Applying the Concepts from Maslow in a Large U.S. Hospice Program

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Dr. Zalenski and Dr. Raspa make a scholarly case for why Maslow’s Hierarchy of Human Need is a framework for the provision of hospice care. They explore the domains of palliative care and indicate how they can be met through the levels of need first described by Maslow in 1954. To summarize, Maslow suggested that human beings have their needs met in a linear way; initial needs must be met before others can be addressed. People first need their physical needs satisfied (e.g., food, pain relief), then the needs for safety (e.g., a stable place to live, enough information), then the needs for love and belonging (e.g., a social network), then the psychological needs for self-esteem. Finally, once all other needs have been met, people can fulfill their need for self-actualization (a sense of personal meaning and value). The patient example in their paper is an excellent demonstration of how a supportive team can contribute to growth at the end of life using this model.

I want to describe how this approach can successfully be made a routine part of a hospice program. San Diego Hospice & Palliative Care now cares for more than 850 patients on any given day with more than 600 employees, including 16 attending physicians and 12 physician fellows. My goal is to reinforce the approach described by Zalenski and Raspa with an organizational example of implementation.

For the past 5 years San Diego Hospice & Palliative Care has used Maslow’s Hierarchy as the conceptual framework for care planning, documentation, patient problem solving, and explaining the scope of care for all patients and families served by the agency. In addition to its utility and applicability, a major benefit has been the improvement in completeness of the care planning process. Prior to its implementation, plans of care for patients enrolled in hospice care often focused heavily on the medical model. Although there was understanding of the sources of suffering from social, psychological, and spiritual issues, there was a lack of care planning to actually deal with them. For example, there has been a clear increase in demand for chaplain and pastoral care visits since we began saying to patients, “One of our team members can help you explore your questions about meaning and value” rather than, “Do you want a chaplain?”

We begin new employee orientation for all employees with an introduction to Maslow’s Hierarchy when we discuss the beliefs of the organization. The keystone to, “We believe no one should live in pain,” is to discuss the many potential sources of pain. We introduce the concept that physical symptoms prevent resolution of other problems and then discuss the potential suffering from fear of abandonment and the unknown, grief at losing one’s family, and threats to self-esteem and dignity. Perhaps the most moving is to have the new employees imagine that they, too, are about to die and then ask what will happen afterwards. In this way, the concepts of the hierarchy of issues and needs become part of the common lexicon for the whole agency.

A few years ago, a friend who was an emergency medicine physician asked me to visit his mother. She had advanced amyotrophic lateral sclerosis and had just started using Bi-Pap at night and tube feedings. She wanted to learn what hospice care could do to help her. My friend the doctor was afraid for me to talk to her without him at her side. I used Maslow’s Hierarchy...
to guide my interview. It only took me a few minutes to talk about being sure she had physical comfort (e.g., pain control when lax joints ached, medicine for shortness of breath when she had more trouble breathing; Maslow’s First Level). I was then able to talk about how some patients are afraid of being abandoned when they were very ill and our team was able to promise to be there when she needed them. I also promised her that she would have all the information she needed to make good decisions (safety and information; Maslow’s Second Level). We talked about her family, both the good parts and the bad, and she was able to tell me, with her son there, that he was so afraid to lose her that he was pushing her to do things she did not want to do (love, belonging, and relationships; Maslow’s Third Level). We talked also about her desire not to be a burden and to retain her dignity (self-esteem; Maslow’s Fourth Level). I told her how much my satisfaction with my career depended on being able to help patients and her willingness to let me provide that help was a gift to me. (If we as caregivers can legitimately convey this attitude, it goes a long way to improving self-esteem.) We finally discussed the things that gave meaning and value to her life (Maslow’s Fifth Level). She was able to describe deep religious devotion. Her son did not share her feelings, but became tearful as she spoke about her willingness to let go to be with God. The entire conversation lasted about 10 minutes. When we were done, she asked for help from the hospice team. Her son walked me to my car so he could tell me that he had never experienced such a conversation. Maslow’s Hierarchy gives an excellent structure for an interview to describing what palliative care can do for a patient.

We implemented Maslow’s structure to the care planning and interdisciplinary reporting processes. Before we learned to use Maslow’s structure, at team meetings I often heard nurses complain of not feeling useful to patients once good symptom management had been achieved. Sometimes they even suggested a patient could be discharged from hospice care because they were in good pain control so didn’t need any more care. With the application of Maslow’s hierarchy, it became immediately apparent how physical symptom control is only the first step. All the interdisciplinary meetings and documentation now address the patients’ needs using the stepwise analysis of physical needs, security issues, love and belonging, esteem, and existential issues.

One benefit of this documentation has been a significant impact on our denial rates. We recently underwent a focused audit of GIP care (general inpatient level of care under the Medicare Hospice benefit) as part of a larger group of hospice programs nationally. More than 40 records were audited, including two with hospital lengths of stay greater than 30 days, with no denials. The average denial rate for the group of hospice programs was 26%. I believe our records of interventions at all levels of Maslow’s Hierarchy were responsible for the excellent review.

Drs. Zalenski and Raspa’s use of their patient’s story confirms how important is the understanding of the whole person to the achievement of what we like to think of as a good death; one that is accompanied by a sense of completeness. I am also delighted that Drs. Zalenski and Raspa presented the story in context with the views of other philosophers because they lend support to the complexity of the whole person model. The additional point to be made is that Maslow’s hierarchy is a useful model for designing and implementing processes of care for an entire population of patients cared for by a hospice agency. It is only one more step to have it be used to design and implement processes of care throughout the health care system.

REFERENCES


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