PALLIATIVE AND THERAPEUTIC HARMONIZATION: EXPANDING THE ORIENTATION OF GERIATRIC MEDICINE

PRINT THIS ARTICLE

Laurie H. Mallery, MD, FRCPC, *is with the Division of Geriatric Medicine, Department of Medicine, Dalhousie University, Halifax, Nova Scotia*

Paige Moorhouse, MD, FRCPC, *is with the Division of Geriatric Medicine, Department of Medicine, Dalhousie University, Halifax, Nova Scotia*

Correspondence may be directed to Laurie H. Mallery, MD, FRCPC, at laurie.mallery@cdha.nshealth.ca.

An important mandate for geriatric medicine is to provide coordinated, comprehensive services for older persons to improve function, mobility, cognition, and the social situation using a multidisciplinary approach. Using this framework, even small interventions can produce meaningful improvements in health, leading to "the joy of geriatric medicine."[1]

But sometimes, in our current culture of cure, as we try to improve treatment response, we paradoxically worsen health. Even geriatricians and geriatric teams can see a patient through their specialty lens, responding to a series of single issues rather than considering the overall state of health. In these circumstances, teams recommend interventions that have little chance of improving quality of life, without paying enough attention to the more pressing reality of underlying frailty and its association with end of life. This approach can prolong the dying process and give rise to poorly managed symptoms.

To better understand this dilemma, two geriatricians asked the question, "How do we address declining health so that frail older adults can receive appropriate care that matches their unique health status and values?" In contemplating this question and reviewing the literature, we recognized a significant gap between existing models of care and a model of care that would honour the significance of frailty when making treatment decisions. To respond to this issue, we developed a new approach, which we call PATH (Palliative and Therapeutic Harmonization). PATH purposefully focuses attention on the final chapter of life using a structured methodology of assessment, communication, and decision-making. This article describes how PATH was established and how it works.

Evaluating the Status Quo

The first step in developing PATH was to reflect on obstacles to optimal care with severe frailty. Based on this review, we acknowledged several challenges to care planning, as described below.

Challenge 1: Medical Models May Not Give Sufficient Attention to Frailty

Health care providers may not assess cognition, function, mobility, and other indicators of frailty before they make recommendations about surgery and other interventional treatments.[2] As such, they do not always recognize the clinical trajectory of terminal frailty and may overestimate life expectancy.[3,4] In particular, ignoring the impact of cognitive impairment on outcomes may result in burdensome interventions for those with dementia compared to those with cancer and similar life expectancies.[5] This approach has been described as the single-illness model,[6] whereby the cardiologist treats the heart without sufficiently considering background illness complexity.

Specialized geriatric health teams may also be culpable of ignoring the deeper meaning of frailty. The application of multiple discipline-specific evaluations creates an epidemic of assessments that do not give proper attention to the pervading condition of poor health. We identified this fragmented approach as a major impediment to appropriate decision-making.

Challenge 2: Existing Communication Strategies May Not Adequately Disclose the Impact of Chronic Medical Conditions on Life Expectancy and Quality of Life

Medical decisions are often made without fully understanding the risk and limited effectiveness of treatment in the context of terminal frailty. Patients and their families are not commonly informed about the decreased life expectancy associated with co-existing, multiple, interacting complex illnesses, particularly when communication strategies place more emphasis on self-determination, autonomy, and the importance of understanding values and preferences[7] rather than providing information. As a result, physicians may be asking patients and families to make complicated health care decisions without adequate data and may impart a more optimistic prognosis than they believe to be true.[8] Consequently, due to inadequate

information, inappropriate choices may be made.[9,10]

Challenge 3: The Over-Reliance on Clinical Practice Guidelines

Evidence-based guidelines created for healthier individuals are indiscriminately applied to frail patients with multiple co-morbidities, even though such persons are consistently excluded from the medical studies that populate the guidelines. Complex medical treatments that work well for healthier individuals almost certainly have less benefit for those who are vulnerable to the adverse effects of medical and surgical treatments, with fewer years of life to experience treatment benefit if it occurs. The lack of accepted standards to direct decision-making with frailty makes it difficult to deliver relevant, responsive, and harmonized care.

The PATH Forward

As an antidote to these obstacles, the PATH developed a model of care that focuses on four core principles (Table 1) and three steps: (1) *understanding* current health status, (2) *communicating* about health issues, and (3) *empowering* decision-makers to make present and future health care decisions. Each step is meant to overcome the identified obstacles to appropriate care at the end of life.

