



RESEARCH REPORT

Palliative Services in General Hospitals and Geriatric Medical Centers in Israel

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The study was funded with a grant from the Israel National Institute for Health Policy Research

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Bentur, N. and Resnizky, S. 2009. *Spiritual Care in Israel: An Evaluation of the Programs Funded by the UJA-Federation of New York*. RR-526-09.

Bentur, N. and Chekhmir, S. 2007. *Nationwide Palliative Training Program in Israel: Evaluation Study*. RR-498-07 (Hebrew).

Bentur, N.; Resnizky, S. and Shnoor, Y. 2005. *Palliative and Hospice Services in Israel*. RR-459-05 (Hebrew).

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Executive Summary

1. Background, Goals and Study Design

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. It focuses on preventing and relieving suffering by means of early identification and thorough assessment and treatment of pain and other physical, psychosocial and spiritual problems. Directive 30/2009 of the director-general of the Ministry of Health required hospitals, nursing institutions and the health plans to establish and provide palliative services within four years and to train specialist staff for the purpose. It also stipulated that the specialist palliative staff should include at least one physician, nurse, psychologist and social worker. The study presents a comprehensive, up-to-date picture of the development and status of palliative services offered in general and geriatric medical centers six years after the directive was issued.

The study was conducted through face-to-face personal interviews with hospital directors, head nurses, heads of departments and units at 25 general hospitals and 10 geriatric medical centers – altogether 50 physicians, 30 nurses, 2 social workers, and 2 administrative managers were interviewed.

2. Findings

2.1 Organization of the Palliative Services in General Hospitals

Multidisciplinary Oncology Institute and Hospice Wards

Three hospitals have a multidisciplinary oncology center, in which palliative services are included as an integral part of the treatment, and two hospitals have in-patient hospices. These five services have been operative since the 1980s or 1990s. The services include a multidisciplinary staff exclusively for cancer patients (with the exception of one hospital, where a hospice physician who holds no other position provides counseling to the other hospital wards). Three of them have strong ties with home-hospice units and home-care units, which ensures continuity of care. All of them are located in large, prestigious university hospitals in or between Jerusalem and Haifa.

Palliative Counseling Service

- ◆ Until 2009, no hospital other than the above-mentioned offered palliative services. In recent years, ten hospitals have developed a range of palliative counseling services, but no hospital has a multidisciplinary palliative staff that meets the requirements of Directive 30/2009.
- ◆ The hospitals have allocated half- to full-time positions for this purpose from their internal resources. Most of the positions are filled by nurses with post-graduate education in oncology or palliative care. The position is held by physicians specializing in palliative care in only two hospitals.
- ◆ The consultants not only visit the wards when called for (like other consultants in general hospitals), but also initiate their visits to the wards in order to ascertain whether there are any seriously ill patients in need of palliative counseling. Over time, their work has become increasingly recognized and the number of referrals to them is growing.

- ◆ Although the counseling should ideally be provided to all patients in need of palliative care whatever the illness, in practice, most of it is provided to patients with metastasized cancer and in most cases it consists almost entirely of symptom management and supporting the families. Most is given within the hospital, with a small amount of counseling provided in daycare units and oncology outpatient departments in the hospitals.
- ◆ Six hospitals have not allocated a position specifically for palliative counseling but do recognize the importance of it. One of them employs a physician who specializes in palliative care and other has a specialist nurse, both of whom are recognized in their hospitals as opinion leaders, but palliative care is not part of their regular jobs.
- ◆ Four additional hospitals do not offer any palliative service and have no trained professionals in this field.

Palliative Staff and Training in General Hospitals

- ◆ In all 15 general hospitals that have authorized positions (part- or full-time) for palliative care and counseling, the positions are filled by professionals who specialize or are trained in palliative care. Most of the nurses have acquired their post-graduate education in oncology or palliative care and eight hospitals have specialist physicians. However, in five hospitals, the specialist physicians work only in the multidisciplinary oncology institute and hospice wards and in only three of them does the physician work as a consultant in all of the other hospital wards.
- ◆ Most of the hospitals have staff members who have participated in in-service or other palliative care training, such as those implemented by Ben-Gurion University, Tel-Aviv University and the Israel Center for Medical Simulation workshops.
- ◆ Some of the hospitals have seminars and lectures on palliative care. Most of these are medium or large prestigious university hospitals in the center of the country, some of which have large oncology departments. No such activity was found in small hospitals in the periphery.
- ◆ All of the hospitals, and this is particularly noticeable in small hospitals in the periphery, approve staff members' requests to participate in external seminars and conferences on palliative care to update themselves and be involved with other professionals.
- ◆ In interviews with 15 physicians and nurses who had received palliative counseling, they reported that it had helped to improve the management of symptoms such as pain and to provide support to the patients' families. The service had contributed to the department by increasing knowledge for example about different combinations of painkillers and dosages of medicine. It also contributed by providing a holistic approach to these patients. Most of the respondents reported that they now seek palliative counseling more than they used to and some reported that in hindsight they understood that it is worth seeking it at an earlier stage. However, most seek counseling mainly for patients with metastasized cancer who are suffering intense pain.

2.2 Organization of Palliative Services in Geriatric Medical Centers

- ◆ Palliative services in geriatric medical centers are provided in three ways: In four of the centers, the palliative approach is an integral part of the general geriatric care in all hospital wards. The predominant approach is care rather than cure, with the aim of alleviating symptoms and reducing

suffering. In two geriatric centers, the palliative approach has been adopted in supportive complex nursing wards only, and not in the other wards and in four centers, palliative work is minimal and consists mainly of a palliative committee that draws up treatment protocols, defines the characteristics of patients needing palliative care, and develops work practices. But little palliative care is provided on a daily basis.

