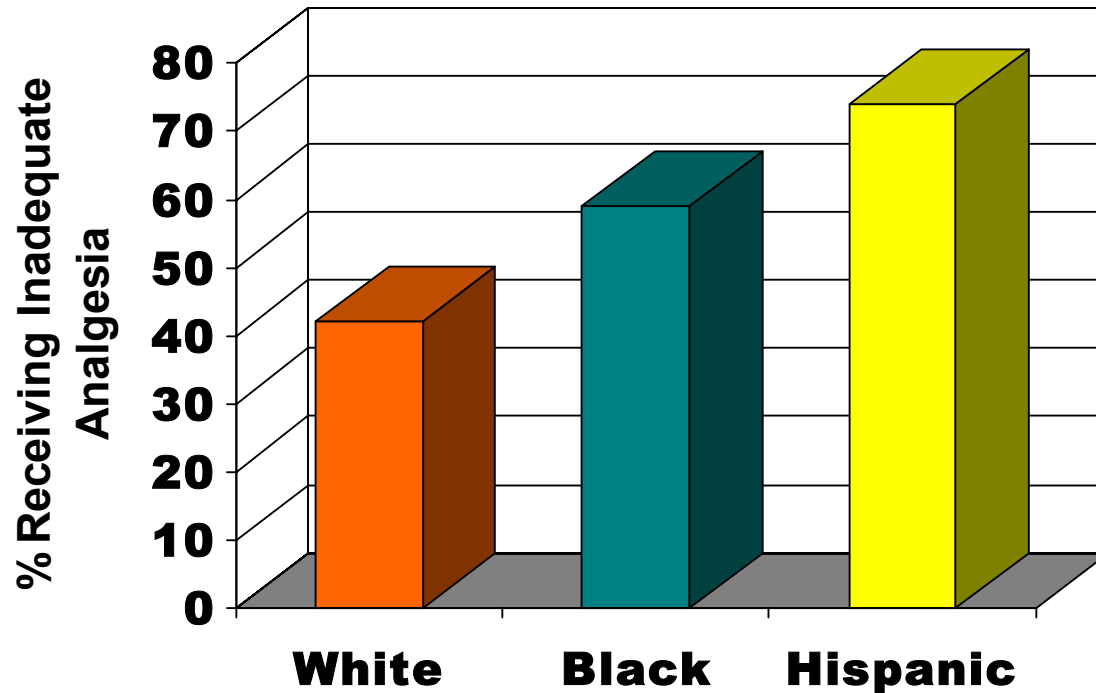
Breitbart et al, Pain 1996

Analgesic Prescribing For 4003 Nursing Home Patients with Cancer and Daily Pain



Bernabei et al. JAMA 1998

Undertreatment of Pain in Minority Patients with Cancer



Cleeland et al, Ann Intern Med 1997

Ethnicity and Analgesic Practice in the Emergency Department



- ⌘ Hispanics twice as likely to receive no analgesia compared to whites ($p=0.003$)
- ⌘ 74% of whites vs. 54% of blacks received analgesics ($p=0.01$)
- ⌘ Blacks were 66% more likely to receive no analgesics
- ⌘ Ethnicity was the strongest predictor of analgesic prescribing

Ethnicity and Physicians' Estimates of Pain Severity

- ⌘ 138 white and 69 Hispanic patients presenting to the ED with external trauma
- ⌘ No significant differences in pain assessment between 2 groups (39.8 vs. 39.0/100, $p=.86$)
- ⌘ No significant differences in physicians estimates of pain intensity (33.6 vs. 29.7, $p=.23$)

Summary



- ⌘ Minorities are significantly less likely to receive appropriate analgesia for a number of painful conditions
- ⌘ Physicians do not appear to underestimate pain in blacks and Hispanics as compared to whites
- ⌘ Patient/physician related barriers have not been will described



