

## Special Video Report Transcript

Headline: Diane Meier of the Center to Advance Palliative Care Talks About Treating Critically Ill Patients

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Diane Meier, professor of geriatrics and palliative medicine at Mt. Sinai School of Medicine and director of the Center to Advance Palliative Care

"When I was a medical student and an intern and resident in internal medicine, I found myself noticing that the more specialized my teachers became, the less they seemed to see the person in front of them. So for example, on my medical school and residency rotations in cardiology, there would be tremendous expertise and depth of sophistication about the functioning of the left ventricle, one of the chambers of the heart. And we would make science-based decisions about what to do next, what imaging studies to do, what medications to prescribe, what procedures to consider, without any discussion as to who is this person, what are their goals in life, are they cognitively impaired, can they afford these medications, can their family manage the device if we put it in. And because my brain is structured as a lumpner and not a splitter, I had increasing difficulty with the fragmentation and the subspecialization of the medicine that I was being trained to do. As a result, after I completed my internal medicine residency, I decided to specialize in geriatric medicine."

"At that time, there was no such field as palliative medicine, and geriatric medicine was really the only subspecialty of internal medicine that focused on whole-person care. And what attracted me to it was precisely that -- that your job was to actually understand this patient as a person, this person in the context of their family, in their context of their faith, in the context of their whole community, their ethnic and cultural background, their socioeconomic background, their literacy, their level of understanding of what was going on with them medically. And that made so much more sense to me. It just didn't make sense to me to write somebody a prescription knowing what you had done was scientifically right but having no idea if they understood what you said, having no idea if they could afford to fill the prescription, having no idea if they or their families would know how to make sure that the prescription was actually taken as ordered. And so I sought a field that said all of these things are your job as a physician, because they're all important to the health and well-being of the patient."

"And so in my initial job after my training in geriatrics, I moved to Mt. Sinai School of Medicine in New York City, where I was a hospital-based geriatrician. So I did some research, and I taught on the medical wards, and I saw patients in the outpatient clinic. And I was continuing to be disturbed by what I saw, which was basically that the

practice of medicine had turned into -- maybe the best description is parallel play. So the typical seriously ill patient would have lots and lots of different specialists taking care of them. So say you have cancer. You would have an oncologist. You would have a hospitalist. You would have an infectious-disease doctor to handle the infections that were the consequence of the chemotherapy. You would have a neurologist because you were confused and delirious as a toxic side effect of the infection or the chemotherapy. You might have a primary care doctor, although that primary care doctor rarely set foot in the hospital or really had anything to do with the decisions or the management in the hospital."

"And what I saw is that amidst all these specialists and all these tests and all these interventions, the patient got completely lost. The family was often viewed by the professionals as -- and this is a bit strong, but I think not wrong -- the family was viewed as the enemy, because the family had a lot of questions and was getting increasingly distressed and was ... and it's very time-consuming dealing with families. And we all had 30 or 40 patients we had to see every day, so people would actually avoid the families and talk about families as a problem getting in the way of the care of the patient. And I also saw, with the best of intentions, physicians causing a great deal of suffering, not only physical suffering -- pain and other symptoms -- but also emotional suffering and spiritual and existential suffering. That is, the patient was no longer the center or the object of what we were doing. The patient became, in some ways, a means to another's end, a means to understanding more about a disease, a means to a procedure or an imaging study."

"What many people don't understand is that palliative care is appropriate with any patient with a serious illness. And let's stop for a moment and think about where most patients with serious illness are. They are not in the hospital. Probably less than a fraction of 1% of a patient's experience with serious illness occurs in a hospital. The vast majority of it occurs in the community, most of it at home and, in some frail older people, in nursing homes or assisted living facilities. So clearly it is urgent to improve access to palliative care outside of hospitals. Why is palliative care right now largely limited to hospitals? Unfortunately, that's because that's where the business case is, because the way hospitals are reimbursed makes it aligned with their both quality and cost objectives to integrate palliative care into hospital care. In the community, on the other hand, there is no business case, no means for supporting a palliative care team outside of the hospital. The good news, though, is that that is changing. Because of the impact of health reform, because of the growth of accountable care organizations and other managed-care type mechanisms for paying for and delivering health care, the business case for palliative care is growing rapidly -- in that it is quite clear that for any of these models to survive both from a financial and a quality standpoint, they have to figure out how to effectively manage the sickest and most costly 1% to 5% of patients. And the sickest and most costly 1% to 5% drive about 50% of spending, and that is the palliative care patient population."