

# Palliative Horizons<sup>®</sup>

Expanding perspectives on caring for people with life-limiting conditions

Vol. 7, Issue 1

January 2012

## Cancer patients have improved survival, better quality of life with early palliative care

Patients with non-small-cell lung cancer who received early palliative care in addition to standard cancer therapies reported better quality of life, lower rates of depressive symptoms, received less aggressive care at the end of life, and had longer survival, according to results of a study reported in *The New England Journal of Medicine*.

“Early integration of palliative care with standard oncologic care in patients with metastatic non-small-cell lung cancer resulted in survival that was prolonged by approximately two months and clinically meaningful improvements in quality of life and mood,” write the authors.

Metastatic non-small-cell lung cancer is the leading cause of cancer death worldwide, with an estimated prognosis after diagnosis of less than one year. However, palliative care has traditionally been delivered late in the course of the disease, despite previous research suggesting that “late referrals to palliative care are inadequate to alter the quality and delivery of care provided to patients with cancer,” note the authors.

Researchers analyzed patient-reported outcomes and electronic medical records of use of health services for 151 patients newly diagnosed with non-small-cell lung cancer (mean age, 65 years; white, 70 percent to 77 percent) between June 2006 and July 2009 at a thoracic oncology care site in Boston. Patients were randomly assigned to receive either early palliative care integrated with standard oncological care, or standard oncological care only.

### KEY FINDINGS

- ◆ Patients receiving palliative care lived nearly two months longer than those in the standard care group (11.6 months vs. 8.9 months).

- ◆ Fewer patients in the palliative care group than in the standard care group received aggressive end-of-life care (33 percent vs. 54 percent).
- ◆ Palliative care patients had significantly higher scores in measures of quality of life compared with those receiving standard care (98.0 vs. 91.5, on a scale of 0 to 136).
- ◆ Half as many patients in the palliative care group as in the standard care group reported depressive symptoms, despite no between-group difference in the use of antidepressants.
- ◆ Patients in the palliative care group were more likely to have their resuscitation preferences documented compared with those in the standard group (53 percent vs. 28 percent).
- ◆ Median duration of hospice care, although short in both groups, was nearly three times longer in the palliative care group than in the standard group (11 days vs. 4 days).

“Previous data have shown that a lower quality of life and depressed mood are associated with shorter survival among patients with metastatic non-small-cell lung cancer,” write the authors. “We hypothesize that improvements in both of these outcomes among patients assigned to early palliative care may account for the observed survival benefit.”

### BENEFITS OF MODERN PALLIATIVE CARE TEAMS

The use by physicians of palliative care services delivered simultaneously with disease-focused treatment remains low, note the authors of an editorial accompanying the study. “This study is an example of research that shifts a long-held paradigm

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# Less than half of cardiologists surveyed would discuss palliative care with late-stage heart failure patients


Despite clear guidelines from the American College of Cardiology/American Heart Association recommending discussion of prognosis, advance directives, and palliative care with patients with advanced heart failure (symptomatic despite therapy), not even half of cardiologists responding to a national survey indicated they would hold such discussions, a research team has found.

“Over half of the cardiologists sampled for this study recommended care that was discordant from these guidelines, and this discordance was worse in the regions performing more intense medical care in the last six months of life,” write the authors of a study published in the *Journal of Palliative Medicine*.

The team analyzed the responses of 614 cardiologists to a questionnaire presenting two scenarios of elderly patients with late-stage heart failure. By practice address, each respondent was assigned to a hospital referral region (HRR). The HRRs were categorized into one of five quintiles, based on the intensity of care in that region during patients’ last six months of life.

