

Damian Jagielski¹, Michał Graczyk¹, Agnieszka Jagielska², Małgorzata Krajnik¹

¹Palliative Care Department, *Collegium Medicum* at the Nicolaus Copernicus University in Bydgoszcz, Poland

²Palliative Care Department, University Hospital in Bydgoszcz, Poland

Is there room for a palliative care support team in an emergency hospital ward? Analysis of the palliative care support team activity at the University Hospital, Bydgoszcz, in 2002–2006

Abstract

Background. Despite the development of this form of activity around the world, there are still only two hospital palliative care supportive teams in Poland: in Bydgoszcz and in Warsaw. The study was aimed at demonstrating the need for the formation and development of supportive teams in emergency care hospitals in Poland.

Methods. Analysis of documents (disease records) of patients under the care of the Palliative Care Support Team at the University Hospital, Bydgoszcz, in 2002–2004, 2005 and 2006.


Results. Between 2002–2006, the Palliative care support team in Bydgoszcz provided a total of 1,441 consultations, including 807 consultations by doctors and 634 consultations by nurses. The total number of examined patients involved 372 persons. The mean age of treated women was 67.27 years and the mean age of treated men was 64.74 years. Most of the patients suffered from tumours (78.49%), although every year the proportion of patients with non-neoplastic diseases (17.20%) demonstrated an increasing tendency. The main reason for the care requests involved a lack of satisfactory treatment of pain (54.57%). The patients were referred primarily by surgical wards (36.4%). Approximately 10% of the patients under the care of the supportive team died in hospital.

Conclusions. The results confirmed the need to form palliative care supportive teams as every year there is an increase in the number of requests for consultation and an increase in the number of patients. The supportive team was shown to play an important role in symptomatic care, in providing appropriate care for patients dying in hospital, in educating the patients, their families and the medical staff.

Key words: palliative care support team, hospital of emergency care

Adv. Pall. Med. 2008; 7: 55–60

Address for correspondence: Damian Jagielski
Palliative Care Department, *Collegium Medicum* of the Nicolaus Copernicus University
ul. M. Skłodowskiej-Curie 9, 85–094 Bydgoszcz, Poland
Tel.: (+48 52) 585 34 61
e-mail: damian.jagielski@cm.umk.pl

 Advances in Palliative Medicine 2008, 7, 55–60
Copyright © 2008 Via Medica, ISSN 1898–3863

Introduction

A supportive team represents one of the organizational forms of palliative care. It is located in a hospital emergency care centre and functions within a given hospital. The main role of the palliative care support team involves granting assistance to medical staff of various departments and clinics for control of pain and of other symptoms. The aims of a hospital's palliative care support team are achieved by giving advice, consultations and support to medical staff, patients, their families and carers. A physician of the supportive team closely collaborates with the physician in charge of a given patient in the ward. Aside from the symptomatic treatment, the supportive team provides or helps to provide psychosocial and spiritual assistance to the patient and his/her close friends/relatives. The team also helps in organizing the care of a patient following his/her discharge from the hospital. The aim is implemented by indicating an appropriate medical institution, by referral to such an institution and by educating the patient, his/her family and carers, aimed at supporting the continuation of such patients' care at home. The supportive team helps to acquire appropriate equipment and assistance that will directly affect the life quality of the patient and his/her family and carers. The subsequent important goal includes help in resolving difficult ethical problems linked to the end of life. Moreover, the supportive teams are engaged not only in directly educating medical staff in the hospital but also family doctors who collaborate with the hospital and are engaged in an editorial activity, targeted at students and other members of the medical community as well as at the patients, their families and the local community.

The palliative care supportive teams enjoy a long and good history in several countries in North America and Europe. Formation of palliative care supportive teams is backed up by epidemiological, medical and economic arguments. The form of palliative care is best developed in countries with an advanced civil society in which the prevailing majority of patients still die in a hospital and not at home.

The first palliative care support team in the world was formed in 1974 at St. Luke's Hospital, New York, including at that time 730 hospital beds and collaborating with Columbia University School of Medicine.

In Europe the first palliative care support team was organized in 1977 at St. Thomas Hospital, London. Formation of the team started an abrupt development in the form of palliative care in Great

Britain, and by 1995 there were 216 supportive teams [1]. In 1989, a palliative care support team was formed in France, creating mobile palliative care teams. Their role was not restricted to hospital activities as they provided telephone advice, especially to family doctors in the vicinity of the hospital [2].

