The Role of Clergy Through the Eyes of a Hospice and Palliative Care Physician

Laurie Hanne DO
Aultman Hospice and Palliative Care

About Me

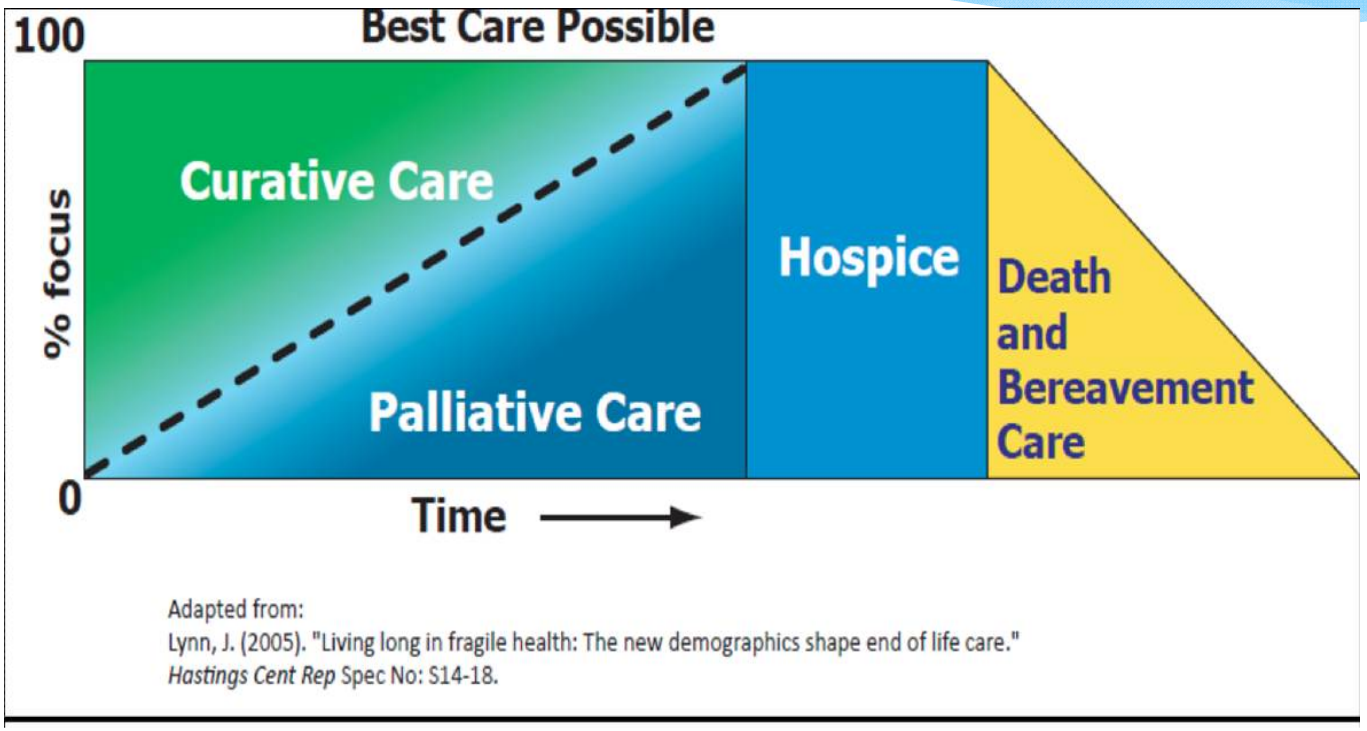
My Training


SIGILLUM COLLEGII WASHINGTONIENSIS ET JEFFERSONIENSIS
JUNCTA JUVANT
1802
1806
MDCCCLXV


PCOM

What led me to hospice and palliative care

My new set of tools



Adapted from:
Lynn, J. (2005). "Living long in fragile health: The new demographics shape end of life care." *Hastings Cent Rep* Spec No: S14-18.