## KEY FINDINGS

- ◆ In a 75-year-old patient with stage IV heart failure and non-sustained ventricular tachycardia, less than one-third of cardiologists would “initiate or continue discussions about palliative care.”
- ◆ Cardiologists in the highest-intensity quintile were less likely than those in the lowest-intensity quintile to hold such discussions in this scenario (23 percent vs. 32 percent).
- ◆ In an elderly patient with stage IV heart failure and an acute exacerbation, less than half of cardiologists indicated they would hold a palliative care discussion.
- ◆ Again, cardiologists in highest-intensity regions were less likely than those in lowest-intensity regions to have such discussions (35 percent vs. 47 percent).

“The work to improve the care of patients with end-stage heart failure is important, challenging, and ongoing,” comment the authors. “[E]fforts to increase awareness of palliative care among cardiologists and knowledge about how to best implement palliative care in heart failure populations are greatly needed.” 


**Source:** “Regional Variations in Palliative Care: Do Cardiologists Follow Guidelines?” *Journal of Palliative Medicine*; November 19, 2010; 13(11):1315-1319. Matlock DD, Peterson PN, et al; Department of Medicine, University of Colorado, Denver; Department of Medicine, Denver Health Medical Center, Denver; Clinical Research Unit, Colorado Permanente Medical Group, Denver; Veterans Affairs Medical Center, White River Junction, Vermont; Dartmouth Medical School, Hanover, New Hampshire.

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## PC consultations, units found effective

Family members of hospitalized patients who received a palliative care (PC) consultation are more likely to rate their loved one’s care in the last month of life as “excellent” compared with families of patients who received usual care (51 percent vs. 46 percent). Further, families whose loved ones were cared for in a dedicated PC unit are even more likely to report excellent care, when compared with those whose loved ones received PC consultations (63 percent vs. 53 percent).

A national survey of bereaved families of patients (n = 5901) who died between July 2008 and December 2009 at one of 77 Veterans Affairs medical centers providing both PC delivery models also found that PC units scored higher than PC consultations in three of four process measures (a do-not-resuscitate order at the time of death, chaplain support, and bereavement contact).

“The fourth, goal discussions, occurred at such a high rate among patients who received palliative care consultations that further improvement would be difficult to achieve,” the authors write in their report published in the *Archives of Internal Medicine*. 

**Source:** “The Optimal Delivery of Palliative Care,” *Archives of Internal Medicine*; 171(7):649-655. Casarett D, et al; School of Medicine, University of Pennsylvania, Philadelphia. “Identifying the Effective Components of Palliative Care,” *ibid.*, pp. 655-656. Chai E, Meier DE; Mount Sinai School of Medicine, New York City.

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# Physicians urged to serve as ‘advocates and guides’ during patients’ final years, months

## Expert stresses importance of estimating prognosis for all elderly patients

With the aging of the nation’s population, clinicians are increasingly likely to find themselves faced with the challenge of planning for the final phases of an older patient’s life. A geriatrics expert has outlined what physicians can do today, through the coming months, and perhaps years, to guide and help older patients achieve the best quality of life now and as they near the end of life.

“In many respects, you can never address the issue of advance care planning too early,” says David B. Reuben, MD, author of an article published in the *Journal of the American Medical Association*, as part of its new series entitled, “Care of the Aging Patient: From Evidence to Action.”

**“I always like to follow my patients through hospice. For me, it’s very gratifying to see them through the final chapter of their lives.”**

~ David B. Reuben, MD

Using the case of Mr. Z, an 83-year-old man who is the sole caregiver for his wife with Alzheimer’s disease and is himself recovering from fall-related injuries, Reuben presents a prognosis-guided approach for addressing short-term, midrange, and long-term issues confronting these patients.

“The approach should begin with an assessment of life expectancy and incorporation of evidence-based care whenever possible,” writes Reuben. Care plans, based on patient goals and preferences, will need to be periodically reassessed, as older patients face physical decline, advanced illness, and death.

“Determination of prognosis provides the context for clinical and personal choices that differ in their consequences and timing,” write the authors of an accompanying editorial.

“Although the wisdom of this approach is understood by patients who have lived through the deaths of friends and family, clinical decisions often fail to incorporate this information.”