- ◆ There is great variance among the centers. While those owned by the Ministry of Health and the Clalit Health Plan offer three types of service, some of which have staff allocated specifically for them, the privately owned centers offer far more limited services.
- ◆ One area in which there are differences is advance care directives. Most geriatric centers hold discussions to clarify expectations and preferences when the patients are admitted and whenever there is a change in their condition and the decisions are documented in the patients' medical records. In a few centers, the process is partial and irregular.

3. Barriers and Challenges to Service Development

All the hospitals have to contend with considerable challenges and barriers to the development of palliative services. The main ones are as follows:

- ◆ The director-general's directive did not allocate earmarked budgets for positions to develop palliative counseling services and the hospitals are required to use their own resources to do so. Most find this difficult, particularly the small and medium-size hospitals, which are less flexible than the larger hospitals in their ability to make changes to the approved staffing positions.
- ◆ Respondents from some of the hospitals feel that the directive is not sufficiently clear and detailed and it is hard for them to know what is required of them. Many noted the need for detailed instructions about palliative work.
- ◆ In the hospitals that have set aside a position for a palliative counselor, s/he works alone without an interdisciplinary staff, even though teamwork is an important principle of palliative care.
- ◆ There is a serious shortage of specialist palliative physicians and nurses. Furthermore, physicians specializing in other branches of medicine are not keen to engage in palliative care and consequently it is hard to find candidates to develop the field and specialize in it.

Currently in Israel, most of the counseling in hospitals focuses on treatment of symptoms and support of family members and does not address other areas. One of the reasons, which the nurses and physicians all agreed on, is that the nurses cannot provide these additional services and there are almost no physicians engaged in that work. However, in recent years, palliative care has been expanded and in addition to prevention or management of symptoms, it also provides assistance to family physicians and primary care providers, to patients and their families in decision-making processes about treatment, assists in coping with therapeutic and ethical dilemmas, clarifying expectations from treatment and selecting care preferences, and in coordinating the various care providers and ensuring continuity of care.

- ◆ Many members of the staff in the general hospitals, particularly the physicians, are unfamiliar with the palliative approach and a few even oppose it, sometimes without even wishing to

familiarize themselves with it. Some believe that life should be saved at all cost and have difficulty conducting an open discussion and managing expectations with seriously ill and terminal patients. There is sometimes also opposition to the palliative approach from the general public, who see it as giving up on life.

4. Conclusions and Implications for Policy

Albeit with a slight delay, directive 30/09 has led to considerable change and development in the approach to palliative care and counseling and many general and geriatric hospitals in Israel are now allocating resources for it. Although the directive allowed the hospitals four years to develop palliative services, it appears that they have begun organizing to do so only in the past year or two – five to six years after the directive was issued.

The study findings show that most of the general hospitals in Israel are aware of palliative care and counseling and are taking steps to develop it. Ten hospitals have allocated at least half a staffing position out of their own resources – in most cases the position is held by a nurse. Only two hospitals have a specialist palliative consultant physician and not a single hospital has a multidisciplinary palliative staff. In addition, five hospitals have had palliative services (in the in-patient hospice or in the onco-palliative ward) for many years. However, the differences among the hospitals are so great that no one service resembles any another. For example, in some hospitals, the palliative consultant deals only with patients with metastasized cancer and not with all the patients who need them. Moreover, six of the hospitals are aware of the importance of this field, but have not allocated staffing positions for it and four hospitals disregard the matter completely.

Alongside the development, all of the hospitals reported multiple difficulties and barriers to developing and improving palliative services. It therefore seems that considerable work must be invested to advance palliative care, some at no cost, some that requires budget inputs.

The main steps to be taken:

- ◆ Issue a director-general's directive defining in detail the requirements of palliative services in hospitals along with the staffing requirements and professions required.
- ◆ Allocate hospitals an earmarked budget for these services, since some of them do not have the necessary funding for them, particularly small and medium hospitals that do not have less flexibility to allocate staff to special tasks than the large hospitals.
- ◆ Address the shortage of specialist physicians and nurses and develop incentives for physicians to work in palliative care.
- ◆ Reiterate and emphasize to policymakers and managers that palliative care not only enhances the quality of care but may also save resources.
- ◆ Substantially increase the familiarity and understanding of the palliative approach and advance care planning among staff members, particularly physicians. To achieve this, there is a need to develop appropriate courseware and require hospital staff to study it in the same way as required

for courseware about infections and blood donation. Other than this, a valuable objective is for all senior hospital staff, particularly physicians and nurses, to participate at least once in palliative in-service training or in workshops on symptom management, end-of-life communication, and other relevant topics. In places where patients are referred to palliative service, the staff must be trained to make referrals far earlier than is current practice.

- ◆ Computerized medical records should have fields and links specifically to topics relating to care preferences and advance care directives, symptom management, and other components of palliative care that will facilitate continuity of care when the patient is transferred from one department or institution to another.
- ◆ Include aspects of palliative care in license renewal process for hospitals and geriatric centers, such as the quantity of specialist staff, details of patients who have received care, and other relevant questions. This is in light of the impression that the peer-review process conducted last year by the Ministry of Health was an incentive to the hospitals to develop services and work practices in this area.
- ◆ Develop a "green track" in the emergency rooms and a computer code in hospitals so that terminal patients can be admitted directly without the usual processing in emergency rooms.

In conclusion, despite the changes and developments that took place in palliative services in general hospitals following the director-general's 2009 directive, large gaps remain between the real and ideal.

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