The New England Journal of Medicine

Established in 1812 as THE NEW ENGLAND JOURNAL OF MEDICINE AND SURGERY

VOLUME 342

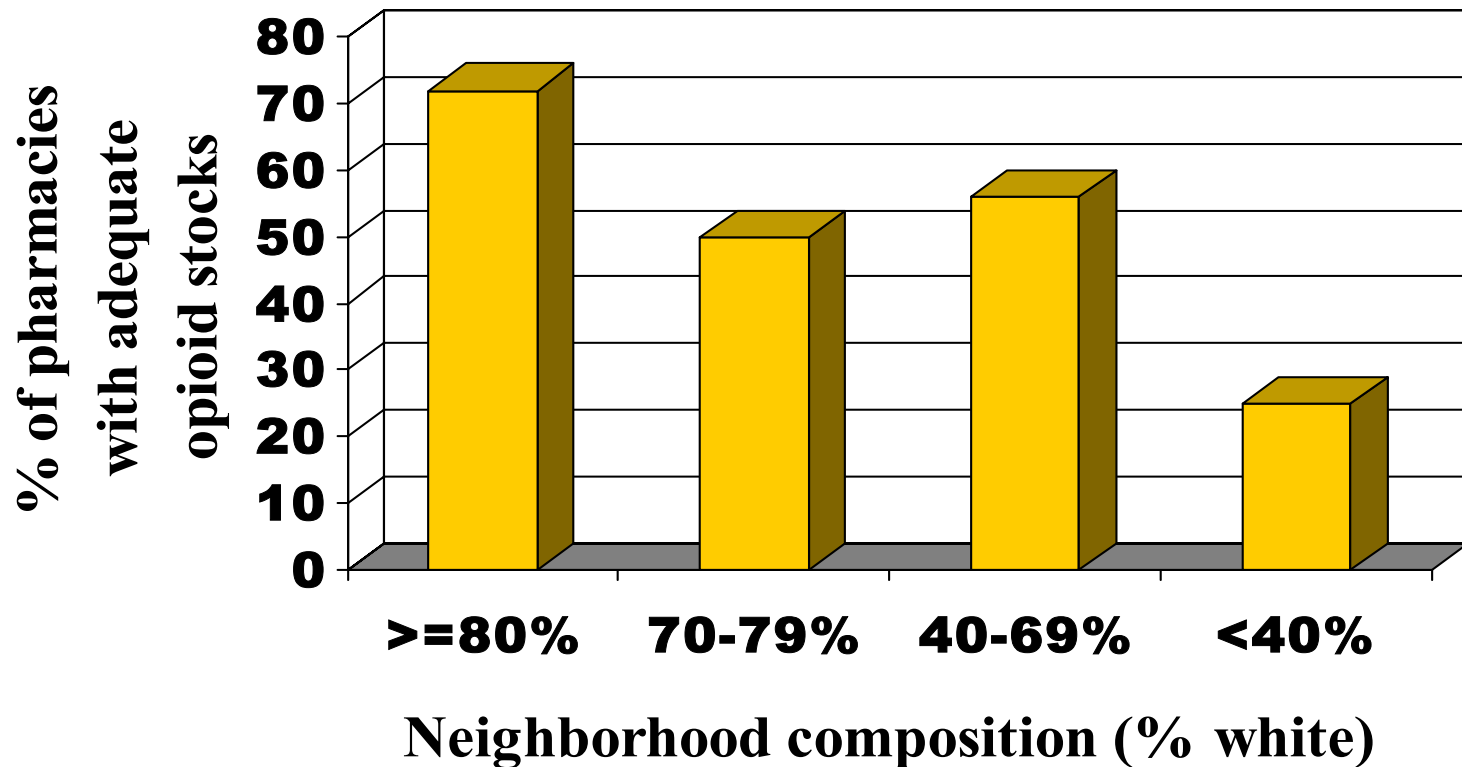
APRIL 6, 2000

NUMBER 14

**“We Don’t Carry That” — Failure
of Pharmacies in Predominantly Nonwhite
Neighborhoods to Stock Opioid Analgesics .. 1023**