In Canada a network of supportive palliative care teams developed widely in hospitals, the first team of this type being formed in 1982 at Henderson General Hospital, Hamilton in Ontario [1].

Financing of the supportive teams for hospital care in emergency care hospitals in the world reflects, first of all, the way of financing the other forms of palliative care in a given country; for example, in Great Britain the teams obtain the funds they need mainly from charity sources, in the United States from health insurance, and in Canada from hospital budgets [3].

All supportive teams in these countries employ not just physicians and nurses but also social workers, chaplains, psychologists, and administration workers, and takes advantage of help from volunteers [1].

Apart from its economic rationale, the dynamic development and spread of palliative care supportive teams reflects a new understanding and novel approach to palliative care. In line with its new definition, formulated by WHO [4], it is supposed not only to alleviate but also to prevent suffering. The latter aspect of supportive activities can be implemented by the team, as they remain in frequent contact with the patient at the earliest stages of his/her disease, e.g. at the time of the diagnosis. On the other hand, the need for formation and development of palliative care supportive teams stems from the necessity to provide honest conditions for patients dying in emergency care hospitals as well as in intensive care wards.

In Poland, there are at present two palliative care supportive teams, the first at the Dr. Antoni Jurasz University Hospital in Bydgoszcz, the other at the Oncology Centre, Marie Curie-Skłodowska Institute in Warsaw.

The principal obstacle preventing development of this form of palliative care in Poland is a lack of contracts for services of the palliative care support team granted by the National Health Fund (NFZ). Therefore, the costs of a team's activity are covered by the emergency hospital in which the given team acts. Despite projects and other efforts aimed at providing grounds for this form of palliative care in Poland by its inclusion to the list of refunded services and procedures, the services fail to be included in

the tenders announced by the NFZ. This caused a termination of activities of the palliative care support team, operational from 1992 to 2005 in the H. Świącicki Independent Public Clinical Hospital No. 2 in Poznań.

The Palliative care support team in Bydgoszcz (STPCB) started its activity in September, 2002. During the preliminary stages it employed just a single nurse, while doctors specialising in palliative care began to be employed in April, 2003. At present, four doctors work in STPCB, linking their consultation duties in STPCB with their work in the Ward of Palliative Care and Clinic of Palliative Medicine at the University Hospital. From August, 2007 the team no longer had the job position of a nurse. STPCB is financed fully from the budget of the University Hospital.

The aim of this study involved an analysis of STPCB's activities between 2002 and 2006 and based on this demonstrates the need for this organizational type of palliative care in an emergency care ward.

Methods

The study was approved by the Ethical Committee of the Nicolaus Copernicus University, Bydgoszcz.

The analysis was conducted on the basis of documents of patients under the care of STPCB between 2002–2004, 2005 and 2006.

The data on STPCB activities between 2002–2004 were obtained from 100 disease records. The remaining 103 records were incomplete and, therefore, apart from the total numbers of patients and of consultations, the respective data were omitted in the detailed assessment of the period. In 2005 and 2006 such defects were much less frequent and full documents of all the patients were analysed. The data obtained from disease records included age, sex, employment status, domicile, family status, caretaking relative, clinical diagnosis, treatment experienced before admission to the hospital, cause of reporting to the hospital, number of STPCB visits, procedures implemented by the referring palliative care support team, place to which the patient was directed.

Results

Between 2002–2006, STPCB provided a total of 1,441 consultations, including 807 consultations by a doctor and 634 consultations by a nurse. At the time STPCB took care of 475 patients (of which 103 patients treated between 2002 and 2004 were not

