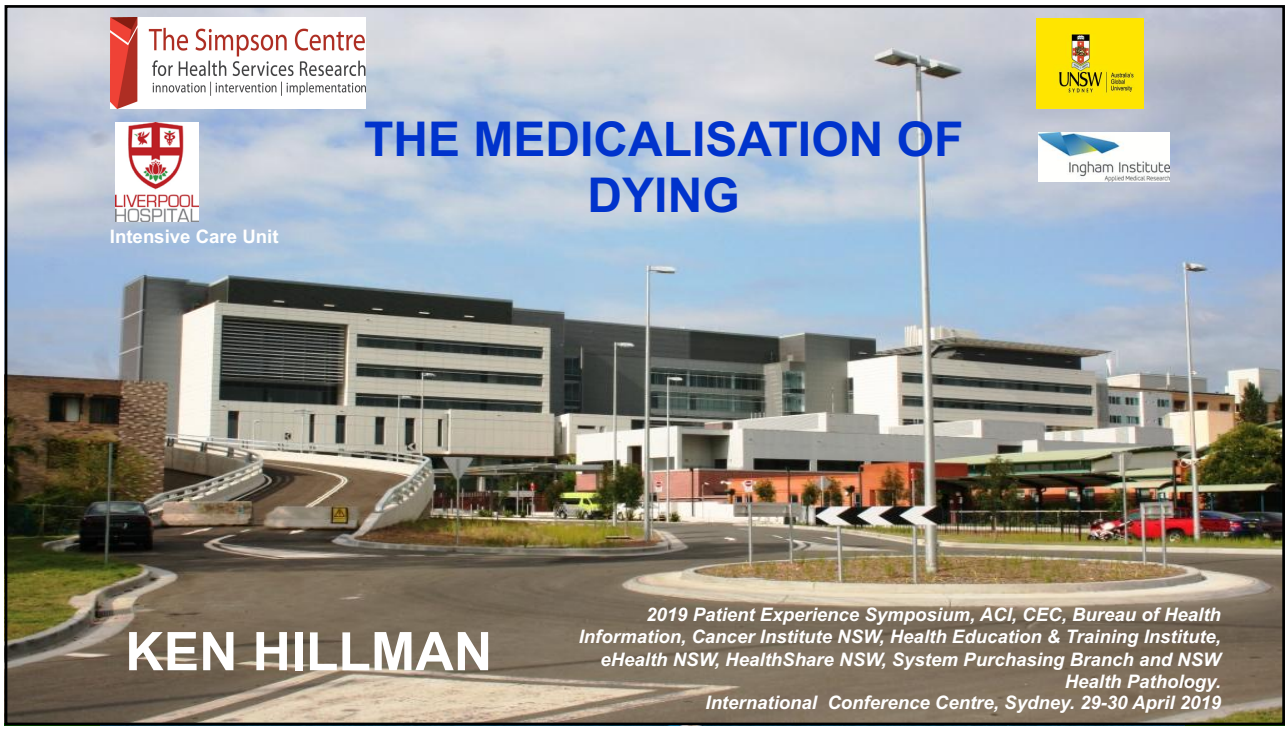
