Palliative Care Assignment #1

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End-of-life practice would not be what it is today if it were not for hospice care. There are numerous social forces that attributed to the hospice movement, but four societal mandates were particularly influential in establishing the hospice movement. According to Zerwekh (2006), the first mandate stated that, “terminally ill persons should have access to appropriate care that attended to body, mind, and spirit” (as cited in Professor Konecny’s lecture). Second, death should be openly expressed, and not considered taboo. Third, it was imperative that medical technology be applied into practice prudently and judiciously. Lastly, the fourth mandate specified that, patients had the right to be proactive and more involved in their own care, and treatment decisions (Zerwekh, 2006). Other social forces that played a role in hospice movement in the late nineties include, growing interest in death and dying, the flourishing of hospice programs, integration of pain and symptom management, concerns with regards to the high cost of dying, focus on pain management, focus on care rather than cure, and ethical issues such as physician-assisted suicide and euthanasia (Matzo & Sherman, 2010).

Hospices provide a plethora of services that ensure care, provide emotional support, relief and management of pain, tailored to the needs and wishes of those with a life-limiting illness, as well as to their loved ones (NHPCO, 2011a). The key feature of hospice care, as previously mentioned, is that it focuses on providing care, instead of finding a cure. Care is usually provided either in the comfort of the patient’s home, in hospice centers, hospitals, nursing homes, and even in other long-term health care facilities (NHPCO, 2011a). But it is important to note that the way Americans approach hospice care is slightly more different to the way the English approached hospice care in the 1970s. According to Zerwekh (2006), American approach to hospice care entailed coordinating home care with the provided inpatient care that the patient was already receiving. Furthermore, Zerwekh (2006) claims that huge emphasis was given on pain management, as well as the management and control of other symptoms that would be debilitating to the patient. Emotional support, counseling, and even spiritual care was provided and available if needed; and so was bereavement support after the patient’s death. Most importantly, the key feature of, and most unique aspect of the American approach to hospice care, was the emerging emphasis on home care. (Zerwekh, 2006)

In terms of eligibility for the Hospice Medicare Benefit, according to www.hospicenet.org, in order to be deemed eligible, the patient must also be eligible for Medicare Hospital Insurance (Part A); the patient must also have both the doctor and the hospice medical director certify that s/he is terminally ill, with “six months or less to live if the disease runs its expected course”; in addition, the patient must sign a statement that s/he has opted for hospice care instead of standard Medicare benefits for the terminal illness. The final criteria, for eligibility for Hospice Medicare Benefit is if the patient receives care from a Medicare-approved hospice program. (“Medicare Hospice Benefits”)

While the word “hospice” is often met with a negative connotation, it is important to explain to dying patients and their family members that the common misconception of its being “*a-place-where-dying-people-are-put-in*” couldn’t be more inaccurate and false, not to mention derogatory. I would explicitly explain that hospice is a type of care provided to those that are terminally-ill and dying. However, contrary to popular fallacies, hospice services are not limited to being provided in a facility: it can be provided in the hospital, or even in the comfort of one’s home. In describing hospice services to patients and their family members, I would make sure to detail its combination of home care, palliative care/pain management, and most importantly, emotional support; Hospice services provide the patient and his/her family members all the physical, emotional, and even spiritual support they need, as the patient faces his/her remaining days of life. Moreover, I would explain that comfort and care are not only provided, but also emphasized in hospice care.

Palliative-care applies the same principles as that of hospice care, albeit to a broader population that “could benefit from receiving this type of care earlier in their illness or disease process” (NHPCO, 2011b). Palliative-care, is further defined by Batchelor (2010) as having “evolved from the hospice movement and has become a care-management strategy to care for patients who have chronic illnesses but are not yet eligible for hospice support.” And just like hospice care, palliative-care can be provided at the comfort of the patient’s home, in long-term care facilities, at the hospital, nursing homes, and in other assisted living facilities (Batchelor, 2010). The palliative-care movement, not only evolved form the hospice movement, but is even made a priority in hospitals in improving patients’ quality of life (Andrews, 2011a). But its evolution stems mainly from the demand for care for the “seriously ill patients, [who] even when not facing death, could benefit from better pain and symptom management and other palliative-care services” (Andrews, 2011b).

Aside from the business aspect of a hospital broadening their clientele when developing a palliative care program, there is also the aspect of how staff members can “enhance their skills in pain and symptom management” which is often a problem when dealing with patients who have chronic and complex medical problems (Andrews, 2011a). Furthermore, according to a 2008 study published in the Archives of Internal Medicine, hospitals with palliative-care programs is actually cost-effective: patients receiving palliative-care services “cost hospitals between $1,696 and $4,908 less per admission” (Andrews, 2011a). Another study, published in *Health Affairs*, also found that “Medicaid patients at four New York state hospitals who received palliative care on average incurred nearly $7,000 less in hospital costs per admission” than those who didn’t (Andrews, 2011b). Establishing palliative-care programs in hospitals would further bring prestige to a hospital, in the eyes of the most important people: its clients. Clients will see firsthand how much care, support, and attention are provided to them by staff, not only from those in palliative-care teams, but also from those throughout the hospital.

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