Family Practice Forum

Family Medicine and Hospice Programs: A Natural Alliance

Paul T. Werner, MD
East Lansing and Escanaba, Michigan

The American hospice movement, like the family medicine movement, is less than two decades old, but it presents the family physician and family medicine educators with an ideal setting in which to practice and teach. Because of the similarities in approaching patient care, these two movements can and should support each other. Practitioners in both areas have knowledge, skills, and attitudes to share with each other, and family medicine would miss an ideal opportunity to foster appropriate growth in its learners were it to omit active participation of its faculty and students in the hospice.

The hospice system offers a holistic program of care for terminally ill patients and their families by using an interdisciplinary approach to provide symptomatic relief for the dying patient and support for the bereaved survivors. As a program of care, the hospice does not depend on a physical structure to accomplish its work. Many programs choose to operate inpatient settings for the provision of this care, either as a free standing unit or as part of an existing hospital or nursing facility. These units may also be called "hospices," but it is the caring, not the place, that denotes the presence of a hospice program. Most hospices aim to keep the terminal patient at home for all or nearly all of the last stages of life, using the inpatient setting only to manage those symptoms in the patient (eg, pain, coma, incontinence) or the family (eg, fatigue, profound grief, family discord) that cannot be controlled with the patient at home. As soon as symptoms are controlled, the patient returns home. Those programs with inpatient services almost uniformly provide home services or contract for them through a home nursing provider.

In all cases, the patient is approached in a holistic fashion, recognizing those elements of the patient's physical, social, emotional, and spiritual life that are unique, and seeking to restore the blend of those elements that represent homeostasis for the individual and the family. Physical symptoms are often the most obvious and may be the primary reason for referral. Hospices offer expert care in the practical therapeutics (eg, for chronic pain, gastrointestinal dysfunction, and skin and mouth care). Simultaneously, support of the patient's emotional life with empathic listening, counseling, and careful use of drug therapy is provided. Each dying patient perceives some meaning or spiritual quality to the dying experience, be it positive or negative. This may be expressed in religious or existential terms. The hospice environment values these aspects of spiritual life, encourages their exploration, and provides pastoral or counseling care where appropriate and desired.

To the hospice team the social aspect of dying is perhaps second only to the physical in importance. When a patient dies, the family context also dies—it can no longer exist as previously. It must grieve, heal, and rebuild with the realization that a loved one is gone. The hospice is a bright source of support for the family before and after death. Before, it provides caring support, encourages the

From the Department of Family Practice, Michigan State University, East Lansing, and Bay de Noc Hospice, Escanaba, Michigan. Requests for reprints should be addressed to Dr. Paul T. Werner, 120 Doctors Park, Escanaba, MI 49829.

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family to assume as much care for the dying as it wishes, and fosters communication among the members and between the members of the family and the larger community, especially in the medical arena. After, it provides follow-up bereavement care, meeting with the survivors on key family anniversary dates and traditional holidays when the memories are acutely vivid and painful. The hospice team provides a bridge back to activity in the larger community, preventing social isolation.

Teams form the care giving element. The hospice successfully puts into action an interdisciplinary approach, usually including nurses, social workers, physicians, lay volunteers, pastoral care providers, and others such as psychologists, nutritionists, and therapists. Many "turf" problems have been solved, and models of group process, sharing of responsibility, and growing interdisciplinary dependence can be witnessed in the hospice teams.

Because only terminal patients are admitted to a hospice program, the emphasis is on symptomatic control. The goal is to allow the patient to be pain free, alert, and able to participate in decisions about himself or herself and the family for a maximum amount of time. To achieve this, hospice workers must become masters of detail in order to provide changes small and large to approach these goals. Clinical pharmacology and practical nursing skills are no more important than interpersonal abilities and an empathic ability to be with the patient and family.

It takes no leap of logic to see that the basic themes in hospice care and family medicine are congruent. Family medicine stresses care of the total person, with attention to the social, emotional, and spiritual domains along with the physical. The title of the discipline implies and underscores the interest in the family as the unit of care. Family medicine also advocates utilization of the team approach to aid patients. Finally, the continuity elements of the hospice, with follow-up of the survivors, are similar to the care-over-time precepts espoused by family medicine.

New hospice programs are evolving by the hundreds in communities of all sizes. Each needs the support of dedicated individuals to grow and to provide care. Family physicians in practice should support or even instigate hospice efforts in the community. Family medicine teachers should likewise support the hospice as a natural place to train residents and students in basic precepts of family medicine. No other setting provides such a rich experiential setting, concentrating so much of family medicine into a single program. Learners are exposed to, among others, holistic care, team care, elements of death and dying, family life cycle, clinical medicine and pharmacology, practical nursing skills, crisis intervention, family unit care, continuity experiences, interpersonal skills (both with patients and coworkers), and elements of community leadership and medicine. Research in hospice care provides a significant area for family medicine study.

Hospices in turn have much to gain from family medicine, primarily physician support. This critical area of need is often most difficult to meet. The natural predisposition of family medicine to family care, continuity, and holism will be welcomed by the hospice. The attention to behavioral, spiritual, and interpersonal issues that family physicians can show will strengthen the hospice program. Finally, through referrals and cooperation, the physician can be a liaison with the medical community to provide education and attitudinal changes that may be necessary to support the hospice.

Suggested Reading

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