



PALLIATIVE CARE CASE OF THE MONTH

“Is She Hospice or Isn’t She?”
Kathleen Curran

Volume 12, No. 20

December 2012

Case: Mrs. M. is a very independent woman who was admitted to the hospital from a nursing home with acute respiratory failure. She was intubated and transferred from the ED to the ICU. In the middle of the night, the patient requested that the mechanical ventilation be removed because this care was not consistent with her goals and values.

Her past medical history included acute myelogenous leukemia, osteoporosis with a displaced shoulder fracture, new onset of atrial fibrillation and decompensated heart failure. She had not been agreeable to treatment for her hematological malignancy and she had been unwilling to seek medical care for her fracture. She had been admitted to the nursing home after a cardiac event, but she had a long history of rejecting medical attention. Her surrogate decision maker, her step-daughter, was at her side and agreed that this treatment plan was not consistent with the patient’s known values and beliefs.

Mrs. M. was extubated and palliative care was consulted to assist with the transition to hospice. Upon meeting Mrs. M, the palliative care nurse practitioner found a very anxious, distressed 79 year old woman who clearly expressed her wishes to be allowed to have a natural death. She was experiencing severe dyspnea, agitation and fear. Despite her symptoms, the patient was able to verbalize her request for communion and transfer to an inpatient hospice facility. A comfort medication plan was initiated which included morphine and lorazepam and the patient began to experience symptomatic relief. The hospice chaplain was able to provide communion for the patient in the ICU.

The patient was transferred to a quiet regular room where she was treated for her symptoms as our transfer plan was initiated.

There was concern that the patient might not survive the ambulance transfer to hospice, so we decided to admit the patient to inpatient hospice at the community hospital. As the patient’s symptoms were controlled she began to want to spend more time enjoying her family. She said to her nurse, “I don’t want hospice now. I want to live.”

Her primary physician team was called and the question was asked, “Is she hospice or isn’t she?”

Discussion: The patient was clearly medically eligible for hospice. Her underlying medical conditions met the CMS criteria for hospice. Her acute respiratory crisis and associated dyspnea made her appropriate to receive inpatient level of care to manage her symptoms. The question is why did she decide that she wanted to reject hospice. It might be that after her severe symptoms were made more tolerable, she reconsidered what she was willing to do to spend more time with her family.

Given the patient had consistently said that she did not want treatments focused on prolonging her life, this change in heart was confusing. The palliative care nurse practitioner was curious about what led to this change and thus, rather than focus on whether she was hospice or not, tried to understand her change of heart by asking her to “help them understand, what had led to her change of heart.”

Personal details in the case published have been altered to protect patient privacy.

For palliative care consultations please contact the Palliative Care Program at PUH/MUH, 647-7243, beeper 8511, Shadyside Dept. of Medical Ethics and Palliative Care, beeper 412-647-7243 pager # 8513, Perioperative/ Trauma Pain 647-7243, beeper 7246, UPCI Cancer Pain Service, beeper 644-1724, Interventional Pain 784-4000, Magee Women’s Hospital, beeper 412-647-7243 pager #: 8510, VA Palliative Care Program, 688-6178, beeper 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s page 958-3844. With comments about “Case of the Month” call Dr. Robert Arnold at (412) 692-4834.



The patient confided to the palliative care nurse practitioner that she had terminated a pregnancy when she was much younger, and she had not yet made her peace with God. She was terrified that she would go to hell when she died and she desperately needed to unburden herself of this fear.

After she received communion and talked to the hospice chaplain, she was able to consider that she was not going to hell, and this decreased her fear of death. She was able to spend time with her family, enjoy the time and be at peace with whatever happened next.

Her condition eventually stabilized enough for her to be transferred to an inpatient hospice facility where she died in the company of her diverse family and friends. A memorial service was held at that facility and her life was honored by her close circle of acquaintances and the staff who had completely and holistically cared for her. The hospice chaplain who provided communion for her in the Community Hospital ICU led the service and remarked about the circle of her life and her ability to forgive herself.

MM had made a conscious decision to stop life prolonging treatment and she was able to communicate what she needed so that she could find spiritual peace. The palliative care nurse practitioner and the hospice staff were able to listen to her non-judgmentally and advocate for her needs. They helped her complete her tasks at the end-of-life tasks so she could die in spiritual peace.

References:

1. Back A, Arnold R, Tulsy J; Mastering Communication with Seriously Ill Patients. Transitions to End-of- Life Care, Uncovering the Big Picture Amidst Fear and Failure; Cambridge University Press 2009; Pg. 108
2. Saunderson C A; End of Life “A Nurses Guide to Compassionate Care “; Psychological, Spiritual and Cultural Care; Lippincott, Williams & Wilkins 2007; Pg. 78-97
3. Byock I; Dying Well Peace and Possibilities at the End of Life; Riverhead Books 1997

Personal details in the case published have been altered to protect patient privacy.

For palliative care consultations please contact the Palliative Care Program at PUH/MUH, 647-7243, beeper 8511, Shadyside Dept. of Medical Ethics and Palliative Care, beeper 412-647-7243 pager # 8513, Perioperative/ Trauma Pain 647-7243, beeper 7246, UPCI Cancer Pain Service, beeper 644 –1724, Interventional Pain 784-4000, Magee Women’s Hospital, beeper 412-647-7243 pager #: 8510, VA Palliative Care Program, 688-6178, beeper 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s page 958-3844. With comments about “Case of the Month” call Dr. Robert Arnold at (412) 692-4834.