Death and dermatology: Hospice and the subspecialties

Aaron Tisack, MD,[a,b] Marc Vander Vliet, MD,[c] and David Ozog, MD[b]

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INTRODUCTION

Make the call. Physicians regard hospice as the best possible end-of-life (EOL) care.[1] Patients who have EOL discussions report earlier hospice referrals and better quality of life near death.[2] Unfortunately, this awareness has not translated into consistent, comfortable, and confident discussions regarding EOL care and the transitioning of patients into hospice. Even in the intensive care unit, key information may not be communicated to patients and their families during EOL discussions.[3] In the inpatient setting, palliative care specialists are often consulted to bridge these gaps, but in the outpatient setting that support may not be locally available. Although subspecialties, including dermatology, do not feature prominently in the hospice discussion, that does not mean they can be ignored. We argue that any physician who may take part in the care of a patient near the end of their life needs to be trained in not only how to care for that patient, but also how to have a dignified discussion about the transition into hospice. It takes only a single patient interaction for any physician to become acutely aware of a lack of preparedness.

CASE REPORT

Our 69-year old male patient had a history of cardiac transplantation 10 years prior and subsequent immune suppression with tacrolimus and mycophenolate mofetil. Over the years, we examined him dozens of times, diagnosing several cutaneous squamous cell carcinomas, including a rapidly progressive tumor of the left helix treated with Mohs micrographic surgery.

Abbreviation used:

EOL: end-of-life

Within 6 months of resection, he presented with a painful mass in his left neck. A biopsy demonstrated poorly differentiated squamous cell carcinoma within his postauricular lymph nodes. Subsequent radiographic examination revealed multifocal, unresectable disease. He was referred to head and neck tumor board and pain management for evaluation.

Within 2 months he developed multiple metastatic cutaneous lesions on the trunk, arms, and nasal tip (Fig 1, *A*). The uncommon nature of the eruptive metastatic nasal lesion was compounded by ulceration. Our patient requested relief from this 1.5 cm tumor on his nose which was "bleeding on [his] newspaper in the morning" and thus psychologically distressing due to its prominent nature. Resection of this tumor was discussed with both the patient and his family with the understanding that surgery would not prolong life but should improve symptoms and provide the dignity he sought. Successful resection was performed in an outpatient setting with local anesthesia. Both the patient and family were thankful, expressing appreciation at each subsequent visit that the bleeding and disfigurement were resolved (Fig 1, *B*).

A few months later, the patient's family initiated discussion of hospice care after additional metastasis and clinical deterioration. I told them to contact his "doctor," but the patient and his family looked confused while saying "you are his doctor". The

From the Wayne State University School of Medicine, Detroit, Michigan[a]; Department of Dermatology, Henry Ford Health System, Detroit, Michigan[b]; and Department of Hospice and Palliative Medicine, Henry Ford Health System, Detroit, Michigan.[c]

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Correspondence to: David Ozog, MD, Department of Dermatology, Henry Ford Health System, 3031 West Grand Blvd, Suite 800, Detroit, MI 48202. E-mail: DOzog1@hfhs.org.

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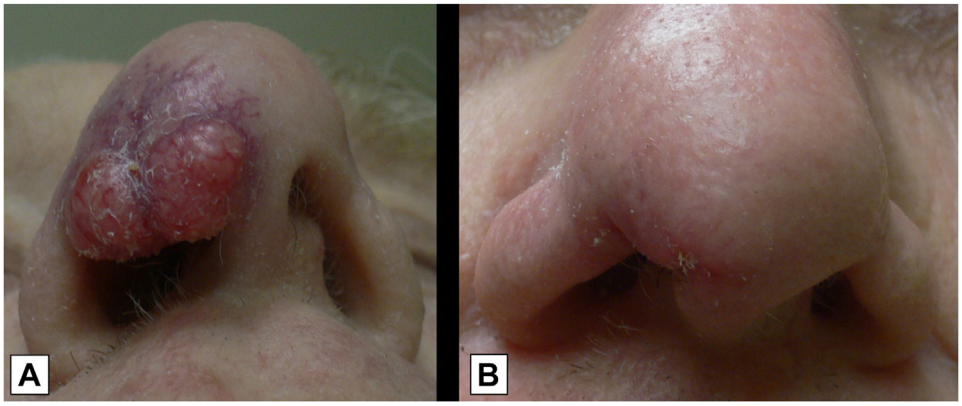

Fig 1. Metastatic cutaneous squamous cell carcinoma of the nasal tip. **A,** Prior to resection. **B,** Two-month follow-up after resection.

patient did not have a consistent relationship with a primary care physician, and the family was requesting that dermatology coordinate care. After realizing my profound error, we contacted hospice services and continued to see him during the last few months of his life. It took less time than a typical preauthorization to find care that fit their needs.

DISCUSSION

Perhaps the most difficult decision a clinician and patient make together is the futility of further treatment. While this is frequently encountered in hospital settings and the oncology or critical care environment, subspecialists only rarely confront this issue. However, it may become increasingly important as patient care shifts from the inpatient realm to outpatient specialists. In our minds, all physicians, including subspecialists, should be prepared to transition patients into hospice care.

Despite the increase in hospice exposure during undergraduate medical training, physicians need further learning during residency to feel prepared for EOL discussions.[4] Implementation should occur not only in oncology or critical care, but across all residencies, including subspecialties. A worthwhile investment, as physicians feel more comfortable with EOL discussions after only a few sessions using simulated patient encounters.[5]

Hospice care involves mainly pain relief and comfort measures, both psychological as well as physical. Our case involving the removal of a metastatic facial tumor underscores other ways that terminal patients can be treated in a dignified manner. All specialties likely have their own unique contributions. Hospice is not complicated, yet many physicians are not aware of the full spectrum of services provided. A brief review of a website such as the American Cancer Society can aid in becoming comfortable with the myriad offerings.[6] We were pleasantly surprised to learn about both family meeting support as well as respite care, designed to relieve caregivers.

Training physicians to undertake EOL discussions and transition patients into hospice care does not have to be a time-intensive task if the training is done in a meaningful and purposeful way. However, the impact on the well-being of our patients may be enormous. All residency programs, including the subspecialties, should prepare residents to compassionately care for patients during all aspects of life, including their final days.

Please - make the call.

Conflicts of interest

None disclosed.

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