### PHYSICIAN INVOLVEMENT WITH HOSPICE URGED

Although the short- and mid-range goals for a relatively robust patient such as Mr. Z are to help him remain independent, at home, and in his community as he becomes frailer, his physician will inevitably be required to help him receive his desired care at the end of life.

Reuben suggests that physicians get to know the team caring for patients they refer to a local hospice, regardless of whether they decide to follow the patients themselves or to allow the hospice physician to be the physician of record. “I always like to follow my patients through hospice,” says Reuben. “For me, it’s very gratifying to see them through the final chapter of their lives.”

In conclusion, Reuben writes, “Mr. Z will need a physician who will serve as his advocate and guide as he confronts the medical and social issues of the last years of his life. Anything less is unlikely to meet his current and future needs.”

Reuben is chief of the Division of Geriatrics,

UCLA School of Medicine, Los Angeles. 

**Source:** “Medical Care for the Final Years of Life: ‘When You’re 83, It’s Not Going to Be 20 Years,’” *Journal of the American Medical Association*; December 23/30, 2009; 302(24):2686-2694. Reuben DB; Department of Medicine, Division of Geriatrics, David Geffen School of Medicine at the University of California, Los Angeles. “Clinical Care in the Aging Century – Announcing ‘Care of the Aging Patient: From Evidence to Action,’” *ibid.*; pp. 2703-2704. Landefeld CS, Winker MA, Chernof B; Division of Geriatrics, University of California, San Francisco, and San Francisco VA Medical Center. “Author in the Room” Teleconference, *Journal of the American Medical Association* and Institute for Healthcare Improvement; February 2010. Accessed at <http://jama.amaassn.org/authorintheroom/authorindex.dtl>.

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that has limited access to palliative care to patients who were predictably and clearly dying.

“The new approach recognizes that life-threatening illness, whether it can be cured or controlled, carries with it significant burdens of suffering for patients and their families and that this suffering can be effectively addressed by modern palliative care teams.”

### PALLIATIVE CARE SUPPORTS PATIENTS AND FAMILIES BY:

- ◆ Assessing and treating symptoms
- ◆ Providing support for decision making and assistance in matching treatments to informed patient and family goals
- ◆ Offering practical aid for patients and their family caregivers
- ◆ Mobilizing community resources to ensure a safe living environment
- ◆ Ensuring collaborative and seamless models of care across care settings

“Perhaps unsurprisingly, reducing patients’ misery may help them live longer,” comment the authors. “The fact that palliative care improved quality-of-life outcomes is consistent with the results of other studies of both nonhospice and hospice palliative care.” 

**Source:** “Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer,” *The New England Journal of Medicine*; August 19, 2010; 363(8):733-742. Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF, Billings JA, Lynch TJ; Massachusetts General Hospital, Boston; State University of New York, Buffalo; Adult Palliative Medicine, Department of Anesthesiology, Columbia University Medical Center, New York City; Yale University, New Haven, Connecticut. “Palliative Care — A Shifting Paradigm,” *ibid.*; pp. 781-782. Kelley AS and Meier DE; Department of Geriatrics and Palliative Medicine, Mount Sinai School of Medicine, New York City.

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Established in 1975, Providence Hospice of Seattle is the third oldest hospice program in the United States—the oldest in the Pacific Northwest. Interdisciplinary care teams visit patients and families throughout King County as part of Providence Health & Services, a broad network of Sisters of Providence-sponsored, non-profit, community-owned programs providing health care, as well as senior, community, housing and education services for the residents of dozens of communities in Alaska, Washington, Montana, Oregon and California.

**Palliative Horizons**®, a publication of Providence Hospice of Seattle, is published four times annually for health care providers to share best practices and progressive thinking, both in philosophy and approach, on palliative care for people with life-limiting conditions. *Palliative Horizons* is available by request for delivery via electronic mail. Other services for health care providers include in-service trainings for clinical staff, public presentations for community members, and clinical consultations.

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