Table 1. Characteristics of the patients under care during the years 2002–2006

Mean age of patients [years]	Women 67.27	Men 64.74				
Age ranges of patients	Up to 18 n = 3	19–35 n = 9	36–50 n = 43	51–65 n = 111	Above 65 n = 206	
Occupational status	Pupils n = 4	Employed n = 77	Pensioners n = 118	Retired persons n = 148	Unemployed n = 5	Lack of data n = 20
Carer	Wife/ /husband n = 177	Other family member n = 147	Unrelated person n = 3	No carer n = 4	Lack of data n = 41	
Gender of patients	Women n = 175	Men n = 197				
Clinical diagnosis	Neoplastic disease n = 292	Non-neoplastic disease n = 64	Lack of data n = 16			
Reason for referral	Pain n = 203	Asphyxia n = 16	Nausea n = 9	Vomiting n = 10	Nursing indications n = 21	Social indications n = 30
Preceding oncological treatment	Surgery n = 100	Radiotherapy n = 23	Chemotherapy n = 32	Lack of data n = 100		
Referring units of SU	Surgical n = 130	Internal diseases n = 70	Neurological n = 42	Laryngological n = 34	Geriatrics n = 46	Urology Orthopaedy n = 17 n = 9
						Emergency medicine n = 9

SU — University Hospital; n — number of patients

Table 2. Profile of the activities of the Palliative care support team in Bydgoszcz in the consecutive years 2002–2006

	2002–2004	Profile of the activities 2005	2006
Non-neoplastic patients	12 (12%)	14 (13.6%)	38 (22.4%)
Reasons for the referral			
Pain	55 (55%)	59 (45.38%)	89 (52.66%)
Other symptoms	19 (19%)	12 (9.23%)	43 (25.44%)
Nursing indications	6 (6%)	1 (0.77%)	14 (8.28%)
Social indications	20 (20%)	7 (5.8%)	3 (1.77%)
Implemented procedure			
Symptomatic treatment of pain	51 (51%)	56 (43.08%)	85 (50.29%)
Other symptomatic treatment	4 (4%)	6 (4.61%)	40 (23.67%)
Treatment of decubitus	0 (0%)	1 (0.77%)	11 (6.51%)
Organization of subsequent care	27 (27%)	34 (26.15%)	53 (31.36%)
Oncological consultation	3 (3%)	1 (0.77%)	7 (4.14%)
Deaths at the hospital	10 (10%)	7 (5.8%)	18 (10.65%)

included in subsequent analyses due to significant defects in their documents). The results obtained from the analysis of documents are presented in Tables 1 and 2.

An analysis of the patient's gender showed that in 2002–2006 the patients included 175 women and 197 men. In 2002–2004 the mean age of patients amounted to 63.8 (SD \pm 14.5) years, in 2005 it was 69.23 (SD \pm 14.16) years while in 2006 it was 64.36 (SD \pm 15.2) years. Most of the patients had passed their 65th year and in only three cases did STPCB care for children.

As far as domicile of the patients was concerned, the large majority of the patients included inhabitants of Bydgoszcz (224), followed by rural inhabitants (66), inhabitants of towns < 50 thousands inhabitants (49) and inhabitants of towns > 50 thousands inhabitants (33). Most, or as many as 194 patients under SPTCB care in 2002–2006 were married, 51 were widows/widowers, 26 were unmarried, and in 101 disease records no data on the subjects could be found. The most frequent cause of reporting to SPTCB involved poorly controlled pain (203 patients) or a need to arrange further care of the patient (30 patients) (Table 1).

On the basis of the medical documents, an analysis of the clinical diagnoses was conducted on SPTCB-treated patients in 2002–2006. The following were diagnosed: 102 patients had tumours of the alimentary tract, 22 had pulmonary diseases, and 15 had tumours of the genital system. A total of 20 patients had disseminated neoplastic disease while for 8 the origin of the neoplastic disease could not be identified. Admission to SPTCB was most frequently preceded by oncological treatment in-

volving surgical procedure and the patients were referred to the supportive team by doctors working in surgical departments (Table 1).

Among non-neoplastic diseases the most numerous group was formed by patients with lateral atrophic sclerosis (13 patients).

Other data subjected to statistical analysis included information on the care subsequent to SPTCB procedures. Most patients were discharged home (176 patients), although regrettably, no detailed data were available on the subsequent care of the patients, e.g., whether they were covered by home palliative care, etc. 103 patients were referred to stationary palliative care. Between 2002–2006 35 patients died (9.41%) in the course of SPTCB procedures, while 17 patients were referred to further palliative care, 10 were referred to long-term care, 11 were directed to another hospital, and 4 were referred to another ward/clinic of the University Hospital. In 16 disease records no data on the subject were available.

