[NM-216] Pediatric Anesthesia and Hospice Medicine: a Perfect Match

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The American Board of Anesthesiology is one of the 11 member boards for the Hospice and Palliative Medicine (HPM) Boards. Nearly 130 anesthesiologists are Board-certified in HPM, but only a few are pediatric practitioners. We believe that pediatric anesthesiologists are uniquely suited for the practice of hospice/palliative care: deep knowledge of complex pediatric conditions in children of all ages, robust skill in managing pain and other distressing symptoms, and ability to engage in difficult conversations with families.

To illustrate our point, we present a case series of 102 consecutive admissions over a 22 month period to an independent, not-for-profit hospice located close to a major children's hospital. Patients ranged from 2 days old to 22 years of age, with a mean age of 75 months. Twenty-five percent of the children were born with major congenital malformations and admitted to hospice directly from the nursery. Another third were children and adolescents with a diagnosis of cancer, most commonly solid tumors or brain cancer. The remainder included a wide array of conditions, congenital and acquired, well known to pediatric anesthesiologists.

To date, 63 patients have died: 32 at home, 24 in our inpatient hospice unit, and 7 in the hospital. Five died following planned removal of life support at home (3) or in the inpatient hospice unit(2). Eight patients were discharged from hospice care because their conditions improved to the extent that they no longer met hospice criteria. Eighteen families revoked hospice care: for 7 of these, the parents chose to resume aggressive care in the hospital. All 7 died in the hospital. Among the remainder, 5 families revoked to seek another medical opinion, then returned to hospice care once they understood the gravity of their child's condition. Median time on hospice service was 25 days; mean time on service was 58 days.

The most common symptom managed is pain, requiring oral opiate therapy or patient-controlled analgesia. Other common symptoms include respiratory distress, anxiety, vomiting, poor appetite, constipation, seizures, and altered mental status. Barriers to regional anesthesia in the hospice setting are systems-based.

Medicaid-approved concurrent care allows patients to receive both curative therapy and hospice care simultaneously. While offering children access to hospice services earlier during a serious illness, concurrent care also supports ongoing denial for both patients and parents, and presents special challenges for the hospice team. The high rate of revocation speaks to parental ambivalence at end of life. Family disruption and conflict, anticipatory grief, and economic hardship are common psychosocial issues requiriong input from a skilled multi-disciplinary hospice team.

Pediatric anesthesiologists are well-equipped to manage both the challenging physical symptoms as well as the family dynamics of the hospice population. The personal satisfaction from dealing with children and their families at end of life is profound. Even part-time, hospice practice offers the busy consultant an opportunity to step back from a busy OR and return to the essence of medicine: caring for others. We encourage our colleagues to learn more about this field.