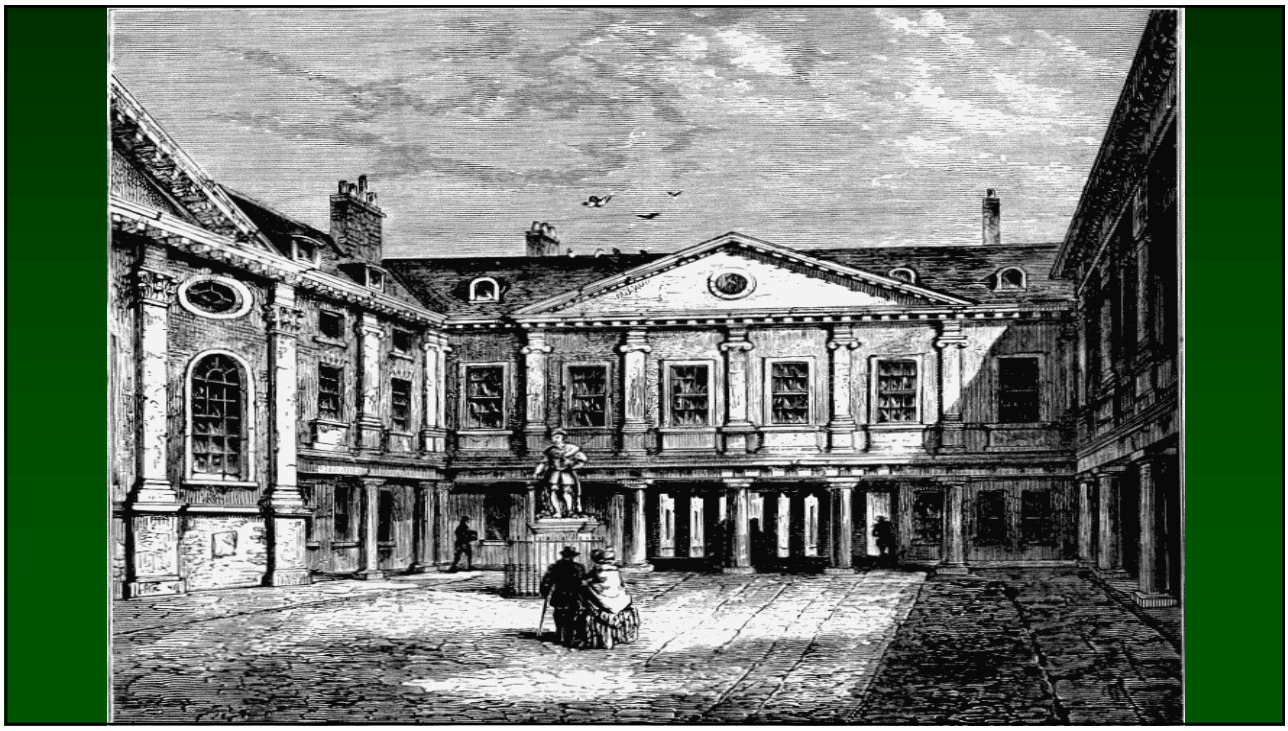