Discussion

The conducted analysis of SPTCB's activities during the years of 2002–2006 has demonstrated an annually decreasing need for services required in an emergency care hospital for services provided within the form of palliative care. The decisive majority, or over 78.5% of SPTCB's patients, has included patients suffering from tumours. Such a result was expected at the start of the studies but it has been surprising to identify such a prevalence of patients, as compared to patients with non-oncological diseases and despite the fact that in Bydgoszcz this is

the Centre of Oncology functions, specializing in treatment of oncological diseases. On the other hand, the University Hospital, within which the palliative care support team functions, has no oncological ward for adults. Possibly the fact that just 17.2% of the group comprised non-oncological patients meant restricted knowledge on accessibility of palliative care for such patients. In parallel, a trend has been noticed in the increase of the number of non-oncological patients referred to SPTCB. Possibly this has reflected the type of information passed on by SPTCB staff during their daily work to other hospital staff and the introduction of practical classes within the supportive team for medical students in the course of their training.

The results of studies have also shown that most of the patients (102 patients) suffered from tumours of the alimentary tract while only 2 patients were affected by pulmonary tumours and 15 patients were affected by gynaecological malignancies. The profile of the patients has failed to reflect any epidemiological structure of tumours in the Polish population. Most probably, this reflected the specificity of the University Hospital, which contains no gynaecological ward while patients with respiratory affections are referred to the Hospital of Pulmonary Diseases in Bydgoszcz.

The most frequent oncological procedure preceding the referral of a patient to SPTCB has involved surgery. This has been linked to a distinct profile of problems than those noted in the Centres of Oncology, which take care of more patients in the course or following radio- and chemotherapy, who suffer not only due to a progressive disease but also due to complications in the treatment. All of this points to the need for accessible supportive teams, which should be able to recognise the specificity of needs in the given hospital in which they function.

The most frequent cause of referrals involved needs of symptomatic treatment, including pain (more than half of all referrals to SPTCB). Similar observations were documented by the supportive team at King's College Hospital in London, even if they documented an even higher proportion (74%) of referrals for anti-pain treatment [3].

In none of the patients has psychological help been registered as the principal cause for the request to extend care of the team to the patient. Most probably this was linked to the failure to notice such needs by the doctors who requested the consultation. The decreasing tendency in requests for social assistance has also been surprising: 20 patients were referred to palliative care for social

reasons in the years of 2002–2004, 7 patients in 2005 and in 2006 just 3 patients were referred to the palliative care of SPTCB. This tendency could be explained as an increasingly positive effect of the efforts made by social workers in the hospital but the second in frequency (subsequent to symptomatic treatment) procedure implemented by SPTCB has involved help in organizing further care after discharge of the patient from the hospital. Thus, the supportive team should either employ its own social worker or secure close collaboration with such a hospital employee. In the available literature we have found no precisely defined procedures which would represent the duties of a social worker in a palliative care support team. They have been defined only for a social worker acting within the frame of the outpatient clinic of palliative care, stationary ward of palliative care, respective ward of daily care and in the home hospice.

The most frequently implemented procedure has involved symptomatic treatment and, first of all, alleviation of pain (192). The need for implementation of appropriate therapy of pain was cited as the main cause for referring a patient to the supportive team, and indicates the unsatisfactory results achieved by doctors working in emergency wards. Rapid implementation of professional pain treatment significantly affects the quality of a patient's life, avoiding unnecessary suffering and frequently abbreviating the period of hospitalization [3].

Approximately 10% of the patients referred to SPTCB died during their stay in hospital. The staff has attempted to create conditions as similar as possible to those at home, securing intimacy, peace and quiet, reducing their interference to the unavoidable activities and has performed in an expert fashion, providing the patient with a sense of safety at the same time. The team has secured the chances of family members to be present with the dying patient, preventing isolation of the patient, which frequently reflects an erroneous understanding of the conditions necessary for a patient who dies in hospital. The activities of the staff have included both symptomatic treatment, nursing care, proper management of the site, educating employees in a given ward or clinic, educating the patient's family, care for fulfilment of the patient's wishes and for spiritual assistance.

Sporadically, SPTCB doctors have been asked by doctors from other wards for assistance in undertaking decisions on cessation of treatment or failure to introduce a therapeutic technique thought to be disproportionate to a given situation. In Poland little attention has been paid till now to persis-

tent therapy, and emergency hospitals show an attitude to save and support lives at any cost. Specialists in palliative care working in SPTCB might help in creating interdisciplinary ethical commissions to help deal with such problems.

