



Case: AM is an 81 year old white male diagnosed with prostate cancer in 2004. Treatment included hormone therapy with good results and control of symptoms until April of 2006. At that time, he experienced increasing back pain and underwent a decompressive laminectomy. He recovered at home with little improvement. He was admitted to the hospital in June with persistent pain and left groin cellulitis.

A diagnostic workup revealed suspicious areas of metastasis in the liver, lungs and pelvis. AM continued to experience increased pain, limited movement and he suffered with significant deconditioning. He was transferred to a transitional care unit with goals of improved pain control, completion of radiation therapy, physical rehabilitation, and ultimately, to return home. At the time of the transfer, he was prescribed several medications, including medications for treatment of prostate cancer and associated symptoms. The Palliative Care Service was consulted to assist in pain control and symptom management.

Discussion: The first encounter with AM and his wife was devoted to a lengthy episode of active listening. In order to gain his trust, we needed to understand his history and the man he was before becoming so ill and losing control. He spent significant time engaged in life review. An engineer by trade, he emigrated here with his young wife over fifty years ago. Married 57 years, their devotion and connection to each other was evident. It was clear that all care decisions would require the consent of the other.

AM had specific requests regarding his goals of care. Yet, he was eloquent in telling us that he was not clear in his understanding of how to achieve these goals and was feeling overwhelmed by “the system”. He was confused by the numerous care providers and the perceived absence of those that were familiar to him, namely his oncologist and PCP who did not have privileges in the transitional care unit.

AM reported pain relief from opiates, yet was reluctant to take them as prescribed because of side effects. He and his wife described his behavior as “loopy” while taking the prescribed doses. He was not using breakthrough doses and was refusing anti-inflammatory agents. He and his wife insisted that the priority was to have “clarity of thinking”

rather than significant pain relief. AM was also concerned about the current status of his cancer. Radiation had not yet been effective and the pain was a constant reminder of his disease. He wanted to understand more about his prognosis and its implications for continued treatment. His most important goal was to try and get “just a little more time” with his wife.

In order to address his uncontrolled physical symptoms, we negotiated with him regarding his medications. We recommended a reduction in his opiate regimen based on his reports of adverse effects. We also suggested acetaminophen around the clock in an attempt to minimize the need for additional opiates. He and his wife agreed with our suggestions and felt empowered by participating in the care planning process.

To respond to his angst and anxiety regarding his cancer, we coordinated follow up with his oncologist and primary care physician. We communicated regularly with these physicians and provided AM with real time feedback regarding their insight into the plan of care. An outpatient visit with his oncologist proved to be pivotal in achieving his trust in the plan of care.

As AM continued to decline and additional cancer treatment was not possible, he and his wife struggled to accept the change in goals. Because AM was becoming less able to communicate and participate in care decisions, his wife desperately sought input from the physicians they had known the longest. We arranged for a meeting between the primary care physician and the patient’s wife and AM was transitioned to hospice care shortly thereafter.

As noted by Dahlin and Giansiracusa (2005) active listening is pivotal in the role of palliative care in order to fully understand and to meet the needs and treatment goals of those in our care. Active listening was the intervention that AM and his wife needed. Without this intervention, the goals of care may have been miscalculated to meet the needs of the team, versus the needs of AM and his wife.

Reference: Dahlin, C. M., & Giansiracusa, D. F. (2005). Communication in Palliative Care. In B.Ferrel & N. Coyle (Eds.), *Palliative Nursing* (2nd ed., pp. 67-93). New York: Oxford Press

For further information please contact the Palliative Care Program at PUH/MUH, 647-7243, beeper 8511., Shadyside Dept. of Medical Ethics and Palliative Care, 623-3008, beeper 263-9041, Perioperative/ Trauma Pain 647-7243, beeper 7246, UPCI Cancer Pain Service, beeper 644 – 1724, Interventional Pain 784-4000, Magee Women’s Hospital, 641-2108, beeper 917-9276, VA Palliative Care Program, 688-6178, beeper 296. For ethics consultations at UPMC Presbyterian-Montefiore, and Children’s call 647-5700 or pager 958-3844. With comments about “Case of the Month” call David Barnard at 647-5701.



