



# Impact

## Service Delivery

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### Case Studies

There are two cases in this “Service & Delivery Systems” module. Each case is written in a context relevant to this module. The first case, Mrs. Gregory, is a common case that can be found also in modules for other topics. The common cases are illustrated with video and audio clips. Example explanations for each case are included. They can be used as a reference to judge your students’ responses.

#### Case 1: Mrs. Gregory

Mrs. Gregory is a 62-year-old woman who has been a patient for many years at the office where you work as an office nurse. For the past few months, she has complained of increasingly severe upper abdominal pain and weight loss. An ultrasound ordered by Dr. Minor revealed a mass highly suspicious for primary liver cancer.

Mrs. Gregory and Gloria, the youngest of her three daughters, come to Dr. Minor’s office to discuss the test results. Dr. Minor discussed the test results, but you were with another patient. You know the family well and expect Mrs. Gregory to understand what Dr. Minor told her, and you plan to instruct her on use of the pain prescription Dr. Minor wrote for her. However, while clarifying her understanding about her illness, Mrs. Gregory becomes resistant. She tells her nurse that there’s nothing wrong with her. She says, “All I need is some herbal remedies to help ease my indigestion.” She leaves after agreeing to try the pain pills suggested by Dr. Minor

Clearly upset with her mother’s behavior and attitude in facing a terminal illness, Gloria, seeks your advice. She wants her mom to confront her disease and the fact she’s dying. However, her two sisters strongly disagree, and tell Gloria they will never speak to her again if she continues to force their mother into confronting her prognosis.

Mrs. Gregory, who has always been fearful of death, continues to avoid discussing her apparent diagnosis of primary liver cancer and poor prognosis. She becomes increasingly distressed by the physical changes that are a part of her condition such as ascites, jaundice, and bruising. In addition, she has become increasingly distraught about the actual process of dying. When her physician asks her if she is in pain, she consistently replies, “I’m in agony, but you can’t

help my kind of pain.” A few days later she has a crisis and is taken to the emergency room. The ER physician speaks with Dr. Minor and they agree that Mrs. Gregory will not be able to return home without skilled care. Since she has been reluctant to admit that she is dying, they fear that neither she, nor her daughters, will agree to hospice care.

- You are a hospice nurse working with the hospital’s hospice program. You have been asked to discuss hospice care with Mrs. Gregory and her daughters since Dr. Minor feels that Mrs. Gregory would feel more comfortable with a nurse. Additionally, if she agrees to home hospice care, you would be familiar to her as her hospice nurse. As you enter the room, what will you say to set the stage for this conversation (keep in mind the communication techniques discussed in the Connections, Communication module)?
- What other interdisciplinary hospice team members’ services might be offered to help Mrs. Gregory and her daughters deal with her fears of death, her pain, the grief that they are all experiencing but not discussing?

**Case 2 and 3:**

1. Read the following case studies "Ellen Arthur" and "George Lincoln." Compare and contrast the type of care each received.
2. Which situation would you want for a loved one or yourself at the end of life? Why?
3. How might you help George Lincoln receive the kind of care his wife had?

To illustrate the variability of care for those who are dying, this section presents several more cases. These cases do not exactly describe a single patient or institution or represent statistically typical patients. The cases synthesize the experiences of the Institute of Medicine's Committee on Care at the End of Life, cases in the medical literature, research findings, and specific problems reported to the committee. Several describe situations that particularly strain care systems. The cases highlight some of the positive and negative features of the care systems available to dying patients and those close to them

**Case 2: Ellen Arthur**

This case, synthesized from the hospice literature and committee experiences, illustrates a patient and family for whom a limited range of hospice services work well and whose personal circumstances support living well while dying.

Ellen Arthur, a 78-year-old retired teacher diagnosed with kidney cancer, underwent surgery and a trial of experimental chemoimmunotherapy. Tests then showed that the cancer had spread to her lungs and bone. She was incurably ill but not imminently dying and could reasonably be expected to live for another year, perhaps two. She felt fairly well except for mild fatigue. She and her husband were financially comfortable, well educated, and surrounded by supportive family and friends. They reviewed the durable power of attorney and related documents that they had prepared many years ago. After several months of fairly normal activity, pain and weakness began to require an increasing amount of medication. Ellen Arthur's physician concluded that she could very well die within the next six months—probably less—and certified this so that she qualified for the Medicare hospice benefit. Her physician coordinated care with the hospice medical director who, in turn, worked with the patient, her family, and an interdisciplinary team to implement the care plan as initially designed and later adjusted as the illness progressed. A hospice nurse was the center of the care team, which focused on two primary problems—fluctuating pain and fatigue. Protocols allowed the nurse to adjust pain medications within defined boundaries, and she advised ways to prevent or soothe other symptoms. For example, she suggested ice chips and glycerin swabs to ease dry mouth and advised balancing rest and activity to reduce the burden of fatigue. The family needed little other direct service from the hospice. Physical therapy and other medical services were not indicated, and the family found emotional and spiritual comfort in their friends and their faith and in

reviewing their life together. Friends also pitched in to provide occasional practical help with meals, errands, cleaning the house, and respite time. John Arthur was informed about how to recognize changes in his wife's condition, especially signs that death was imminent. He knew that if something happened that he could not handle—seizures, for example—he could call the hospice any time, day or night, and help would be sent. The Arthurs were informed that if they called 911 in such an emergency, the protocol for paramedics in their jurisdiction required attempts at resuscitation and other interventions and transport to the hospital. Ellen Arthur died at home with her husband at her side (pp. 90-91). From *Approaching Death. Chapter 4 The Health Care System and the Dying Patient Case histories -- quality of care and care settings* (1997) Institute of Medicine, Committee on Care at the End of Life. Used with permission.

### Case 3: George Lincoln

This case illustrates the disruptions that may be caused by health care restructuring and consolidation. George Lincoln was an 84-year-old retired engineer whose health gradually deteriorated as multiple organ systems began to fail. Through his former employer's health plan, he had long been enrolled in a large HMO. He had been pleased with the HMO, which arranged much appreciated hospice care when his wife died of breast cancer several years earlier. Then, however, the HMO was sold to a corporation with out-of-state headquarters, his personal physician was not on the new provider list, many of his numerous medications were switched to lower-cost drugs, and referral to a cardiologist experienced with very old patients proved difficult. Mostly confined to his home (and often to his bed) and experiencing considerable physical distress but still mentally alert, Mr. Lincoln concluded — with considerable equanimity — that "my time is coming." He raised the issue of hospice care with his new primary care physician. He discovered that the HMO's long-standing relationship with a community hospice had been terminated in favor of referrals to a fairly new organization. Mr. Lincoln was not told that as a Medicare beneficiary he was not limited to this hospice, and he found the new hospice provided a much-reduced level of care — and caring. He was, in any case, too fatigued and depressed to complain (pp. 94-95). From: *Approaching Death. Chapter 4 The Health Care System and the Dying Patient Case histories -- quality of care and care settings*. (1997) Institute of Medicine, Committee on Care at the End of Life. Used with permission.