

Where, When and How to Die: Insights into Issues of Critical Nursing in Cancer

Shulamith Kreitler

School of Psychological Sciences, Tel-Aviv University

And, Department of Pediatric Hemato-Oncology, The Edmond and Lily Safra Children's Hospital, Tel-Hashomer

2nd International Conference on Nursing and Healthcare

November 17-19, 2014, Chicago, USA

E-mail: <krit@netvision.net.il>

General Introduction

The uplifting of the taboo concerning death and dying, has given rise to a new set of issues that is being increasingly discussed by patients and their family members:

1. Place of dying, i.e., home, hospital, nursing home
2. Time of dying, i.e., phase of the disease and degree of suffering
3. Manner of dying, i.e., under one's control or not

Study 1: Where to die? This is the Question

Frida Barak, MD, Sophia Lipshitz, MSc, Hani Kaufer, MSc, Ruthi Nathanel, MSc,
Oncology Unit, Government Hospital Barzilai, Ashkelon

Nava Siegelman, MD *Maccabi Sick Fund, Israel*

Yasmin Alkalay M.A. *Department of Sociology, Tel-Aviv University*

and

Shulamith Kreitler, PhD, *School of Psychological Sciences, Tel-Aviv University and
Psychooncology Research Center, Sheba Medical Center, Tel-Hashomer*

Background

The question where to die is one of the most bothersome and difficult questions increasingly discussed in recent years. Rather than an issue of location or site, place of death has turned into a basic psychosocial indicator of end-of-life quality for the terminally ill . Most patients (70%) prefer to die at home; about 30% die at home.

Objectives

To examine medical and demographic variables as predictors of the place of dying, compared to the patient's preference

Method

- *The participants were 326 cancer patients, of both genders, with a mean age of 63.25 years, who have died in 2000-2008 and have been treated by the palliative care unit of a major hospital in southern Israel.*
- *65.7% died at home and 33.4% in the hospital.*

Method: Variables

- *The data was extracted from the patients' files. The examined variables were*
 - *demographic* (age, gender, marital status, ethnic background, number of years in Israel until death),
 - *medical* (age at diagnosis, diagnosis, nature of last treatment one got, patient having got nursing care, patient having got care of social worker, patient having got care of a psychologist, family got care of a social worker, patient had a special caregiver) and
 - *sociological* (having insurance, having worked in Israel, living alone or with family, living with one's children, living in self-owned or rented house, family members working).

Results

Logistic regression with dying in hospital or at home as dependent variable and the following predictors: ethnic background, social work support for family, living in own or rented house, living alone or with family, family members working in Israel, and time since immigration.

Model Summary: R Square = .109, Nagelkerke R Square = .109

	B	S.E.	Wald	df	sig	Exp(B)
Ethnic background: Nonashkenzi vs Ashkenazi	-.777	.423	3.368	1	.460	.460
Family got social worker care	.614	.276	4.945	1	1.848	1.848
Lives in own or rented house	.745	.346	4.632	1	2.107	2.107
Lives alone or with family	.659	.388	2.884	1	.089	1.933
Family members worked in Israel	-.061	.311	.039	1	.844	.941
Time since immigration to death	.001	.001	.194	1	.659	1.001
Constant	.309	.585	.279	1	.597	1.362

Results

- *All six predictors together yielded a significant model ($\chi^2=22.06$, $df=6$, $p<.001$) and the total variance explained by all these variables amounts to 10.9% (Nakelkerke R square = .109; -2 Log likelihood = 318.128). The B exponents of the logistic regression show that*
- *social worker care for the family, living in a self-owned house and living with one's family doubled the patient's chances of dying at home,*
- *whereas having an Ashkenazi ethnic background reduced the chances almost by half.*
- *whether one's family members worked or not and the length of one's stay in the country barely affected one's chances of dying at home or not.*

Logistic regression with dying in hospital or at home as dependent variable and the following predictors: ethnic background, social work support for family, living in own or rented house, living alone or with family, family members working in Israel, time since immigration, marital status and diagnosis

		B	S.E.	Wald	Df	Sig.	Exp(B)
Step 1 ^a	Ethnic background: Nonashkenzi vs Ashkenazi	-.781	.424	3.402	1	.065	.458
	Family got social. worker care	.569	.287	3.923	1	.048	1.767
	Lives in own or rented house	.662	.354	3.503	1	.061	1.939
	Lives alone or with family	.356	.429	.688	1	.407	1.428
	Family members worked in Israel	.362	.446	.660	1	.416	1.437
	Time since immigration to death	.000	.001	.069	1	.793	1.000
	Married	.092	.312	.087	1	.768	1.096
	Diag breast vs other cancers	-.645	.359	3.219	1	.073	.525
	Constant	.662	.586	1.274	1	.259	1.939

For Step 1: $\chi^2=24.270$, $df=8$, $p<.002$; Model summary: -2 Log likelihood = 302.718, Nagelkerke R Square = .123

