

Review Article

Integration of Palliative Care in the Hospital Setting

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Palliative medicine has shown demonstrated benefit for patients with serious illness, their families, and hospital systems. As such, the demand for palliative care services is growing at a fast pace, and health care facilities frequently struggle to develop and implement effective and sustainable methods of providing this care. As with any new system, challenges and barriers naturally exist to instituting palliative care. Undertaking careful assessment, planning, and resource allocation can provide the greatest likelihood of success when developing these novel yet much needed models of care. This summary paper offers a qualitative overview of the potential benefits and the rationale to implement robust palliative care systems. We briefly review the history of palliative medicine in the broadest sense and address several seminal works from the US palliative care literature. Core practices to establish and advance palliative medicine are suggested. Commentary is provided on some of the particular barriers to palliative system development that may need to be addressed in the context of Korean medical culture. Collectively, we hope this overview can contribute to a framework within which such research and development can occur, leading to increasingly effective and sustainable palliative medicine in Korea.

Key Words: Palliative medicine, Delivery of health care, Cultural characteristics, Korea

INTRODUCTION

The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems 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, psychological, and spiritual (1).” Palliative care improves the quality of life by providing expert treatment from pain and other distressing symptoms, integration of psychological, social, and spiritual aspects of patient care, and provision of timely, compassionate, and patient/family centered decision support as patients and families navigate not only their illness but also an increasingly complex medical system. The goal is neither to hasten

nor postpone death; rather, palliative care affirms life and regards dying one of life’s normal processes.

Palliative medicine utilizes a team approach to most effectively address the multifaceted needs of patients and families. It is thus a complement to disease modifying therapies, appropriate at any time during a serious illness, and should be used concurrently with curative treatments. Near the end of life in particular, curative or disease modifying treatments can become more burdensome than beneficial, with high associated side-effects and little, no, or adverse effect on longevity. In these instances, hospice medicine, a subset of palliative medicine, continues treatments focused on quality of life, including care for bereaved family after the patient’s death. In this manner, hospice and palliative medicine augment curative medicine to provide holistic, patient centered care throughout the illness trajectory. In the simplest terms, many physicians now refer to

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palliative medicine as living well with serious illness. The Center to Advance Palliative Care housed at Mount Sinai in New York also adds in the definition of palliative care that it provides an “extra layer of support” to the patients and families (2).

HISTORY

The modern palliative care movement began in 1967 when Dame Cicely Saunders founded St. Christopher’s Hospice in England. Saunders defined the concept of total pain as the suffering that encompasses all of a person’s physical, psychological, social, spiritual, and practical struggles (3). In 1969, essential work by Elisabeth Kubler Ross interviewing patients about their concepts and feelings about death, was published in her seminal book *On Death and Dying* (4). Further integration in US occurred in institution of the Medicare Hospice Benefit in 1982, which provided a reimbursement structure allowing patients with decreased life expectancy to receive interdisciplinary supportive care while avoiding unwanted hospitalization. Essentially patients were allowed now to live the last stage of their lives in the comfort of their own homes or with family with support of an interdisciplinary team. In 1995, the SUPPORT study in the US documented high levels of unnecessary suffering of hospitalized patients with cancer and other life-limiting illnesses, and the national Death in America project that examined attitudes and culture about end of life care. There is now increasing demand for palliative medicine services, with the number of US hospitals providing palliative care services increasing from 600 to over 1600 in the preceding ten-year period (5).

EVIDENCE

Anecdotal evidence that palliative medicine is valuable seems obvious to many on an instinctual level. Yet, to fully advocate for palliative medicine as well as develop and promote best practice standards, evidence-based methodologies must be applied. Challenges to effective research among palliative care patients include high rates of attrition that cause methodological shortcomings, however, the body of high quality scientific literature regarding palliative is ever expanding (6).

Among the most important is the study by Temel et al “Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer (7),” wherein patients with metastatic lung cancer were

randomized to receive either standard oncologic care or standard oncologic care and concurrent palliative care focused on symptom control and psychosocial support for patients and families. Patients receiving both oncologic care and early palliative care had lower rates of depression, a better quality of life, and better mood scores. They also received less aggressive care at the end of life, yet had statistically significant longer survival than did patients receiving standard care alone. Study design precluded determination of a causal relationship between PC and survival, although follow-up studies now underway are designed to further elucidate the correlation. In the meantime, several other studies have demonstrated a survival benefit with concurrent palliative care.

A frequent concern over implementing palliative care is that patients may lose hope and deteriorate more rapidly if prognostic information is discussed openly. The role of palliative medicine is to enhance the level of hope for many things in life and share the hope for cure when possible. Commonly stated to hope for the best but prepare for the worst. Public opinion research in the US, however, shows high level of concerns related to the exchange of information between patient and physician and the quality of time spent, patient understanding of illness, and patient involvement in treatment decisions (8).

Rather than diminish hope, open discussion may in fact maintain hope. Among American patients with advanced cancer and no chance of long-term cure, Smith et al found no difference in hope before and after honest clinical information was provided, based on a validated measure and state of the art decisional tools (9). It was concluded that hope is not damaged by truthful prognostic or treatment information, even when bad news is given. Certainly, any serious news should be delivered carefully, with empathy, and within culturally appropriate contexts, but we propose that failure of health care providers to do so may lead to feelings of betrayal, abandonment by the health care system, and a more deleterious effect on hope than otherwise. Promotion of false hope or unrealistic expectations has the potential to lead to increased anxiety among patients and families, a sense of failure, and can contribute to complicated grief and bereavement.