WHO Definition of Palliative Care

* Palliative care is 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, psychosocial and spiritual.

Hospice

* Medicare benefit based on suspected prognosis of 6 months or less
* Provides visits from hospice nurses for education, aide for personal care, social worker for care needs/resources, chaplain, and physician

The Nature of Suffering and Goals of Medicine – by Eric Cassell

* “Suffering is a state of severe distress associated with events that threaten the intactness of personhood or the interconnected physical, social, spiritual, and psychological aspects of self”

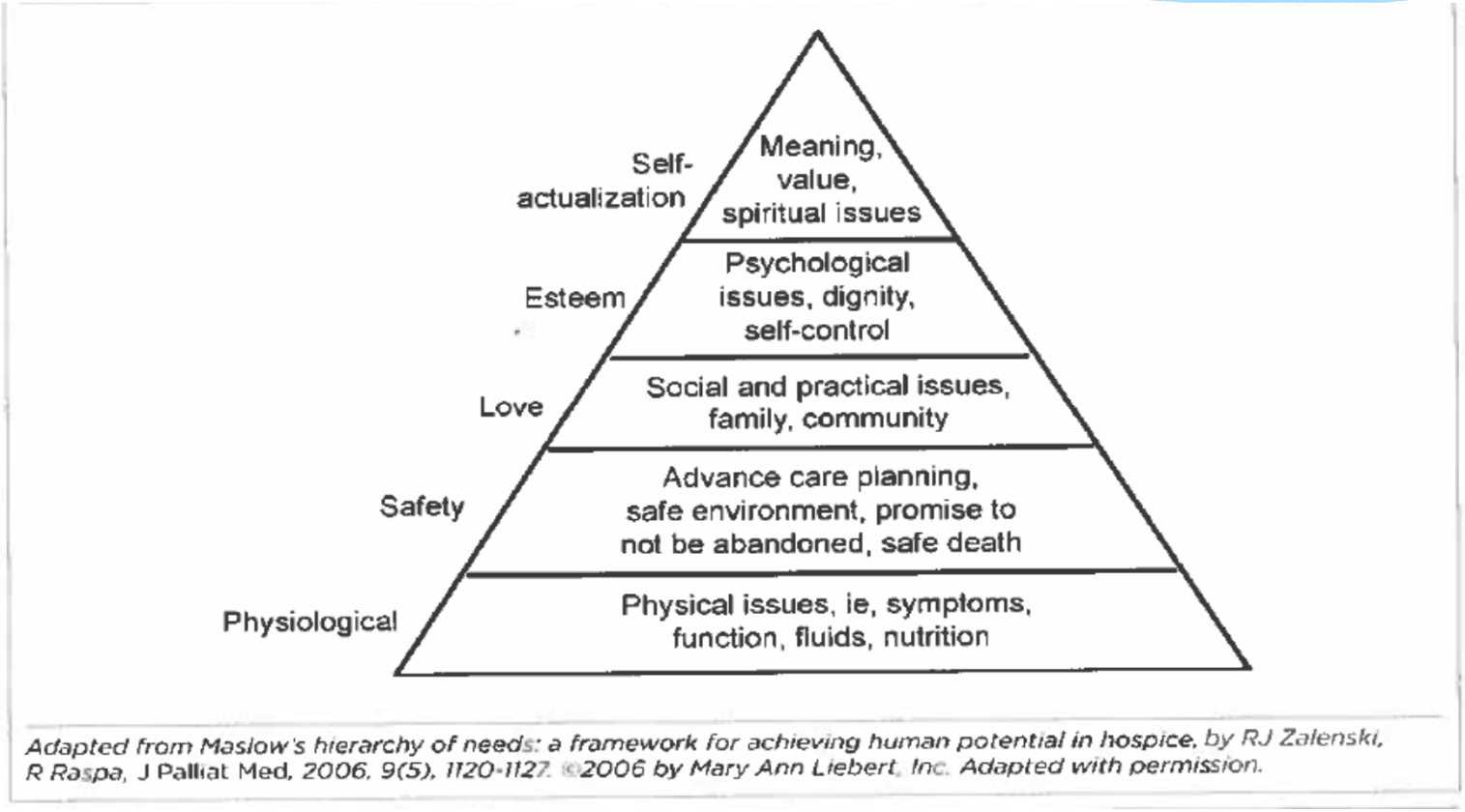
Deconstruction of Suffering

* Minimizing suffering to physical distress
* Avoiding the meaning of patient's suffering
* Relying too heavily on data and testing
* Forgetting psychosocial, existential, and spiritual aspects of suffering

Total Pain

* Described by Dr. Cicely Saunders
* “ Intense suffering frequently experienced by dying patients and their family as they traverse the continuum of living the last months of life, dying, death, and bereavement.”