A further logistic regression

- *Two further predictors were added. These variables had in the crosstab analyses only marginal significance: being married or not and the diagnosis (breast cancer or other cancers).*
- *The effect of these variables was: being married increased the chances of dying at home, having a breast cancer diagnosis decreased the chances.*
- *Of the eight variables used as predictors only the variable of the family having had the social worker care had a significant contribution in this context,*

Results

- The findings indicate that the chances of dying at home are higher if the patient is non-Ashkenazi, the family got social worker care, the patient lived in a self-owned house, the patient lived with his family, the family members worked, and the patient's stay in Israel since immigration was longer. Logistic regression showed that all the predictors together yielded a significant model accounting for 10.9-12.3% of the variance.*

Conclusions

- *(a) The predictors of site of death are of a varied character. They are partly economical, (e.g., living in an owned and not rented house), partly sociological (e.g., being non-Ashkenazi, living with one's family), and partly medical (e.g., having a diagnosis other than breast cancer). The predicting variables cover the whole range of domains that may affect the patient.*
- *(b) The predicting variables are related significantly to the site of death when they are considered each singly, and when considered all together they yield a model that predicts significantly the chances of dying at home. The percent of the variance accounted for by the model is 10.9 to 12.3%.*
- *© The dependence of the significance of the contribution on the context suggests that in applying the findings it is advisable to rely on several variables rather than on one or another of the predictors in this study.*

Conclusions

The findings suggest that in order to enhance the chances of the patient to die at home it is necessary to consider a variety of factors, and mainly to provide support and help to the family by means of social work services.

Background

Study 2: Nutrition in advanced cancer patients: Its demographic and medical determinants and its impact on quality of life

*Frida Barak¹, Shulamith Kreitler², Nava Danieli-Zigelman³,
Yasmin Alkalay⁴ Arie Ostrovsky⁵*

*Tel-Aviv University, Barzilai Hospital in Ashkelon, and
Maccabi Sick Fund Service*

Background

- Proper nutrition is an important factor in helping cancer patients withstand the difficulties of the disease and of the various treatments they undergo. However, the ability to eat well or absorb the nutrients is hampered by various side effects of cancer and cancer treatments.
- As a result, 51% to 80% of patients with advanced cancer were found to suffer from malnutrition and weight loss. The condition of advanced protein-calorie deficiency is often referred to as the cancer anorexia-cachexia syndrome.

Objectives

The objectives of the study were to examine nutritional characteristics in advanced cancer patients, to determine their relation to demographic and medical factors and to explore their impact on quality of life.

Method

Participants: 61 cancer patients of both genders, with advanced disease, living at home, getting mostly palliative treatment, but no parenteral nutrition.

Tools:

- A questionnaire about demographic and medical background,
- A questionnaire about nutritional habits and difficulties
- the Multidimensional Quality of Life Inventory-version 1.
- Medical information was extracted from the files

The Questionnaire of Nutritional Habits and Difficulties

Nutritional	
1.No. of meals per day	Mean=4.02, SD=1.39 (range: 1-8); 1-4 67.2%, 4-8 32.8%
2.Ingesting nutritional supplements	Yes 6.6%, No 93.4%
3. Ingesting vitamins	Yes 1.6%, No 98.4%
4. Amount of food eaten	Less than before disease 85.2%, More 14.2%
5. Appetite	Little or none 31.1%, medium or fine 68.9%
6. Difficulty eating	Yes 16.4%, Little or none 83.6%
7. Number of reasons stated for difficulty in eating	One or none=90.2%, 2 or more = 9.8% (overall range: 0-7)
8. Inability to eat	Yes, often 32.8%, No, rarely 67.2%
9. Changes in eating or food	Yes 24.6%, No 75.4%
10. Changes in the taste of the food	Yes 32.8%, No 67.2%
11. Bitter or bizarre taste in the mouth	Yes 54.1%, No 45.9%
12. Amount of fluids drunk per day	Number of glasses: Mean 8.23, SD=2.77; 1-7 glasses per day 50.8%, more than 8 glasses per day 49.2%
13. Fullness in stomach	Mostly yes 42.6%, No or rarely 57.4%
14. Nausea	Often yes 44.3%, No or rarely 55.7%
15. Vomiting	Often yes 14.8%, No or rarely 85.2%
16. Experiencing food as disgusting	Often yes 19.7%, No or rarely 80.3%
17. Difficulty to swallow	Often yes 21.3%, No or rarely 78.7%
18. Difficulty to drink	Often yes 9.8%, No or rarely 90.2%
Index A: Nutritional difficulties ^a	Mean=3.24, SD=2.98 (range: 0-10)
Index B: Nutritional changes ^b	Mean=.57, SD=.76 (range: 0-2)
Index C: Nutritional normalcy ^c	Mean=3.69, SD=2.23 (range: 0-5)

Results: Nutritional indices as dependent variables

Results of regression analyses with demographic and medical variables as predictors and nutritional indices as dependent variables