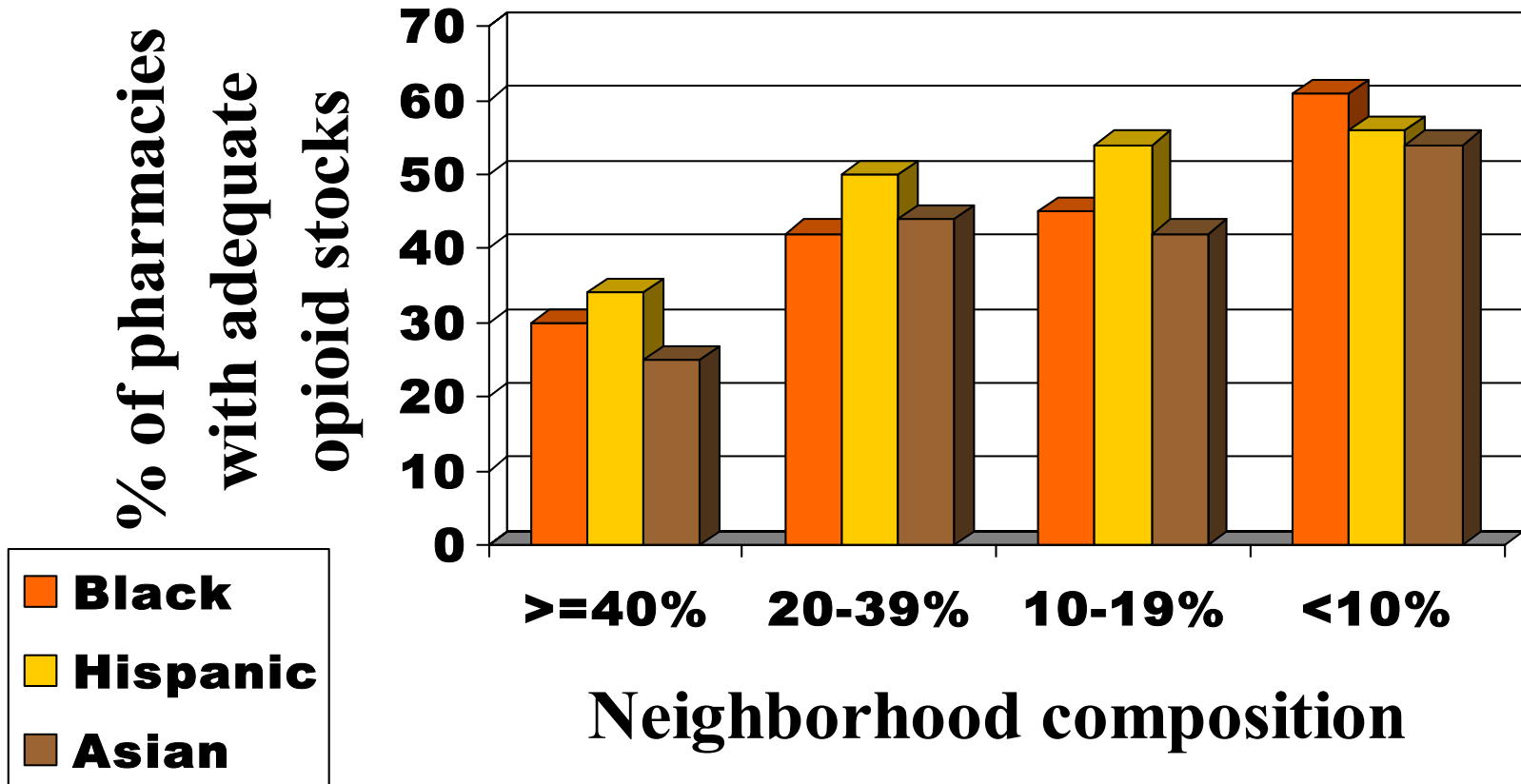
R.S. MORRISON, S. WALLENSTEIN,
D.K. NATALE, R.S. SENZEL,
AND L.-L. HUANG

% Of NYC Pharmacies with Adequate Opioid Stocks to Treat Severe Pain by Neighborhood Composition



Morrison et al, NEJM 2000

% Of NYC Pharmacies with Adequate Opioid Stocks to Treat Severe Pain by Neighborhood Composition



Morrison et al, NEJM 2000

The Problem...



- ⌘ Physician education
- ⌘ Physician – patient communication
- ⌘ Access to care for underserved

What should be taught?



- ⌘ Pain and symptom management
 - Knowledge
- ⌘ Doctor-patient communication
 - Attitudes
- ⌘ Better advance care planning

Deficiencies in medical education



- 74% of residencies in U.S. offer no training in end of life care
- 83% of residencies offer no hospice rotation
- 41% of medical students never witnessed an attending talking with a dying person or his family and 35% never discussed the care of a dying patient with a teaching attending

Billings & Block JAMA 1997;278:733.

Deficiencies in medical education con't



- ⌘ Half oncologists rate pain management as fair to very poor
- ⌘ 1998 survey showed only 30% responding oncologists report training as very helpful in terms of addressing the palliative care needs of people with cancer

The Good News



- ⌘ End-of-Life (EOL) education now REQUIRED in undergraduate medical education and strongly recommended in residency training
- ⌘ US Liaison Committee on Medical Education now requires clinical instruction include important aspects of EOL care
- ⌘ Accreditation Council for GME requirements
 - Int med and med subspecialties in 2000 should receive instruction in palliative care

The case of Ms. C., what happened?



- At the request of the nurse case manager, a palliative care consultation was requested 45 days into her hospitalization. The palliative care team met with the patient's two daughters and health care proxies. Both daughters revealed limited understanding as to their mother's underlying condition and her Alzheimer's disease.

