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Perspective
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Primary Palliative Care for Hospitalists

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Perspective

On a typical wintery day in Minnesota, a hospitalist sat with a patient's daughter in the family waiting room. The patient was an elderly woman with advanced dementia. She was admitted to the hospital with sepsis from aspiration pneumonia. "I never thought mom would die from 'sepsis'," said the daughter. "She is supposed to die from dementia!" cried the daughter. She burst into tears and mumbled, "If I hadn't put her in the nursing home, if I had been feeding her myself..." The patient had previously expressed to the daughter her wish of being allowed a natural death. In desperation, the daughter asked the hospitalist if mechanical ventilation and enteral feeding would be beneficial, hoping it would only be for a short period of time.

Admissions to the hospital are often turning points in a serious illness trajectory, and it is during these hospitalizations that the need for palliative care increases. Hospitalists are naturally positioned to help patients and families navigate their illnesses in times of complications and/or acute decompensations. These interactions are opportunities for patients to understand their prognosis, and for hospitalists to understand patients' values and preferences. By aligning treatment plans with patients' values and preferences, hospitalists have the unique opportunity to impact satisfaction and quality of life even after the discharge from the hospital [1].

Recognizing the potential impact on patients' quality of life, the Society of Hospital Medicine (SHM) has proposed a new care delivery model, named primary palliative care. In this model, hospitalists and their teams are primary palliative care providers. The SHM's Center for Quality Improvement and The Hastings Center have developed an implementation guide for the aforementioned model, called Improving Communication about Serious Illness [2].

In this care delivery model, hospitalized patients are assessed for decision-making capacity on admission, and screened for serious illness during the hospitalization. Examples of serious illness include life-limiting conditions such as dementia, advanced cancer, COPD, heart failure, and end stage renal disease. Trained hospitalists and their teams will initiate discussions with patients who need clarification of prognosis and goals of care, while palliative care specialists can be consulted for more complex cases. At the time of discharge, a change in patient preferences will be communicated to outpatient clinicians for continuity of care.

The primary palliative care delivery model could expand access to palliative care for an aging population, which has been growing faster than the palliative care specialists' workforce. Additionally, by incorporating primary palliative care into hospital medicine, the primary palliative care delivery model can be more sustainable than the consultation model. This is because hospital medicine is one of the fastest growing medical specialties in the United States [3].

One of the required upfront investments for this care model is educational support for the hospitalists, including symptom management and, perhaps more importantly, communication skills. Applying statistical data to individual patients for prognostication and conveying prognostic information in a meaningful manner are difficult tasks, even for the most trained oncologists [4]. Therefore, educational support for hospitalists is essential in the success of this care delivery model.

Another important investment would be providing resources for process integration, which requires operational support from hospital leadership. The SHM believes that the primary palliative care delivery model can improve the quality of care with a patient-focused approach. This would be in line with progression towards value-based payment system and other reforms that shift reimbursement patterns to reflect what people want and need towards the end of their lives [5,6].

In summary, with support from the system and hospital leadership, hospitalists have unique opportunities to improve quality of life at various turning points in serious illness trajectory. The primary palliative care delivery model proposed by SHM is one framework that increases value of care and expands access to palliative care for patients with life-limiting conditions.

Returning to the case of the elderly woman with advanced dementia, the hospitalist clarified that 'sepsis' indicated the severity of the patient's pneumonia. He also explained to the daughter that dysphagia and infections are frequently-encountered complications of advanced dementia [7]. Upon learning the disease trajectory of dementia, the daughter decided to honor her mother's wish for a peaceful and natural death. We were able to protect the patient from life support and artificial feeding. Her family were very appreciative.

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