The Simpson Centre
for Health Services Research
innovation | intervention | implementation
UNSW SYDNEY
Ingham Institute
LIVERPOOL HOSPITAL
Intensive Care Unit
THE MEDICALISATION OF DYING
KEN HILLMAN
2019 Patient Experience Symposium, ACI, CEC, Bureau of Health Information, Cancer Institute NSW, Health Education & Training Institute, eHealth NSW, HealthShare NSW, System Purchasing Branch and NSW Health Pathology.
International Conference Centre, Sydney. 29-30 April 2019

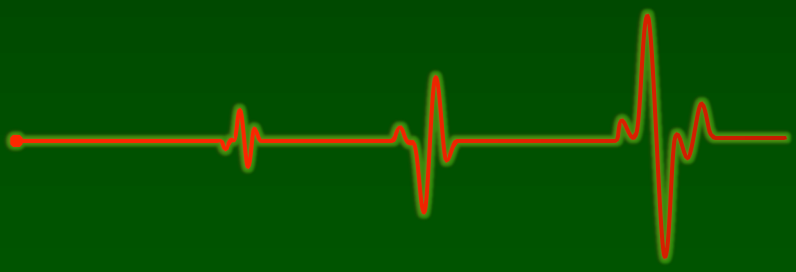
BACKGROUND


Savings Bank
of Australia

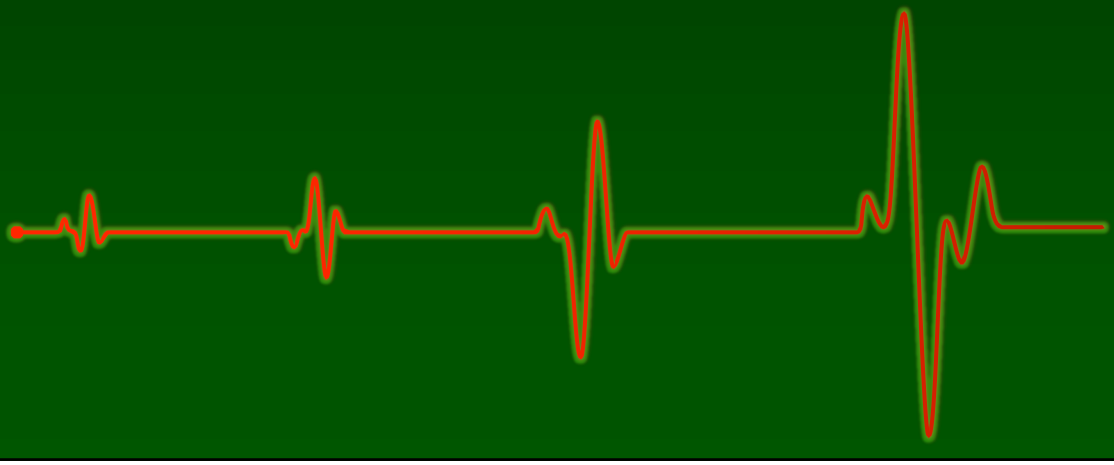