Maslow's Hierarchy of Needs



Adapted from Maslow's hierarchy of needs: a framework for achieving human potential in hospice. by RJ Zalenski, R Raspa, J Palliat Med, 2006, 9(5), 1120-1127. ©2006 by Mary Ann Liebert, Inc. Adapted with permission.

Developmental Tasks of the Dying

* Managing physical symptoms
* Maintaining or renewing a sense of identity
* Maintaining or enhancing relationships
* Obtaining closure to worldly affairs

Dignity

* “The qualilty or state of being worthy, honored, or esteemed.”
* “Notion of being able to maintain feelings of physical comfort, autonomy, meaning, spiritual comfort, interpersonal connectedness, belonging, and courage in the face of impending death.”

What I need your help with

* Listening
* Challenging
* Re-framing hope
* Prayer
* Reassurance

Spiritual Pain

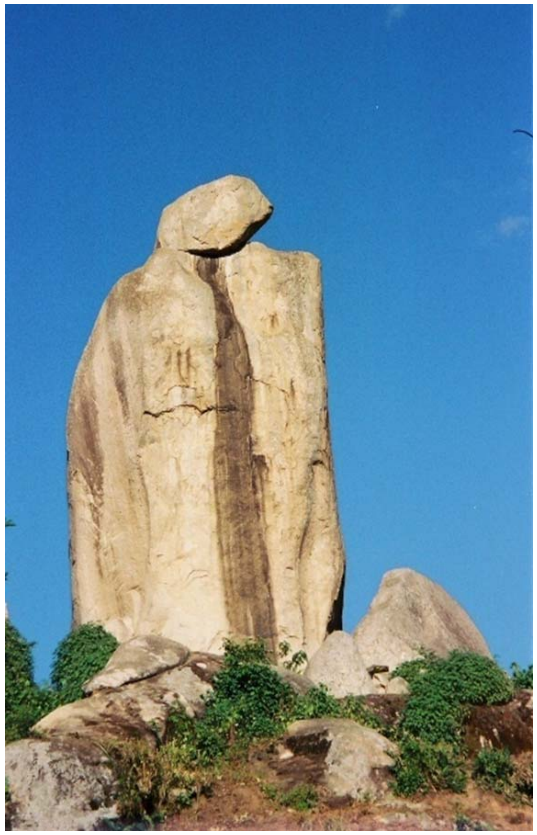
* National Consensus Project for Quality Palliative Care
* “The aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or the sacred.”