Step 1: Understand

As a remedy to the traditional health assessment that gives inadequate attention to frailty, step 1 (understand) of PATH embraces Comprehensive Geriatric Assessment (CGA) to assemble a complete picture of health. This step is meant to help teams, physicians, patients, and families recognize the importance of frailty for decision-making, as follows:

1. *Improving team understanding:* To enhance team understanding, we developed an expanded CGA called the *Collaborative* Comprehensive Geriatric Assessment (CoCGA). Using a standardized approach and training program, this assessment helps all team members gather information that paints a full picture of health in order to create a common language and skill set, reduce redundancy, increase trust between team members, and help each health professional take a more directive role in care planning. (The CoCGA is available in the manual *PATH Clinic Module 1: Team Based Assessment and Care Planning*, which can be requested by contacting info@pathclinic.ca.)
2. *Improving physician understanding:* PATH helps medical specialists and surgeons understand the pervasive prognostic significance of frailty, as brought to light by the goals of care that emerge from CoCGA. Following CoCGA, the frailty burden becomes the centrepiece for decision-making.
3. *Understanding cognition:* Particular attention is given to dementia as it is progressive and affects the risk-benefit balance of complex treatments. Understanding the stages of dementia using the Brief Cognitive Rating Scale[11] and the Functional Assessment Staging Tool (FAST)[12] improves team and family awareness of dementia severity and what to expect in the future.

At the end of this first patient encounter, the physician and team meet with the patient and/or decision-maker to briefly introduce the dementia stage, where applicable, and level of frailty. A second visit is scheduled to discuss the findings in more detail. Educational materials, written by PATH physicians, provide an overview of the process.

Table 1. The PATH Principles for Care Planning

People want and deserve detailed information about their health and how their conditions may affect them in the future.
Physicians must anticipate the impact of each condition on overall health and take time to describe this to patients and families.
Health care decisions should only be made after full disclosure of the longer-term risks and benefits.
An organized approach to information gathering can help patients make more informed health care decisions.

PATH = Palliative and Therapeutic Harmonization..

Step 2: Communicate

The second step (communicate) facilitates realistic decision-making by honestly and thoroughly describing current medical conditions and their expected trajectory. This transfer of knowledge puts decision-makers in an informed and autonomous position from which to apply their values and goals to reach appropriate decisions. Without this step, people may walk blindly into adverse outcomes and protracted suffering.

Due to dementia, PATH communication often occurs with the surrogate decision-maker rather than with the patient. We use a semistructured script that describes the stage and prognosis of each co-morbidity, how illness contributes to frailty, and the expected worsening of health over time. In this communication scheme, we pay particular attention to describing dementia and other serious illnesses, such as heart failure, kidney disease, and chronic obstructive pulmonary disease.

The PATH approach may differ from other models of care planning because it focuses on providing information and allowing the decision-maker to express treatment preferences within the context of overall health and prognosis. The encounter can involve intense emotions and catharsis. PATH participants often describe that they are hearing information about disease progression and prognosis for the first time, and although the content of the discussion can be upsetting, almost all participants indicate that the process is useful for future care planning. A nurse-led debriefing session may follow the initial discussion. Additional PATH-specific written materials are provided to relay information about dementia staging (using narrative and descriptive writing) and decision-making with frailty.

Step 3: Empower

The final PATH visit (step 3, empower) builds upon the first two visits by encouraging decision-makers to apply newly learned concepts, such as frailty, dementia, and prognosis. The session begins by discussing foreseeable decisions, including resuscitation, artificial nutrition, hydration, hospitalization, dialysis for chronic kidney disease, surgical interventions, the use of antibiotics, and other medical treatments. The potential effects of each intervention on cognition, mobility, function, symptom control, and quality of life are discussed. We provide decision-makers with a framework of questions that will help

Table 2. Decision Framework: Questions to Ask during a Health Crisis

1.	Which health conditions are easily treatable? Which are not?
2.	How much frailty is there? How will frailty make treatment risky?
3.	How can symptoms be safely and effectively managed?
4.	Will the proposed treatment improve or worsen function and memory?
5.	Will the proposed treatment require time in hospital? If so, for how long?
6.	Will the proposed treatment allow more good quality years, especially at home?
7.	What can we do to promote comfort and dignity in the time left?

Table 3. PATH Knowledge Translation Materials

PATH manual of instruction: The assessment of frailty
Guide for making medical decisions
Stages of dementia narrative
Understanding frailty
Preparing for death at home or in the hospital
Wallet cards with framework questions (to ask during a crisis)
Documentary film about four PATH families
Website: www.pathclinic.ca
The Salami Salesman and His Daughter Falafel: A personal story about dying, by Laurie Mallery, with care planning by Paige Moorhouse (Authorhouse.ca or Amazon.ca)
Training program to teach the PATH process to health professionals with manual for instruction
Diabetes guidelines for long-term care developed by Diabetes Care Program, Nova Scotia

PATH = Palliative and Therapeutic Harmonization..

them gather the information they need to make informed decisions in an organized manner (Table 2).

We practise applying the framework with hypothetical examples of health crises pertinent to the patient. The framework questions are then provided in a wallet-sized card for future use. We encourage decision-makers to contact us when faced with difficult decisions so that we can work through the framework questions together.

