The Integration of Palliative Care Into Medical Care

Dean Schuyler, MD, and John Franklin, MD

EDITOR'S NOTE

Through this column, we hope that practitioners in general medical settings will gain a more complete knowledge of the many patients who are likely to benefit from brief psychotherapeutic interventions. A close working relationship between primary care and psychiatry can serve to enhance patient outcome.

Dr Schuyler is a psychiatrist on the palliative care team at the Ralph H. Johnson Veterans Administration Medical Center in Charleston, South Carolina.

Dr Franklin is a geriatrician and internist on the palliative care team at the Ralph H. Johnson Veterans Administration Medical Center in Charleston, South Carolina.

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Corresponding author: *Dean Schuyler, MD, Geriatrics/Extended Care, Ralph H. Johnson Veterans Administration Medical Center, Charleston, SC 29401 (deans915@comcast.net).*

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Working as part of a palliative care medical team for a number of years has provided a continuing exposure to the landscape of medicine. Some elements of health care have changed. For example, the number of consultations to our team has increased. Some elements of training in health care, however, have remained the same. Some physicians think of palliative care only when their patients reach the end of life. This concept represents a loss for the patient and for his or her family as well.

Palliative care emphasizes the patient's comfort above all else. It captures the essence of what medicine ought to do well: diminish pain, enable sleep, enhance appetite, reduce anxiety and depression, and abort diarrhea and constipation. It could incorporate much that is taught in medical training[1]: diagnosis, history-taking, examination skills, and the importance of family meetings. It provides the basis for an interdisciplinary approach[1] to the patient. It can improve the quality of a patient's life and, at times, has been shown to prolong survival.[2]

Unfortunately, for some in medicine, who happen to think in terms of black and white, palliative care is juxtaposed with curative intent. Logically, palliative care should occur in parallel with a focus aimed at curing the underlying illness. It should begin at the time of diagnosis, not with the anticipation of death.

Skilled palliative care requires a willingness of the health care professional to form a relationship (engagement) with the patient. Formation of an effective treating relationship increases the likelihood that history-taking will be accurate and useful. Further, the likelihood of being told about the patient's complaints increases with the presence of an effective relationship.

The integration of palliative care into physician education has been a lengthy, uphill battle. A recent review[3] captured the process of teaching a new paradigm amid the fund of medical knowledge imparted to today's doctors. The case presented here highlights the value of a palliative care approach to a man with end-stage illness.

CASE PRESENTATION (DR FRANKLIN)

Mr A was a 78-year-old veteran who served in both the Korean conflict and the Vietnam War. He was referred to our Palliative Care Clinic by the cardiology service because of end-stage cardiac disease. He had a high symptom burden, which had been refractory to the full armamentarium of cardiac medications. He had been "doing fine" until the previous 6 months, when he had become increasingly symptomatic with progressive worsening function. His disease trajectory prior to referral included 4 hospital admissions in the previous 3 months. Medical comorbidities included hypothyroidism, diabetes, obstructive sleep apnea, chronic kidney disease, and paroxysmal atrial fibrillation. Complications of diabetes included neuropathy, nephropathy, and retinopathy. His symptom burden included worsening angina at rest, abdominal pain, insomnia, dyspnea at rest, and muscle pain in his legs, back, and shoulder. He also had lower extremity edema, weakness, fatigue, nausea, and constipation. He was independent in all activities of daily living and was bedridden for 8 of the 24 hours.

Mr A's goals of care included the ability to function well, with the best possible quality of life, and meaningful family interactions for whatever time he had left. It was important for him to continue his volunteer work as a lay deacon in his church. He was not a candidate for invasive interventions. His desire was to return immediately to the hospital if he became symptomatic. He did not want people coming into his home to care for him. His children did not want him "to be put on morphine so that he spends the rest of his life drugged."

The initial palliative intervention involved engaging Mr A and developing a trusting therapeutic relationship. Mr A and his wife were informed about hospice and palliative care: what they are, how they differ, how they are alike, and how the various services could benefit him. He was started on low-dose morphine for the treatment of dyspnea and refractory angina. Heart failure was treated by the adjustment of diuretics according to a weight-based algorithm. He began to feel better, with more endurance, less dyspnea, and improved sleep. He was able to continue his volunteer work at his church. It took nearly 4 months before Mr A had his first and only emergency room visit. He was treated and sent home.

Four months after referral, Mr A was once again symptomatic. At this point, he was started on transdermal fentanyl. Renal function had deteriorated so that he now had stage V chronic kidney disease. He became refractory to diuretics. He now spent 16–20 hours bedridden or in a recliner. He agreed to start home hospice services. He was now able to sleep in his bed for the first time in months. For 6 weeks, Mr A continued to do well. Then, he developed severe chest pain, but declined to go to the emergency room for evaluation. He decided that comfort would now be his primary goal. Transmucosal immediate-release fentanyl was added for breakthrough pain, and his symptoms improved once again.

When I last saw Mr A in the Palliative Care Clinic, he had developed some delirium and was spending most of his day in a recliner. He became increasingly symptomatic, heralding progression to the stage of actively dying. Four days later, he died peacefully at home, surrounded by his family.

DISCUSSION (DR FRANKLIN)

Nonhospice palliative care functions as an additional layer of support for patients and families dealing with serious, severe, or life-threatening illness. It can be provided anywhere along the disease continuum regardless of whether curative or comfort-directed therapies are sought. The goals of palliative care include improving quality of life and reducing suffering related to symptom burden. Despite significant advances in the treatment of cardiac disease, approximately 5 million Americans are diagnosed with heart failure each year, with approximately 280,000 deaths.

This population has had only limited access to palliative care because it has been misunderstood by the public and by many physicians as well. Palliative care is sometimes equated to hospice/end-of-life care. While palliative care is best initiated at the time of diagnosis, late referral limits the documented improvement in quality of life, increased overall satisfaction, reduction in symptom burden, futile health care utilization, and unnecessary hospitalization.

This case demonstrates a significant change in disease trajectory from 4 hospitalizations in the 3 months prior to referral to only 1 emergency room visit in the final 6 months of Mr A's life. He experienced decreased symptom burden, including decreased anxiety and depression, as well as improved function. For much of his remaining life, he was able to continue volunteering at his church. He had an increased quality of life, and his family felt supported in their journey.

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