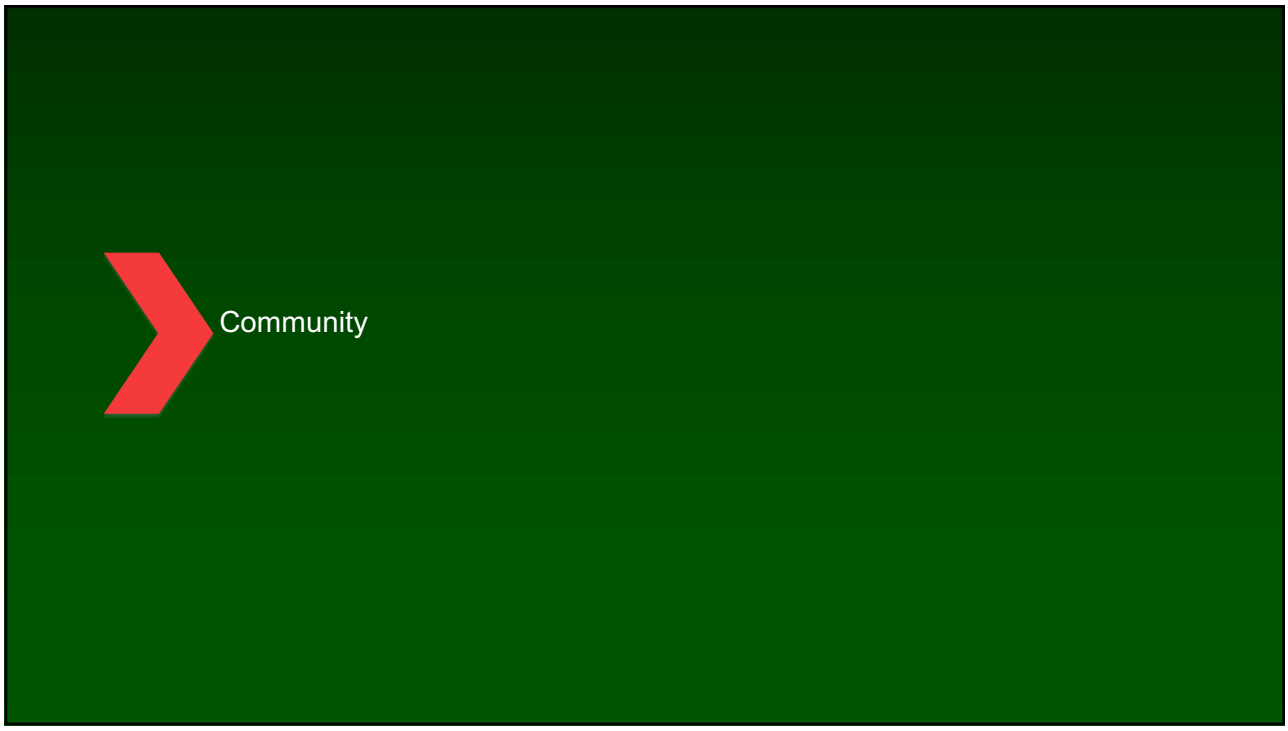

WEST END

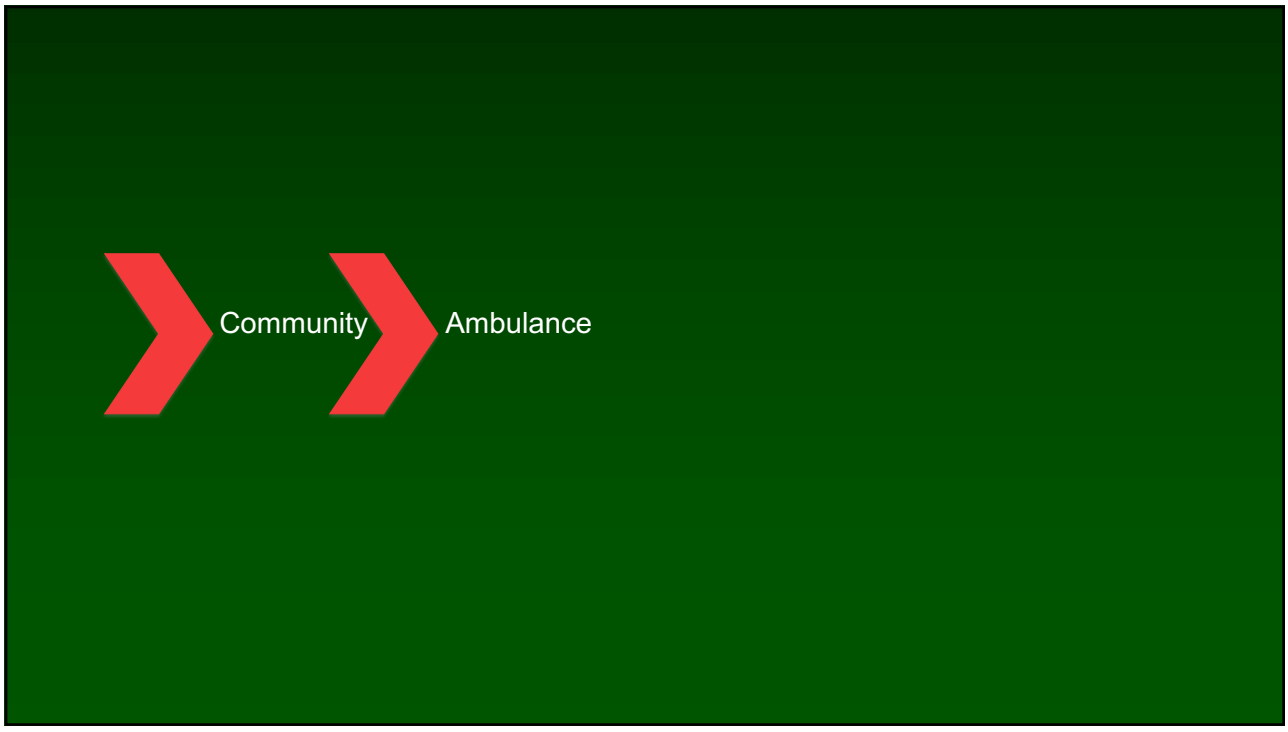
Explosion of Technology

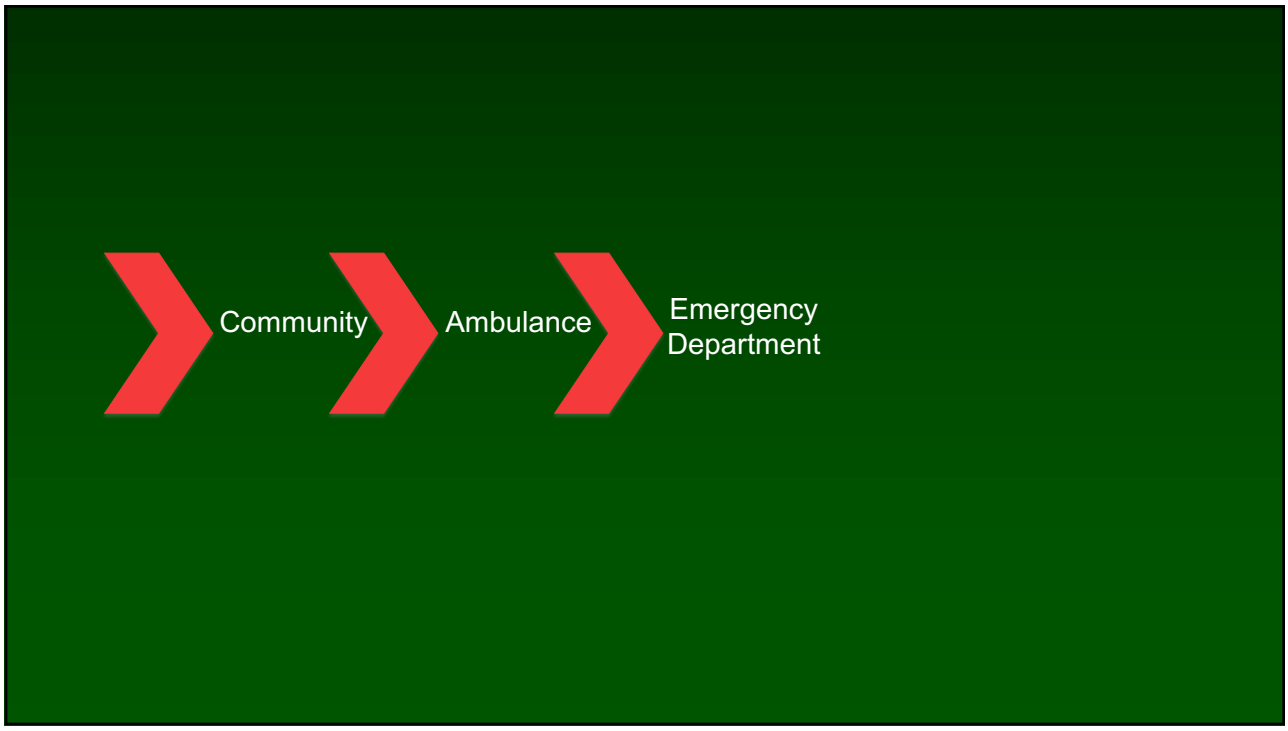


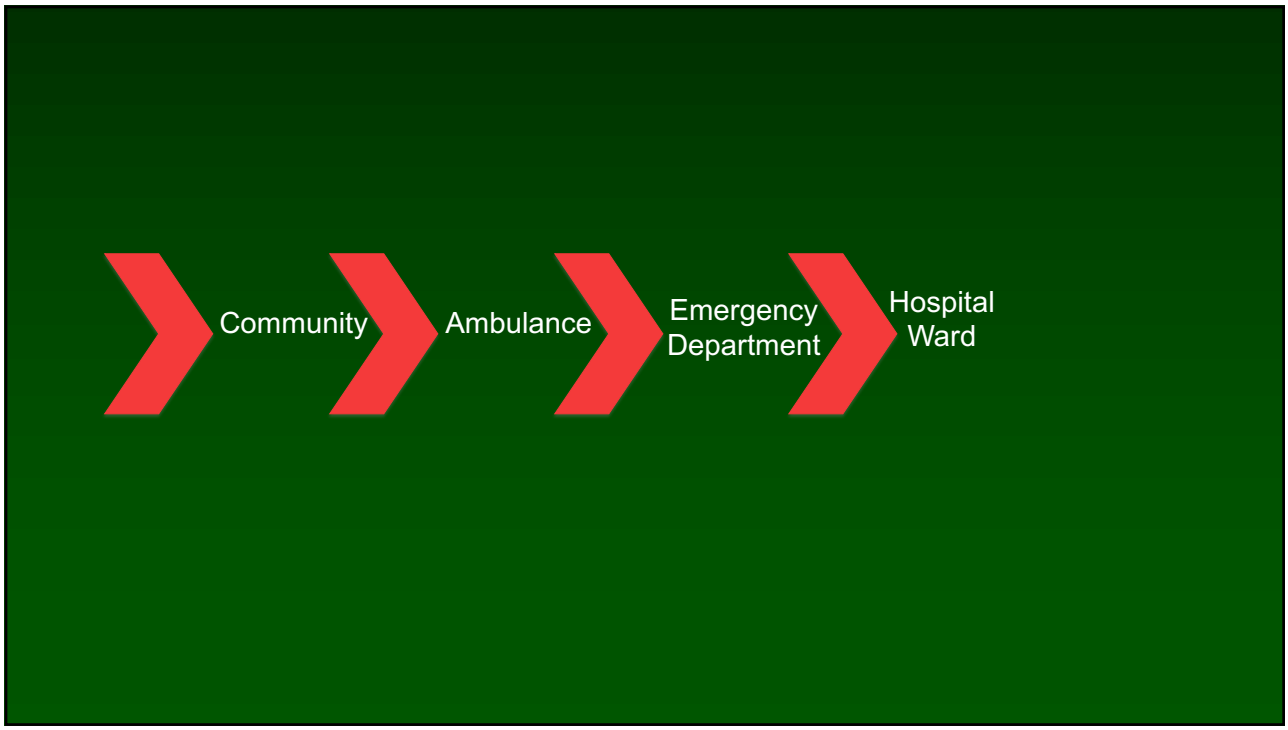
How Did this Happen?