Results

The PATH strategy of assessment, communication, and empowerment changes the way patients and families make important treatment decisions. After engaging in the PATH process, the majority of patients/families change their care plan regarding cardiac surgery, general surgery, dialysis, or other medical treatments. With the support of the PATH team, several patients (some of whom had recurrent hospitalizations) opted for treatment at home, with several home deaths supported by the PATH team. Several specialty appointments were cancelled, such as biannual vascular surgery appointments to follow the size of an abdominal aortic aneurysm, where surgery would be risky. Medications were optimized and several procedures and tests, such as colonoscopy, were cancelled.

Some patients who were referred to PATH were not frail. One patient was referred to evaluate "dementia" prior to cardiac surgery for severe aortic stenosis, but was found to be hearing impaired with normal cognition. In this case, the patient was encouraged to proceed with surgery. The results of the PATH process are being formally analyzed.

The PATH has helped in many ways. With specific training, team members are able to increase their scope of practice, which improves team functioning. PATH has enhanced the relationship between geriatricians and other specialists, such as cardiologists, nephrologists, and surgeons, and between physicians and patients/families. For the most part, the feedback about PATH is extremely positive, with most families appreciating the opportunity to have a straightforward talk about the significance of frailty. We continue to develop resources to support the program (Table 3).

PATH Example

The following case illustrates a typical PATH interaction.

Mr. White was an 89-year-old man with very severe, terminal-stage dementia (typified by being non-ambulatory and non-verbal), as well as chronic kidney disease and diabetes. He was meticulously cared for at home by his wife and children. Over six months, Mr. White had been admitted to the hospital four times, mostly to treat infection. The staff in the hospital discussed end-of-life care, but the family did not want to change their approach, which entailed treating each new infection in hospital. Mr. White's physician requested a PATH consultation.

The social worker and geriatrician went to Mr. White's home and met with Mrs. White and her six children. The family described that Mr. White always had a hard time in the hospital, where he became agitated and distressed. In contrast, at home, where his family provided compassionate care, Mr. White was comfortable and calm. We continued with a detailed conversation about Mr. White and suggested that it would be easier on Mr. White to receive his medical care from home. The family said that this was not possible, as the family physician did not perform home visits. We indicated that the family could contact the PATH physician during the next health crisis and acknowledged the importance of timely care.

Over time, the PATH team bonded with the White family and all

Key Points

- *There are few care models that honour the significance of frailty when making treatment decisions.*
- *To respond to this issue, we developed the PATH (Palliative and Therapeutic Harmonization), which purposefully focuses attention on the final chapter of life due to frailty.*
- *The PATH uses three steps: (1) understanding current health status, (2) communicating about health issues, and (3) empowering decisions-makers to make present and future health care decisions.*
- *Each step is meant to overcome the identified obstacles to appropriate care at the end of life.*
- *The PATH changes the way patients and families understand their health status and make medical decisions.*

future medical treatments were provided at home, including the treatment of pneumonia with antibiotics. There was no further hospitalization, and 8 months after the initial PATH visit, Mr. White died peacefully in his home. Within the thank you note received by the PATH team was the following sentence, which embodies the intent of the PATH model: "Your support and kindness enabled our beautiful husband and father to pass with the dignity and grace he so well deserved."

Acknowledgements

This program has received financial support from the Canadian Dementia Knowledge Translation Network (CDKTN), the Negus Fund, the innovative fund from Capital District Health Authority, in Halifax, Nova Scotia, and the Nova Scotia Health Research Foundation.

This article has been peer reviewed.

References

1. Rockwood K. MacKnight C. The Joy of Geriatric Medicine Textbook. In press.
2. Rockwood K, Hubbard R. Frailty and the geriatrician. Age Ageing 2004;33(5):429–30.
3. Hanson LC, Eckert JK, Dobbs D, et al. Symptom experience of dying long-term care residents. J Am Geriatr Soc 2008 56(1):91–8.
4. Travis SS, Bernard M, Dixon S, et al. Obstacles to palliation and end-of-life care in a long-term care facility. Gerontologist 2002;42(3):342–9.
5. Zapka JG, Carter R, Carter CL, et al. Care at the end of life: focus on communication and race. J Aging Health 2006;18(6):791–13.
6. Rockwood K. An unsuitable old age: the paradoxes of elder care. CMAJ. 2005;173(12):1500–1.
7. Tulsky JA, Fischer GS, Rose MR, et al. Opening the black box: how do physicians communicate about advance directives? Ann Intern Med 1998;29(6):441–9.
8. Lamont EB, Christakis NA. Prognostic disclosure to patients with cancer near the end of life. Ann Intern Med 2001;134(12):1096–105.
9. Travis SS, Bernard M, Dixon S, et al. Obstacles to palliation and end-of-life care in a long-term care facility. Gerontologist 2002;42(3):342–9.
10. Mitchell SL, Kiely DK, Hamel MB. Dying with advanced dementia in the nursing home. Arch Intern Med 2004;164(3):321–6.
11. Reisberg B, Ferris SH. Brief Cognitive Rating Scale (BCRS). Psychopharmacol Bull 1988;24(4):629–36.
12. Reisberg B. Functional assessment staging (FAST). Psychopharmacol Bull 1988; 24(4):653–9.