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Case Report

One Rain Does Not Make a Crop–Continuum of Care to Improve End-of-Life Care for Bariatric Patients

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ABSTRACT

Care of persons weighing over 500 lbs. poses additional challenges. For at least the past 20 years, training methods, resources, and equipment have been available to meet the demands of people weighing up to 500 pounds. However, this is not the case when exploring care options for the person weighing greater than 500 pounds. Hospital beds, magnetic resonance imaging (MRI) and computerized tomography (CT) scan beds, etc. are not usually designed to bear the weight of over 500 lbs. persons. According to Hale and others (2020), in 2017-2018 the age-adjusted prevalence of obesity in adults was 42.4%, and there were no significant differences between men and women among all adults or by age group. This case report illustrates the unique challenges and opportunities encountered by morbidly obese patients and healthcare professionals during end-of-life (EoL) care situations. It also categorically highlights the challenges, contextual discussions, and potential opportunities for healthcare delivery models to standardize and implement safe, effective, efficient, compassionate, person-centered, cost-effective care when serving bariatric persons.

Keywords
Bariatric patients; End-of-life; Compassionate care; Death with dignity; Palliative care physician.

CASE REPORT

A 68-year-old woman, terminally ill was transferred from an acute care ward to our newly inaugurated palliative care unit. She had many medical co-morbidities, was living alone, had no immediately available next of kin, was not compliant with medical appointments or medications and she weighed 670 pounds. Our tertiary healthcare facility and interdisciplinary teams were eager to serve her but neither familiar nor prepared to meet or surpass the special care needed for a bariatric person who was terminally ill and non-communicative. The route to the originally designated accommodation was impractical, so we had to devise a detour right away. That seemingly simple thought entailed 6-8 logistical arrangements and coordination between 5 disciplines within few minutes and a physician-nurse dyad leadership to orchestrate changed plans. A new room was assigned. Housekeeping was summoned to clean the room, clerical staff and medical administration changed room numbers and provided assignments etc. Allotted mattress could not accommodate patient's body habitus, so we joined two side by side beds horizontally, converted a 2 bedroom into a single patient room and gently transferred her onto the bed. Patient was stuporous and could not cooperate. We quickly summoned help from a total of 6 staff and transferred our patient onto the bed. During the initial physical examination, severe skin excoriations under both breasts and a hard, large mass on her left inner thigh were noticed. Her breasts were very big and needed much support on either side to keep them in place. Their consistency felt very different with many lumps as well. It was difficult to figure out if there were masses or if that was a natural texture of breasts of a morbidly obese lady. Prior medical documentation did not highlight these findings. The patient was stuporous and could not give history. There was no immediate family in attendance. It took 3-days to trace her next of kin. Autopsy consent was obtained from them. Family innocently inquired if we would pay them for giving consent. The family was surprised to see her in this form and reported that they last saw her over 5-years

ago when she weighed around 250 lbs. After her expected demise, a body bag was borrowed one from a community facility that had room to accommodate persons up to 700 lbs. The patient's body was transferred to the hospital morgue. There were challenges with the capacity of elevators–a service elevator was located. Then the morgue indicated that their shelves could not accommodate bodies of these dimensions. The body was transferred to a funeral home. The pathologist was requested specifically to address the hard lesion on her left inner thigh and lumps in her breasts. However, the requested information was not available in the autopsy reports. While there was contentment from one small teamlet for stepping up the standards of care and making several exemptions to provide best possible care to this lady during the last days of her life, as an established and modernized healthcare facility, the patient's ultimate phase of life was chaotic and undignified due to unpreparedness of our health care system.

Subsequently, another challenge erupted which was a roller coaster ride that felt like rearranging the deck chairs on the Titanic.

End-of-life (EoL) journey should be an affordable and pleasant cruise and not a ride on the Titanic.

Challenges in current standardized and established healthcare delivery models during EoL care (EoLC) provision to terminally ill bariatric patients are listed in Table 1.

DISCUSSION

There are potential opportunities for global healthcare delivery models to raise the bar for safe, effective, efficient, personalized, compassionate, cost-effective care provision that lend dignity to bariatric persons facing EoL scenarios with finite life spans. These junctures could be the last opportunities to serve them and facilitate good closures for all impacted by this situation. Despite global acknowledgement regarding escalating prevalence and growing concerns regarding emerging bariatric trends, societal and healthcare delivery model gaps in appropriate care provision to bariatric patient, serious stigmas and inattention to resolutions and crossing the chasms prevail.

CONCLUSION

Above discussion prompts some valuable insights. More investment is needed in the continuum of care, holistic care approaches to bariatric patients both during death and decedent care coordination. Working together, a better future could be built with thoughtfully and pragmatically orchestrated implementation strategies to transform EoLC into a dignified, smooth and safe exit to another horizon for all, but especially bariatric patients. Individuals working in silos may continue to raise the bar within their sphere of influence and expand their comfort zones. Healthcare delivery systems face a critical need to overhaul their models of care across the continuum of care for this special patient population. Table 1 mentions some valuable and potential opportunities and recommendations to facilitate such transformations.

"*One rain does not make a crop*". – native Indian saying.

Table 1. *Challenges and Opportunities to Improve End-of-Life Care for Bariatric Person*

Categorical Challenges	Context–End-of-Life Care Healthcare Delivery Model for Bariatric Persons	Potential Opportunities for Healthcare Professionals and Organizations
Clinical competence	Theoretical knowledge about special care needs of bariatric persons exists–but gaps prevail to translate such awareness to bedside care.	Be proactive and be prepared. Disseminate best practices. Emphasize person-centered care and innovative ideas.
Equipment, space, and logistical needs	Limits exceed industry standards.	Address and improvise alternate options as exceptions.
Caregiver and provider impact.	Unusual demands could lead to exhaustion, burn out and emotional distress	Be vigilant and address compassion fatigue in both formal and informal caregivers.
Standard Operating Procedures	Unfamiliarity and sudden events could be potential barriers to facilitate death with dignity.	Provide easily accessible "just in time" practical guidelines and benefit from subject matter and work experts.
Decedent care	Post-death protocols and needs impose distinct delineation from established routines.	Alert and engage decedent affairs, social workers, coordinate burial benefits ahead of death.
Employee health and occupational hazards	Direct care providers could potentially incur occupational injuries due to extreme physical demands and necessary protective equipment to handle additional stresses etc.	Demonstrate sensitivity to operations, leadership engagement and preoccupation with failure integral to High Reliability Organization (HRO) concepts.
Staffing models	Care of bariatric persons necessitates adjustments in staffing models and expertise needed.	Align staffing models to deliver safe patient handling and care provision.
Communication skills, sensitivity	Terminally ill bariatric persons merit provisions for death with dignity.	Facilitate and ensure critical communication skills and sensitivity among healthcare teams
Family meetings, autopsy discussions	Next of kin and surrogate decision makers, especially if not actively involved in patient's care need much help to cope. Pathologists would benefit from focused requests and insights	Offer effective bereavement services, facilitate a good closure for dying persons and survivors. Engage in clear communications for targeted autopsy requests.
Healthcare delivery system care models	Awareness, cooperation, and collaboration between various clinical, administrative, academic, leadership hierarchal channels.	Collective, cohesive engagement and cumulative wisdom with shared goals to provide excellent end of life care to bariatric persons to be the goal.