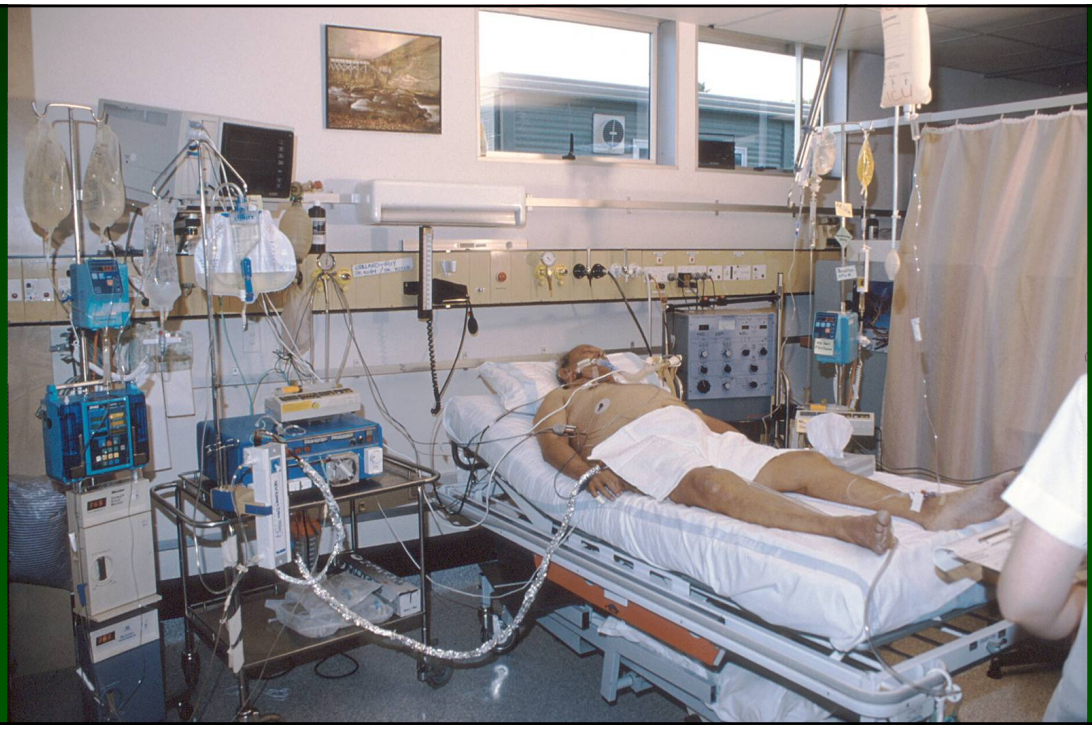

Community


Community
Ambulance


Community
Ambulance
Emergency Department


Community
Ambulance
Emergency Department
Hospital Ward

Community → Ambulance → Emergency Department → Hospital Ward → ICU



MYTH

Hospitals are good places to die

9/0628

DYING SAFELY IN HOSPITALS

The management of end-of-life care in hospitals is dangerous:

- Patients at the end-of-life are not recognised
- Management is inappropriate, resulting in futile care and suffering for patients

Inter J Cl Practice 2009; 63: 508

THE CHALLENGE OF MEDICALISATION

- Increasing number of aged people
- Increasing number of aged coming into EDs via ambulance
- Increasing number of aged patients in ED
- Increasing number of aged patients in hospitals

The Lancet 2016;387:2145

HAVE WE ASKED THE ELDERLY FRAIL ATTENDING EDs AND BEING ADMITTED TO HOSPITALS?:

"IS THIS WHAT YOU WANT?"

MOST DEATHS IN HOSPITAL ARE IN THE ELDERLY and are INEVITABLE

Clinical Medicine 2016;16:530

OVER ONE-THIRD OF ALL HOSPITAL INTERVENTIONS ARE NON-BENEFICIAL

Int J Qual Health Care 2016;28(4):456-469

THE ESTABLISHMENT OF URGENT CALLS TO PATIENTS IN HOSPITALS - MET/RRS

- Early detection of deteriorating patient. Now in many hospitals around the world
- Prevention of adverse events such as cardiac arrests and deaths

WE DIDN'T ANTICIPATE THAT MANY CALLS WOULD BE FOR PATIENTS WHO WERE NATURALLY AND PREDICTABLY DYING

AND YET ALL THE INFORMATION WAS THERE…..

> 80% of patients suitable for palliative care are admitted to acute hospitals in their last year of life

Arch Gerontol & Geriatrics (in press)

- 70 % of people want to die at home
- 70% will die in acute hospitals

J Am Dir Assoc 2016;17:188-92

URGENT CALLS FOR END-OF-LIFE

One-third of all RRS calls are for patients at the end-of-life

CCM 2012; 40: 98

PUT IN PERSPECTIVE

- 45,000 RRT calls/year in NSW
- 15,000 calls for end-of-life issues/year in NSW

MEDICALISATION OF DYING

- Doctors programmed to treat and cure
- Daily reports of medical miracles
- Little training of physicians around dying and death
- Time and reimbursement restrictions
- Uncertainty around the diagnosis of dying

THINGS WILL GET WORSE

- Ageing population
- Single diagnosis and Active Management Model

Europ J Intern Med 2017; 45: 84-90

MORTALITY AT HOSPITAL DISCHARGE IS OUTLIVING ITS USEFULNESS AS AN OUTCOME FOR THE ELDERLY

It's hard to die in an ICU or acute hospital

- 50% of older patients admitted to an ICU have died within one month of discharge and many more have suffered serious functional decline over the following 12 months
- ie they were at the end-of-life

INFECTION IS THE MOST COMMON REASON FOR ADMISSION TO HOSPITAL FOR THE ELDERLY FRAIL

THE “SURVIVING SEPSIS CAMPAIGN”

RE-EXAMINING THE CONCEPT OF 'SURVIVING SEPSIS'