Conclusions

An analysis of SPTCB's activities in the years of 2002–2006 argues for the need to form hospital palliative care supportive teams. This is expressed in the growing number of requests for consultation and the growing number of patients covered by SPTCB's care, including a significant proportion of patients dying in the emergency care unit at the hospital who have to be provided with appropriate adequate conditions for the dying, and in the need for educating the patient, his/her family and medical staff. The index of needs for consultation of specialists in palliative care in an emergency care hospital involves the highest share of referrals to SPTCB due to the absence of appropriate pain treatment. The need for formation of such teams is also indicated by economic factors: an appropriate symptomatic treatment and help in arrangement of the subsequent care of a patient frequently shortens his/her stay in hospital.

References

1. O'Neill WM, O'Connor P, Latimer EJ. Hospital Palliative Care Services: Three Models in Three Countries. *J Pain Symptom Management* 1992; 7: 406–413.
2. Lassauniere JM. A mobile palliative care team. *Eur J Pal Care* 1994; 1: 130–131.
3. Adamczyk A, Krajnik M. Palliative care support team acting in an emergency care hospital (in Polish). *Mag Med — Med Pal* 2004; no. 12/2004: 54–57.
4. World Health Organization 2002 www.who.int/cancer/palliative/en/
5. Eilershaw JE. Assessing the effectiveness of a hospital's palliative care team. *Pal Med* 1995; 9: 145–152.
6. Higginson I. Clinical and organizational audit in palliative care. In: Doyle D, Hanks GWC, MacDonald N (eds). *Oxford Textbook of Palliative Medicine*, 2nd ed., Oxford Medical Publications, Oxford University Press 1998: 67–80.
7. Cummings I. The Interdisciplinary team. In: Doyle D, Hanks GWC, MacDonald N (eds). *Oxford Textbook of Palliative Medicine*, 2nd ed., Oxford Medical Publications, Oxford University Press 1998:19–28.
8. Doyle D. The provision of palliative care. In: Doyle D, Hanks GWC, MacDonald N (eds). *Oxford Textbook of Palliative Medicine*, 2nd ed., Oxford Medical Publications, Oxford University Press 1998: 41–51.
9. Clinch JJ, Dudgeon D, Schipper H. Quality of life assessment in palliative care. In: Doyle D, Hanks GWC, MacDonald N (eds). *Oxford Textbook of Palliative Medicine*, 2nd ed., Oxford Medical Publications, Oxford University Press 1998: 83–93.
10. Corr CA. Death in modern society. In: Doyle D, Hanks GWC, MacDonald N (eds). *Oxford Textbook of Palliative Medicine*, 2nd ed., Oxford Medical Publications, Oxford University Press 1998:31–39.
11. Scott JF. Palliative medicine education. In: Doyle D, Hanks GWC, MacDonald N (eds). *Oxford Textbook of Palliative Medicine*, 2nd ed., Oxford Medical Publications, Oxford University Press 1998:1169–1196.
12. Jodrell N. Nurse education. In: Doyle D, Hanks GWC, MacDonald N (eds). *Oxford Textbook of Palliative Medicine*, 2nd ed., Oxford Medical Publications, Oxford University Press 1998: 1203–1207.
13. Wallwork L. Palliative care in non-malignant diseases: a pragmatic response. *Intern J Pal Nurs* 2000; 6:186–191.
14. McQuillan R, Forbes K. The provision of palliative care service in a teaching hospital and subsequent evaluation of that service. *Pal Med* 1996; 10: 231–239.
15. Ruzniewski M, Zivkovic L. Difficulties faced by hospital palliative care teams. *Eur J Pal Care* 1999; 6: 11–14.
16. Brazil K, Thomas D. The role of Volunteers in a Hospital-Based Palliative Care Service. *J Pal Care* 1995; 11: 40–42.
17. Dunne K, Sullivan K. Family experiences of palliative care in an acute hospital setting. *Intern J Pal Nurs* 2000; 4: 170–178
18. Foulkes M. Hospital referrals of the terminally ill for hospice care. *Eur J Pal Care* 1996; 3: 65–67.