A 85-YEAR-OLD WOMAN WITH MULTIPLE medical problems, including dementia, coronary artery disease, renal insufficiency, and peripheral vascular disease, was admitted to our hospital with urosepsis. Her hospital course was complicated by the development of dry gangrene of her left foot, Candida sepsis, *Clostridium difficile* enterocolitis, and multiple deep sacral and trochanteric pressure ulcers. When housestaff asked her son if he wanted us “to do everything,” he always answered yes. She was able to be weaned from the ventilator and was transferred to a medical unit for continued treatment of hospital-acquired *C difficile* enterocolitis and wound care of her multiple stage 4 ulcers. She underwent 4 surgical debridements under general anesthesia in the operating room over a several-month period but remained persistently febrile despite continuous treatment with broad spectrum antibiotics.

*See Invited Commentary on page 1172*

The patient was withdrawn, tense, and turned toward the wall in a fetal position, but she screamed and cried out for her mother, moaned in pain, and tried to hit and strike out at the nurses when they performed her twice-daily dressing changes. She refused all efforts to feed her or offers of sips of fluid and received all nourishment and hydration through her feeding tube. She did not respond to the voice or touch of her son or grandchildren when they visited.

On day 63 of her hospitalization, a palliative care consultation was requested by the nurse manager on the floor because of nursing staff distress about their perception of having to hurt the patient during dressing changes. The attending physician had refused to order preprocedure opioids before dressing changes because he was concerned that it would increase her cognitive impairment and confusion. With assent of the attending, the palliative care team met with her son (her health care proxy) and her 2 grandchildren.

During a 90-minute discussion, the team asked the family what they hoped we could accomplish for their mother and grandmother. The son asked, “Can’t you do something about her pain?” The team reviewed the hospital course and clarified her diagnoses, prognosis, and what to expect in the future with her family. Sources of her escalating discomfort and pain were identified, and the benefits and potential risks of opioid analgesics discussed. The son asked for a trial of opioids, and his request was relayed to the attending physician, who agreed with the plan as long as the palliative care team took responsibility for prescribing and managing the opioid analgesic regimen, as he was not comfortable doing so. A treatment plan was initiated that included low doses of concentrated liquid morphine for the pain (5 mg every 6 hours via gastrostomy tube around the clock) with preprocedure dosing of an additional 5 mg 30 minutes before each dressing change. Antibiotics were discontinued because she had demonstrated no improvement after 6 weeks of broad spectrum treatment. Fevers were managed with acetaminophen. Within 12 hours her mental status was improved enough that she recognized and smiled at her son and tolerated her dressing changes without evident distress or agitation. Two days later the patient moved back to her original nursing home for continuing palliative and wound care from a hospice team, who managed her complex and twice-daily wound care and her pain management. Calls to the family after discharge revealed that the patient was comfortable and more interactive than she had been in months. After she died months later, the family wrote to our CEO and called to express gratitude to the palliative care team for the comfort and peace that she experienced during the last few months of her life.

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