Rural Community-Based Palliative Care Program

Case Studies

Case #1: Jane Brown

Jane Brown is 66 years old with a clinical diagnosis of early dementia. Her husband John, age 72, is in good health following treatment for prostate cancer three years ago. The Browns have three adult married children, who live in other states and have not visited their parents in several years. Jane makes an appointment with her primary care provider to talk about her dementia, what she might expect in the future, and what decisions she or her family might need to make. She is concerned about being “kept alive” for many years in a facility if she is not able to recognize her family. She has had personal experience with a family member who died of dementia.

Her primary physician asks if there is someone who could arrange a family conference with Jane, John, and their adult children (linked in by phone). As the family physician for this couple, she knows that John has a history of alcohol abuse and is at risk for recurrent prostate cancer. The physician anticipates that the discussion at the family conference will include providing medical information about the course of dementia, potential future treatment decisions, and planning how to provide psychosocial and spiritual support for Jane and John. How might your community respond to this situation?

Case #2: David Jones

David Jones is an 89-year-old resident of Timber Pines Nursing Home. He is widowed and has one nephew who visits monthly. David has CHF and COPD, as well as pain due to osteoarthritis. Over the last six months, he has been hospitalized twice for trouble breathing and acute heart failure. When he returned to the facility, he was confused for several days. His medications were changed in the hospital during the last admission, and he is now more uncomfortable and has difficulty walking.

The care team at the nursing facility notes that the advance directive names David’s nephew as the surrogate decision maker. However, David admits he has not talked with his nephew about his wishes. The care team realizes that David is at risk for future hospitalizations and may lose decisional capacity. They also wonder if David understands that he is getting sicker.

Should David continue to be transferred to the hospital as needed? If not, how will his symptoms be managed at the facility? What would be important in managing his pain and trouble breathing? What role would David’s nephew play in the discussion and plan?

Case #3: Eleanor Rigby

Eleanor Rigby is a 75-year-old woman who resides in an assisted-living apartment. Her medical history includes coronary artery disease, emphysema, chronic renal disease, and rheumatoid arthritis. She is widowed and has one son who lives over 1000 miles away. Eleanor worked for over thirty years as a legal secretary.
Case #3: continued

Eleanor has told her physician that it is very important to her to stay independent for as long as she can. Her sister died in an ICU after two and a half weeks of “suffering” and she does not want that to happen to her. She was recently hospitalized for an exacerbation of her emphysema. As she comes into the clinic for a follow-up visit, the nurse notices that Eleanor is moving very slowly with a stooped posture and is having difficulty breathing.

If Eleanor is hospitalized again, how can you work with Eleanor and her son to ensure her wishes are best met? How might your community organizations work together to ensure continuity of care if she can return to her assisted-living apartment? What services are in your community to help Eleanor stay in her assisted-living apartment if the decline in her health continues?

Credit: Content developed by: Lyn Ceronsky, DNP, GNP, CHPCA, FPCN