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The worst infraction of all

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It all started with the h1n1 flu season. I work on a palliative care floor in a hospital where sometimes we experience the exceptions. Sometimes we get someone who miraculously starts to recover after being a designated candidate for palliative care. It could be someone with a delayed recovery from a chronic obstructive pulmonary disease exacerbation, or someone with dementia and an associated infection, who recovers unexpectedly again. Or it could be a patient with cancer who almost succumbed to side effects of rigorous chemotherapy, only to bounce back after arriving on our palliative care unit (PCU).

This time it was a 93-year-old frail elderly woman with an intracranial bleed. She came to us weak and taking nothing by mouth. Within days of receiving (or experiencing) the excellent nursing care on our unit she was beginning to eat and to respond to the nurse's conversations. She was no longer terminally ill, but she was still frail and nonambulatory, and still in our PCU.

As we went through the ward, trying to decide who would benefit from the h1n1 vaccine, we offered the vaccine to our ambulatory patients, to those who were worried about the flu, but not to our elderly woman recovering from her bleed. Not one of the care team even thought to offer it to her. Yet if she had been on any floor of the hospital other than our palliative unit, she would have been encouraged to receive it as a matter of course.

As it turned out she died quite suddenly 10 days later of, we think, cardiac causes, so she would not have benefited from the immunization anyway. But what bothered me the most was that we did not offer it to her. I first laughed it off as instinct. I justified it by saying that there must have been something in her clinical picture that told us she was not a candidate.

But on further reflection, all palliative care physicians know that projection of prognosis, even by the keenest, most experienced clinician, is fraught with problems. This was not instinct at work. This was PCU prejudice, leading to inconsistent treatment of patients based on the ward they were placed in. I had met PCU prejudice before, when I had experienced administrative resistance to my performing a biopsy on a palliative care patient's wound. But administrations come in many hues. Some are helpful to a fault; others, not so much. They have their job to do. And I could not do mine without them. But it is my job to advocate for my patients, regardless of whether they are receiving palliative care or are at the end of life, appropriately placed or not.

This was the worst infraction of all in my estimation. I had not advocated justly. I had let my palliative goggles blur my vision in treatment of my patient. I had neglected this 93-year-old woman's care and undermined her value in the process. This sacred trust is not to be minimized. She will forever be a reminder to me to watch out for PCU prejudice, and to treat every individual who arrives at our ward with the custom care they so truly deserve.

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