The Institute to Enhance Palliative Care Receives \$300,000 in Support from The Heinz Endowments for Post-Graduate Medical Fellowship in Palliative Care

The University of Pittsburgh's Palliative Care Fellowship Program, which prepares medical professionals for careers in palliative medicine, will operate under a new name and be supported through a three-year, \$300,000 grant from [The Heinz Endowments](#) to the Institute to Enhance Palliative Care. As one of only nine accredited programs in the country that combines patient care experience with rigorous training in clinical research, the fellowship stresses communication, ethical and legal decision-making skills, as well as bereavement support and interdisciplinary team work associated with patient care. Its research component sets Pittsburgh's program apart from most other palliative care fellowships in the United States, and positions its graduates for leadership positions in this growing field.

The Heinz Endowments' grant, under which the fellowship will be named in honor of the late Senator H. John Heinz III, will provide vital bridge funding during the period leading up to official recognition of palliative medicine as a medical subspecialty. That designation will make the fellowship eligible for federal funding through the Medicare program. "It is impressive that Pittsburgh is ahead of much of the rest of the country in developing palliative care training and promoting it as a specialty," Howard Heinz Endowment Chairman, **Teresa Heinz**, said in announcing the grant. "We wanted to support the groundbreaking work with funding, but I personally wanted to support its mission through my late husband's name, since so much of his work in government was about supporting families through better medical care." The palliative care program is especially close, she said, to John Heinz's authoring legislation that provides for hospice services under Medicare. "The medical profession now recognizes the urgent need to address the palliative care needs of our rapidly aging population, and medical educators are racing to keep up," said David Barnard, Ph.D., professor of medicine and director of the Institute to Enhance Palliative Care.

The Institute to Enhance Palliative Care Hires New Staff Member

Paige Hepple joined the Institute team this summer as project coordinator. At the Institute she is focusing on project management, communications, proposal writing and development for the Institute and for the [Coalition for Quality at the End of Life](#) (CQEL), a consortium of the leading health care providers, insurance companies, professional organizations, and community groups in the Greater Pittsburgh region. Projects include advance care planning, community education, end-of-life care needs assessment, and initiatives to strengthen community-based research capabilities of palliative care researchers at the University. Ms. Hepple earned her BS in professional writing with additional concentration in nonprofit management from Slippery Rock University. Previously, she did writing, research, and project work for Pittsburgh-based nonprofit consulting firm [Dewey & Kaye](#).



New and Improved Institute Website

The Institute to Enhance Palliative Care's website has been improved and updated. It continues to be housed within the domain of the University of Pittsburgh's Division of General Internal Medicine. Please visit <http://www.dgim.pitt.edu/iepc/index.asp> to learn more about the Institute and all of the important things happening in palliative care at the University of Pittsburgh.

The [University of Pittsburgh Schools of the Health Sciences](#), in collaboration with [Family Hospice and Palliative Care](#), established the Institute to Enhance Palliative Care in 2003 to improve access to and quality of palliative care in western Pennsylvania. The Institute's mission is to educate health care providers, conduct research, raise awareness among the community, and advance public policies regarding palliative care.

For further information please contact the *Palliative Care Program* at PUH/MUH, 647-7243, beeper 8511., *Shadyside Dept. of Medical Ethics and Palliative Care*, 623-3008, beeper 263-9041, *Perioperative/ Trauma Pain* 647-7243, beeper 7246, *UPCI Cancer Pain Service*, beeper 644 – 1724, *Interventional Pain* 784-4000, *Magee Women's Hospital*, 641-2108, beeper 917-9276, *VA Palliative Care Program*, 688-6178, beeper 296. For ethics consultations at UPMC Presbyterian-Montefiore, and Children's call 647-5700 or pager 958-3844. With comments about "Case of the Month" call David Barnard at 647-5701.