- 85 year old admitted with UTI. Urgent call on general ward Septic, low BP, semi-conscious
- Easy to treat: The 'surviving sepsis' protocol Early recognition; IV Fluids; Antibiotics
- Success for septic protocol!! Discharged home and died naturally 2 weeks later
- Nobody thought that the patient may have a *terminal disease* and be in the last few months of life

PNEUMONIA USED TO BE 'THE OLD PERSON'S FRIEND'

THE SURGE IN TREATMENT AS DEATH BECOMES CLOSER

In Australia, a dying person will have:

- 8 hospital admissions in the last year
- 2 ED visits
- a 60 – 70% chance of dying in hospital

MJA 2011;194:1-4

HOW DO WE RECOGNISE ELDERLY PATIENTS AT THE END-OF-LIFE?

THE CriSTAL TOOL – medium term prediction of end-of-life

29 easily collected items

- Age
- MET criteria
- Chronic health status
- Previous hospital and ICU admission
- Frailty measures
- Nursing home status

BMJ Supp and Pall Care 2015;5:78-90

9/0410

Clinical Frailty Scale


1. Very Fit


2. Well


3. Managing Well


4. Vulnerable


5. Mildly Frail


6. Moderately Frail


7. Severely Frail


8. Very Severely Frail


9. Terminally Ill

DALHOUSIE UNIVERSITY
Inspiring Minds

THE CriSTAL TOOL

- Validated in 14 acute hospitals, 5 countries and over 3000 patients
- Major predictors:
  - AGE
  - DISEMINATED CANCER
  - FRAILTY

Arch Gerontol Geriatr 2018;76:169-174

SYSTEM FOR MANAGING ELDERLY PATIENTS NEAR THE END-OF-LIFE

RECOGNITION trigger for RESPONSE

RESPONSE

RECOGNITION TOOL

- Uncertainty
- A flag to begin conversation about ageing, frailty and end-of-life

LINKING TO A PATIENT-CENTRED RESPONSE

'BOTTOM-UP' SYSTEM FOR MANAGEING ELDERLY PATIENTS NEAR THE END-OF-LIFE

- RESPONSE – patient-centred
- Attitudes and beliefs
- Honest and empathetic discussion about current health and future
- Empowering people to make own choices translated into ACD
- Appropriate follow-up

STATES WORSE THAN DEATH

Doubly incontinent	55%
Relying on ventilator	50%
Cannot get out of bed	45%
Demented	45%
Relying on feeding tube	35%
Full-time care	35%
Living in a nursing home	30%
Continued to live at home	5%
In a wheelchair	2%

JAMA 2016; 176: 1557

TURNING POLICY INTO PRACTICE

- Almost no awareness at any level of any organisation about any end-of-life policies
- Recommend tying policy to implementation and evaluating the policy by its implementation

Health Policy 2017; 121: 1194

"It is easier to write ten volumes of philosophy than to put one principle into practice

Stephan Zweig 1847

FRAIL AGED - TERMINAL CONDITION
MEDICINE SEES IT AS A DISEASE

To be cured or delayed or controlled

Age-Related Frailty Is Not Curable

CO-MORBIDITIES or CHRONIC HEALTH CONDITIONS

- Normal and predictable age-related conditions
- Irreversible and progressive
- Associated with increasing frailty, infections and falls
- **These are *MARKERS* of nearing the end-of-life, not necessarily treatable conditions**

THE ELDERLY FRAIL PATIENT'S EXPERIENCE

- Repeated hospitalisation in last few months of life
- Not recognised as increasingly frail and near the end-of-life
- Not included in any discussions about empowering them to make choices about their own Goals of Care

WHAT HAPPENS IF A PATIENT HAS:

- A heart attack Cardiology
- A stroke Neurologist
- A GIT bleed Gastroenterologist
- Burst appendix Surgeon

- ……..and if it was one of us, we would want the 'best'

WHAT HAPPENS IF A PATIENT IS DYING:

No agreement about recognising it and if and when it is eventually suspected who would manage it:

- The Home Team
- Palliative Care specialist
- Geriatrician
- A new type of specialist