...The case of Ms. C.,



- Two consecutive 90 minute family meetings with the involved daughters and the patient's granddaughter resulted in a greater understanding of her underlying illness, the development of a plan of care that included transfer to a nursing home, withdrawal of antibiotics, initiation of morphine for pain resulting from her pressure ulcers, initiation of spoon feeding for comfort, a DNR order, and a plan not to re-hospitalize the patient if she were to develop a fever.

...The case of Ms. C.,



- The patient was subsequently discharged 2 days later when a nursing home bed became available. A Hospice referral was made. The family expressed tremendous satisfaction with the resolution of her hospitalization and continued to visit her daily in the nursing home where she was reported to be interactive and comfortable until her death 2 months later.

Current system: Cure versus Care Model

Life
Prolonging
Care

Medicare
Hospice
Benefit

D

E

A

T

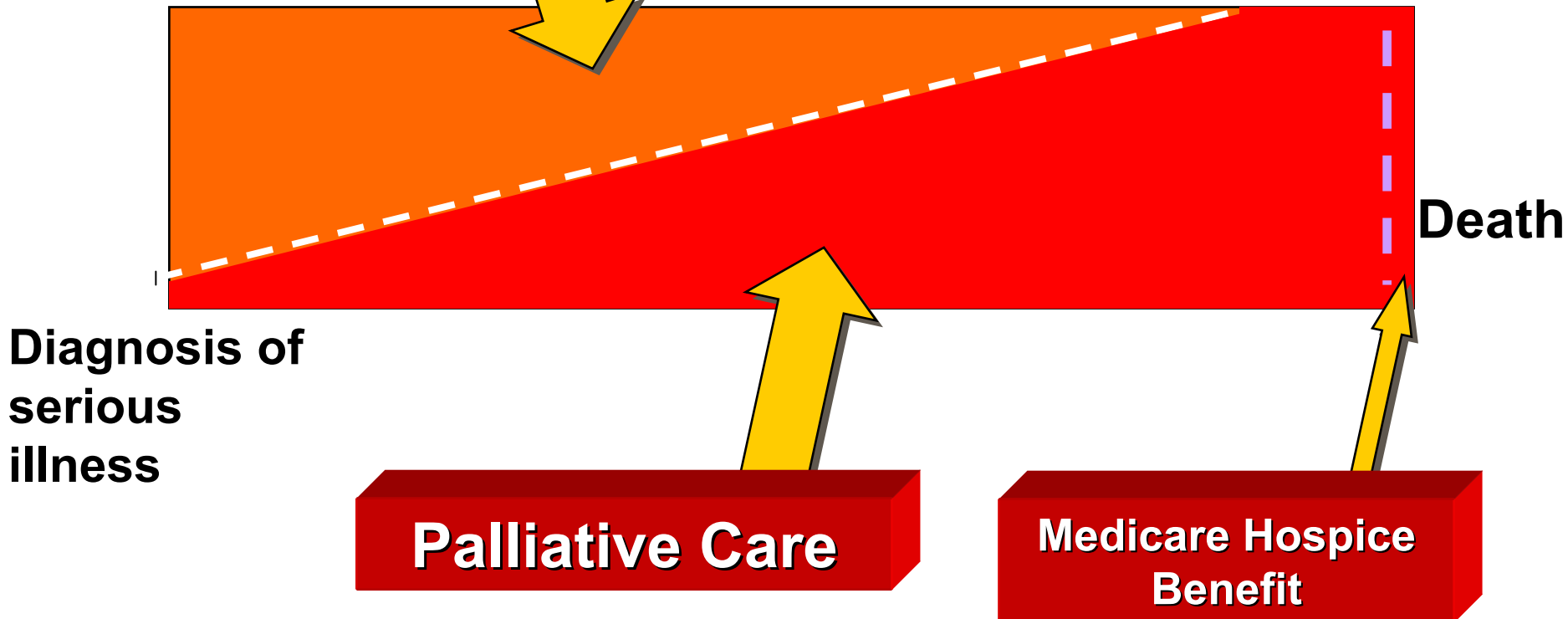
H

Disease Progression-years



Palliative Care's Place in the Course of Illness

Life Prolonging Therapy



Advise for Public Policy



- ⌘ Support improved physician education
- ⌘ Promote Hospice-Palliative care partnerships
- ⌘ Address issues of access
- ⌘ Demonstration projects

Frist-Kennedy Bill *Quality Cancer Care*