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Which Ethical Considerations Should Inform Hospice Decisions About Caring for Patients With Obesity?

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Abstract

Hospice and palliative care clinicians have the potential to advocate for high-quality medical care for patients with obesity. This article explores current evidence on obesity at the end of life and ethical questions that emerge when a decision is made to enroll a patient with obesity in hospice.

Obesity at the End of Life

Hospice is designed to provide dignity in the dying process. The nature of hospice care often requires intense caregiving and close attention to symptom management. Hospice care occurs in various care settings, such as a patient's home, a nursing facility, or an inpatient setting, ideally according to the patient's best medical interests and preferred goals of care.

Given the increasing prevalence of obesity in the US adult population,¹ more hospice providers are enrolling patients with obesity, although these providers are not always thoroughly prepared to address the unique needs of an obese population. Hospice often cares for patients who are underweight or emaciated due to advanced disease or chronic illness, which can contribute to the lack of support some patients with obesity might experience once enrolled in hospice. Patients with obesity in hospice, for example, might have caregivers who are unable to physically attend to their care requirements.^{2,3} Such care requirements can include attendance of several caregivers or use of special equipment to turn the patient.⁴ In general, more resources are needed to support patients with obesity in hospice than to support underweight or normal weight patients.²

There is little research on care provided at the end of life in the context of obesity.^{2,3,5,6} One retrospective study demonstrated that, among community-dwelling Medicare fee-for-service beneficiaries who died between 1998 and 2012, those with a higher body mass index (BMI) were less likely to receive hospice care.² The predicted probability of hospice entry was 40% lower for decedents who were morbidly obese (BMI of 40kg/m²) than for those who were of normal weight (20kg/m²).² Decedents with obesity were

also less likely to die at home and more likely to have higher Medicare expenditures in the last 6 months of life.²

In this article, we first discuss resource allocation for hospice patients with obesity and the moral dilemma that such allocation presents for hospice directors. We then discuss a framework for integrating values into decision making and show how it can be applied in decision making processes for enrolling patients with obesity in hospice.

Justice and Resource Allocation at the End of Life

Patients with obesity in hospice often require more—and sometimes different—resources compared with patients who are normal weight or underweight. In one inpatient hospital sample, patients who were morbidly obese required an average of 4.5 nursing staff to assist them with walking and 2.9 to assist them with bathing.⁷ Although these staffing ratios are necessary to mitigate the risk of back injury for staff,⁸ they are difficult to achieve consistently, partly because of the fixed per diem payment Medicare provides for hospice care.⁹ In the setting of fixed payments, increased staffing needs might create a financial disincentive to enroll patients with obesity. While the per diem reimbursement does not specify that hospice providers cannot enroll patients who will cost more than a specific amount per day, hospice providers need their average total costs to fall below what is reimbursed for services in order to maintain business operations, especially as Medicare imposes an annual cap on the hospice benefit per beneficiary.¹⁰

Hospice directors are therefore faced with a moral dilemma: How might a fixed pool of resources be justly distributed? One argument about resource allocation—that a population with a “[self-inflicted illness](#)”¹¹ such as obesity and its sequelae should receive lower priority in accessing health care resources—fails to withstand scrutiny both normatively and empirically.^{11,12} But if patients with obesity require more resources than patients of normal weight, how can hospices treat all groups of patients fairly and compassionately? This question is faced by hospice directors on a daily basis, as patients often have different needs, and the fixed per diem payment for care services does not take medical complexity or the cost of care into account.

Many resource allocation strategies are based on long-term benefit, the most classic example being assigning higher priority for organ transplantation to a younger person than a person who has already lived a long life.¹³ Strategies for allocating resources to promote long-term benefit include maximizing total years of life saved or quality-adjusted life years gained. Another strategy is to provide resources relative to need, which is more likely to be useful for hospices.¹⁴ Patients in hospice are typically not expected to live longer than 6 months¹⁵; life years saved and quality-adjusted life years gained, for instance, might not differ much between patients with obesity and patients of normal weight. Given the high prevalence of obesity in the United States,¹ there will be

a growing number of patients with obesity who are eligible for hospice. While hospices must work within the per diem reimbursement constraints, investment in resources, infrastructure, and staff training that would best serve an obese population might decrease care costs over time.

Value Prioritization in Quality-of-Life Decision Making

A fundamental tenet of hospice is preserving quality of life. It follows that to determine the value of a hospice program, quality-of-life assessments should be employed by hospice directors when assisting in decisions about enrolling and caring for patients with obesity. In order to examine priorities in quality-of-life decision making at different levels within the health care system, Sutherland and Till set forth a 3-tiered framework that includes micro-level decision making (valuing individual benefit), meso-level decision making (valuing needs of specific patient groups), and macro-level decision making (valuing population health and resource allocation).¹⁶ In what follows, we show how this framework might be applied in decision making for patients with obesity.

Meso- and macro-level decisions. Enrolling patients with obesity in hospice involves meso-level decisions about whether and how to meet their needs and what resources will be required to do so. These decisions should be informed by hospice patients with obesity, as healthy patients will have difficulty predicting hospice needs.¹⁷ Macro-level decisions regarding resource allocation involve pooled or shared resources and therefore present difficult trade-offs between competing needs for limited resources.^{16,17,18} It is likely that more—and sometimes different—resources will be needed to adequately care for hospice patients with obesity. Specific examples include (1) availability of larger ambulances or other transport to avoid unnecessary delays of care in hospice; (2) aligning nursing and ancillary staff shifts at inpatient hospices to match the needs of patients, such that more staff are on hand to help at certain predictable times when care needs are greatest; and (3) durable medical equipment capable of meeting the needs of hospice patients with obesity (eg, specialized beds and wheelchairs, mechanical lifts, larger therapy tables capable of supporting higher weight limits, and wider walkers). Some inpatient hospice facilities have delimited spaces specifically for the care of patients with obesity, such as one or two larger rooms with wider doorways to accommodate larger equipment.¹⁹ While other patients may use these resources as well, designating specific resources for patients with obesity is an example of macro-level decision making that recognizes that hospice resources are limited and that enrollment decisions are influenced by the presence or absence of such specialized resources.

Micro-level decisions. Patients with obesity often face bias, [stigma](#), and discrimination from health care professionals.^{20,21} Micro-level decision making by hospice clinicians and patients holds the potential to address these issues by clearly prioritizing the patient's quality of life, tailoring care to the patient's needs, and advocating for needed resources.

Creating policy that enables the best possible care for all patients in hospice, including those with obesity, is important from a justice standpoint. Leaders in the field of palliative care themselves are advocating for a national agenda to address inequities of care.²²

Conclusion

Hospice and palliative care clinicians' fiduciary responsibility to all patients at the end of life is a special one because it encompasses the provision of care to patients with many different types of illnesses requiring many different types of resources, often within a short time frame and within a financially constrained system. Ethical considerations of justice, resource allocation, and quality of life in such a system reveal the moral values and standards of the profession. Although hospice providers have implemented ways of allocating resources to provide quality care for patients with obesity, more research on caring for this population is needed to inform necessary policy change.² Hospice and palliative care clinicians have an important role to play in equitably addressing the needs of patients at the end of life, whether or not they are obese.

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