Dimensions of Spiritual Need

* Situational Transcendence
  * Seeking hope, purpose, meaning in their current situation
* Moral and Biographical Transcendence
  * Make sense of their life and achieve peace and closure
* Religious Transcendence
  * Religious reconciliation, divine forgiveness, and receiving religious rites and sacraments

It takes a village

* Knowledge
* Active Listening
* Presence



Case 1

* An elderly male who has been cared for at home by his daughter for several years who has become increasingly debilitated and required multiple recent hospital admissions.
* During this hospital stay patient develops respiratory distress after aspirating liquids into his lungs and is transferred to the ICU.
* ICU staff relates to patient's daughter recommendation to not proceed with intubation due to his poor health and to change code status to DNRCC
* Daughter agrees with recommendation and Chaplain called for emotional support for the daughter
* Patient passes shortly after prayer led by Chaplain

Case 2

* Elderly woman is hospitalized for lethargy and worsening shortness of breath
* Found to have end stage heart failure and recommendation has been made by cardiologist to not proceed with any invasive interventions
* Husband in agreement with this recommendation however not interested in talking about end of life care because his church has a prayer chain and he is expecting a miracle for his wife

Case 3

* 19 years ago patient was in a care accident and as a result became paraplegic
* When asked about spirituality her husband relates that at the time of her care accident she heard a presence tell her that it would be alright
* She has been diagnosed with a terminal cancer
* Her husband tells me that he is concerned that she may not still feel as if God is with her

Case 4

* A widowed male sees his primary care physician for a new cough and a chest x-ray is ordered showing a lung mass
* Patient wishes to not pursue biopsy or treatment but rather let “nature take its course”
* His PCP enrolls the assistance of a palliative care team
* The social worker assists with getting him Meals on Wheels and assistive devices as he becomes weaker
* The physician meets with the patient to have a discussion regarding prognosis and recommends hospice
* Patient struggling with his declining health and loss of autonomy – wishing he would die saying that he misses his wife and wishes to be reunited with her
* Reveals to the Chaplain that he has regrets from his time in the military and wishes to be forgiven
* Patient able to pass peacefully at the hospice house

Case 5

* Patient in the acute specialty hospital who received a tracheostomy following an episode of respiratory failure
* He had been making progress with weaning from the ventilator but recently had been requiring more time on the ventilator again
* Patient requesting to speak with hospice and to be prescribed dilaudid and ativan
* I met with the patient and his disease severity did not match his request for hospice
* With more questioning he shared that he did not feel encouraged by some of his care team members and he felt as though he was suffering without hope for improvement in his condition. He identified himself as a Buddhist.
* I scheduled medication for pain and insomnia and consulted with the Chaplain regarding the fundamental principles of Buddhism
* Over the following week that patient reported improvement in his sleep and pain. Got a hair cut. In addition he was able to tolerate increasing periods off of the ventilator and he was eventually able to be discharged out of the hospital

References

* Cassell E.J. *The Nature of Suffering and the Goals of Medicine.* New York, NY: Oxford University Press; 1991.
* Saunders CM. The challenge of terminal care. In: Symington T. Carter RL, eds. *Scientific Foundations of Oncology.* London: Heinemann; 1976:673-*679.*
* Lynn J. Learning to care for people with chronic illness facing the end of life. JAMA. 2000;284(19):2508-2511
* Albers G, Pasman HR, Fufup ML, de Vet HC, Onwuteaka-Philipsen BD. Analysis of the construct of dignity and content validity of the patient dignity inventory. *Health Qual Life Outcomes.* 2011;9:45.
* Kissane DW, Treece C, Breitbart W, McKeen NA, Chochinov HM. Dignity, meaning, and demoralization: emergin paradigms in end-of-life care. In: Chochinov HM, Breitbart W, eds. *Handbook of Psychiatry in Palliative Medicine.* 2nd ed. New York: Oxford University Press: 2009.
* Puchalski C, Ferrell B, Virani R, et al. Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. *J Palliat Med.* 2009:12(10):885-904.
* Mako C, Balek K, Poppito SR. Spiritual pain among patients with advanced cancer in palliative care. *J* Palliat Med. 2006;9(5):1106-1113
* Moadel A, Morgan C, Fatone A, et al. Seeking meaning and hope: self-reported spiritual and existential needs among an ethically-diverse cancer patient population. *Psychooncology.* 1999;8(5):378-385.