Concern about the net cost to provide palliative care has been shown to be less relevant than initially believed in the US. Team-based care involving not only doctors and nurses but also social workers and pastoral care appears potentially costly for a health system to provide, and in fact, in the US, most palliative services are able to cover only a portion of their expenses through

billing. However, by decreasing intensive care unit length of stay and reducing other direct costs, Smith et al showed an overall cost reduction of 66~74% among patients after specialist palliative care was provided (10). Similar results confirmed by many studies since. In addition to partial billing support and health system support due to cost appropriateness of care, many US palliative care services are additionally funded by philanthropy from grateful patients and families. A multi-faceted approach to determining the value of palliative medicine services and thus the cost structure must be individualized to the particular health care system or hospital.

METHODS AND PROCESSES

Ongoing and appropriate process implementation is necessary to effectively implement palliative medicine. To help promote palliative care program development and implementation in acute care settings primarily, the Center to Advance Palliative Care (CAPC)TM was founded in 1990 (11). While a comprehensive review of all processes required to initiate and sustain a palliative care are beyond the scope of this review, addressing core aspects in an organized approach is essential to ensure the greatest likelihood of sustainable palliative care development. To do so, CAPC suggests a number of core modules. Within the US, a select group of eight institutions designated Palliative Care Leadership Centers (PCLCs) are further tasked with supporting palliative care development, providing general core or custom evaluations based on a consultative model. These learning modules can certainly be adapted and utilized in a culturally appropriate manner to help guide PC program development in other countries such as Korea.

Requisite processes that most systems will need to address can loosely be organized into in clusters surrounding preparation, operationalization, and evolution. Some overlap between clusters may exist, and individual components of different modules may apply to a greater or lesser degree depending on system size, resources, economic and reimbursement structures, and cultural considerations (12-16).

1. Preparation
 - a. Needs assessment
 - b. Baseline data
 - c. Mission alignment
 - d. Policies and procedures
2. Operationalization
 - a. Internal marketing
 - b. Patient identification

- c. Staffing and team development
3. Evolution
 - a. Metrics and measurement
 - b. Outreach and philanthropy
 - c. Ongoing cyclical quality improvement

CAPC further delineates specific features of the above clusters. In particular, Weissman and Meier present recommended operational features. Twenty-two specific recommendations, from expert panel consensus based on National Quality Forum Preferred Practices, are grouped into twelve domains, with “Must Have” and “Should Have” features identified (12).

While individual programs will of necessity vary between hospital systems due to a multitude of factors, as between cultures, standards of care must be pursued, formalized, and implemented. In 2011, The Joint Commission released the Advance Certification Program for Palliative Care which recognizes inpatient hospital systems demonstrating optimal patient and family-centered palliative care via formalized team processes, vertical and horizontal mission alignment and leadership support, full-spectrum coordination of care, and application of evidence-based medical practices (17). We believe these certification standards can be utilized to suggest both intermediate and long-term benchmarks to an emerging set of palliative medicine best practices.

Author Commentary on Palliative Medicine in Korea

In November 2012, the authors visited Seoul Korea to participate in the Yonsei University International Symposium on Early Integration of Hospital Palliative Care for Cancer Patients and Their Families. In addition to speaking on various topics during the formal symposium, a professional consultation with Severance Hospital was undertaken with the goal of ongoing advancement of palliative medicine within the system. The authors had the opportunity to meet multiple health care providers and learn about several aspects of health care and Korean culture that are integral to palliative medicine in this setting.

Palliative medicine and hospice has a long established history at Severance Hospital. Yet, in order for palliative medicine to be optimally integrated several challenges remain must be addressed. Technology in Korea has advanced rapidly and continues to do so. Increasing urbanization had led to changes in living arrangements, and increasing work demands have led to less availability from members of younger generations to directly care for members of

elder generations when in poor health. Even if adult children were physically and financially able to directly care for their parents, the latter may be hesitant to request this out of concern for becoming a burden upon their children. Western style hospitals are frequently now the place of care at the end of patients' lives.

Within Western style hospitals, multiple specialists in multiple different roles provide various elements of care. Due to the complexity of multiple domains of palliative care, it requires a team-based approach. But due to the relative newness of many of these roles, as well as the newness within Western medicine of the domains of care needing attention, care can remain fragmented.

Despite rapid technological change, Korea remains a traditional culture with strongly held values. Within these values, Western medicine may be seen as a method of care whose goal is entirely focused on physiological disease-modifying therapies. Psychological, social, emotional, and spiritual care, previously addressed through traditional methods, may be unavailable in current medical domain, leaving a gap where patient and family needs are not fully met.

As such, the potential benefit from palliative care needs may be unrecognized by patients, families, and health care providers, and the gap may perpetuate itself. When recognized, systems may not be adequately developed to meet the need. The unfortunate result, whether due to lack of recognition or lack of a method of response, is that potentially relievable suffering persists. In addition the payment mechanism on a national level for palliative care and hospice services must be further reformed in order for a comprehensive system of care for all patients in all stages of illness can be truly realized.

To the Korean reader, therefore, we propose the following questions for thought: How should a culturally harmonious method, that meets the complex needs of the symptomatic or the dying patient and family, be integrated into the system of western-style medicine being practiced in Korea? Can the practice of medicine truly regain the designation of the art of healing instead of the science of curing? Is palliative care part of the solution?

SUMMARY

Palliative care is a rapidly emerging field of medicine that provides team-based, patient and family centered care specializing in symptom management and decision support at any point during life

limiting illness. The body of literature surrounding palliative medicine continues to develop and shows increased patient and family satisfaction, decreased distress during serious illness, high levels of cost appropriateness, and initial data has shown an associated survival benefit in some instances. In response to these benefits, concurrent palliative care to complement disease modifying treatments is increasingly in demand. As palliative services expand, best practice standards of care are now being implemented. Ongoing research about palliative medicine in Korea will be needed to develop culturally appropriate systems and implement best practices there.

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