

Program to improve palliative care falls short of hopes

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There may be no simple one-size-fits-all approach to improving end-of-life care in ICU settings, according to a recent study from some of the world's leading researchers in palliative care.

The study, which will be published online ahead of the print edition of the American Thoracic Society's [American Journal of Respiratory and Critical Care Medicine](#), showed that an intervention designed to improve doctor-patient communication and overall satisfaction of families whose loved ones died in critical care settings failed to improve family satisfaction after the death of their loved one, or to better communication between doctors, nurses and families.

"We were surprised that it was a negative study," said J. Randall Curtis, M.D., M.P.H, immediate past president of the ATS and lead author of the study. "It is very difficult to change busy critical care clinicians' - including both nurses and physicians - behavior patterns, because they have a lot of pressures on them. While we designed the intervention with that in mind, it was more difficult than we anticipated."

Twelve Seattle/Tacoma-area hospitals took part in the study and were randomized to receive the intervention or to serve as controls. The intervention specifically addressed five components: clinical education, local champions, academic detailing, clinician feedback of quality data, and system supports, and took place over 13-20 months. Outcomes were assessed by comparing family satisfaction with the death of their loved one before and after the intervention, both within single institutions and

across all.

Doctors and nurses at each institution that received the intervention underwent training designed to increase their communication skills with one another and with families, and were instructed to discuss end-of-life options openly, as appropriate, with families. The hospitals that were randomized as controls received the intervention after completion of the study.

"Our focus was communication, but that is something difficult to change in general," said Dr. Curtis. "Tasks are easier to convey and more concrete, whereas this communication skill is more complex and therefore harder to teach and maintain, especially through an externally implemented program."

The primary outcome measured was the family's satisfaction with the ICU experience after the death of their loved one. All families whose loved one had died either in the ICU, or within 30 hours of ICU discharge, were sent validated questionnaires designed to assess their assessment of the "quality of dying and death" and their overall satisfaction with the ICU experience. Of the 1924 patient who had died in the study, 822 family members (43 percent) responded to the questionnaires. However, there was no detectable difference in the satisfaction of families, regardless of whether the institution where their loved on had died had received the intervention.

"I do not think that our results indicate a failure of [palliative care](#)," said Dr. Curtis. "I think it is clear that palliative care does good, a fact that has been shown through many studies. However, we did show that the method we used of implementing changes as a package from an external source does not work. We asked whether this intervention could improve families' experience with the death of their loved one in the ICU, and the answer was no."

Dr. Curtis believes that palliative care can be improved in institutions more effectively through an internal commitment to the process and through interventions that are developed and supported at the local level, rather than as a set of changes administered from external sources and delivered to institutions as a package. "When we first did this intervention in our own [hospital](#), we were able to show improvements in communication among nurses and doctors and nurses ratings of end-of-life care, but we were not able to export that to other institutions," he said.

Improving palliative care may be one of the more effective ways to both reduce healthcare costs and improve outcomes. "A significant portion of our healthcare spending is at the very end of life," said Dr. Curtis.

"We have a real challenge in the U.S. in terms of addressing the problems of our healthcare system," he said. "On one hand, we are trying to increase access and quality, but on the other, we are focused on reducing costs. Palliative care is one of the rare instances where all three of these goals can be met through a single intervention. Effectively improving education among doctors and patients, as well as family members, nurses and social workers, can both improve quality of care and patient/family satisfaction and reduce costs. This is an area of care that is especially important in our current time."

Provided by American Thoracic Society

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