Variables	Unstandardized Coefficients		Standardized Coeff.	t
	B	Std. Error	Beta	
Dep.: Index A [Nutritional Difficulties]				
Gender	-1.009	.708	-.182	1.426
Age	-.043	.034	-.156	1.241
Mobility	-2.582	.842	-.464	3.067**
GI	-.069	.747	-.012	.093
Dis. Stage	-.355	.833	-.063	.426
Chemo present	1.230	.948	.164	1.297
R= .482, R²=.232, F=2.722* (df=6/54)				

Results

- Regression analyses showed that demographic and medical variables predicted the indices of nutritional difficulties and changes in nutrition, with mobility and gender (being female) as the major predictors

Results: Quality of life as dependent variable

- Results of regression analyses with demographic and medical variables and Index A. Nutritional difficulties as predictors and quality of life factors and total score as dependent variables

Variables	Unstandardized Coefficients		Standardized Coeff.	t
	B	Std. Error	Beta	
Dep.: Quality of life (total mean)				
Gender	-.243	.100	-.283	-2.428*
Age	-.009	.005	.203	1.769(p=.08)
Mobility	.301	.124	.348	2.420*
Index A: Nut. Difficulties	-.036	.019	-.232	1.925*
GI	-.249	.104	-.286	2.392*
Dis. Stage	-.255	.116	-.291	2.195*
R= .614, R² =.377, F=5.410*** (df=6/54)				

Results

- Regression analyses showed that the index of nutritional difficulties and demographic and medical factors, mainly mobility and gender, predicted the patients' quality of life.

Conclusions

- The conclusions are that nutritional difficulties are common, that they are lower when mobility is high, and that they affect negatively the patients' quality of life.

Study 3: The Effect of Psychological, Familial, and Supportive Factors on the Course of Disease and Quality of Life of Patients in Intensive Care Units

Sarit Harel and Shulamith Kreitler

Tel-Aviv University and University of Haifa

Background

- In recent decades there has been in the Western world a steady increase in life expectancy of the population due to technological and medical advances. These developments also led to a substantial increase in the number of patients with complex diseases who need increasingly intensive care wards . Such patients are usually exposed to increased risks of mortality. Studies of factors that may affect the development of patients' medical condition usually focused on medical factors and only rarely on psychosocial factors. The present study focused on examining the potential impact of these factors on the health status and quality of life of patients in intensive care.*

Objectives

To examine the relationships between the patient's attitudes , family and support on the course of disease in patients hospitalized in intensive care and their quality of life a week after release.

Method

- *Participants: 49 patients who were admitted to the Intensive Care Unit in a Hospital Center. The subjects are patients hospitalized in intensive care for more than 24 hours, whose age is over 18 years and they meet the criteria for hospitalization in an intensive care unit.*

Method: Tools

- *A medical questionnaire - Physiology and Chronic Health Evaluation II Acute-(APACE) at the beginning of hospitalization*
- *Medical information questionnaire upon completion of hospitalization*
- *A demographic information questionnaire*
- *A questionnaire about family functioning (Kissane),*
- *A cognitive orientation questionnaire of survival which assesses the patient's motivation to recover (Kreitler)*
- *An inventory of support (Kreitler),*
- *a multidimensional questionnaire of quality of life (Kreitler & Kreitler).*

The Cognitive Orientation Questionnaire of Survival

- *Beliefs about the following four major issues:*
- *Focusing on relevant issues*
- *Maintaining one's independence*
- *Preserving routine*
- *Self expression*



Motivational Disposition

The vector defines
the motivational
disposition for
recovery and
survival

Results

Predictors	B	SE	Beta	t	p	R2
Support	.380	.172	.327	2.211	.03	0.108
Beliefs	1.764	.724	.437	2.438	.02	0.321

F=2.919, df=6/37, p=.02

Results

- *The dependent variable representing the APACHE, length of hospitalization and the difference in quality of life between before and after hospitalization was predicted significantly by the factor of support by family and nurses and by the patient's survival beliefs. The entire model explained 32.1 % of the variance.*

Conclusions

The findings demonstrate that the variables of attitudes and beliefs based on the cognitive orientation questionnaire and support contribute to predicting the medical state of the patient in intensive unit care, the patient's length of hospitalization, and his/her quality of life before and after hospitalization. Hence, psychological factors and support should be considered by the staff in the intensive care units, so as to help the patient get as much help as possible in improving his/her medical state and quality of life.

General Conclusions- 1

- *Taking care of cancer patients in the advanced stages of the disease is a challenging task.*
- *The three described studies showed that the patient's wellbeing in this stage depends on psychosocial factors.*
- *Dying at home (as the patient prefers) is promoted by social worker care for the family, living in a self-owned house and living with one's family*

General Conclusions- 2

- *Quality of life: The patient's state depends on one's nutritional difficulties. Mobility and a low index of nutritional difficulties contribute to raising the patient's quality of life.*
- *Medical state and quality of life in intensive care units are affected positively by support (by family and nurses) and by the patient's survival promoting beliefs.*

General Conclusions- 3

Individually targeted care can and should be provided for patients in advanced stages of the disease

Thank you for
your attention



Krit@netvision.net.il