# Palliative Care in Oncology

## The Data Support the Marriage

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Komen Early Career Researchers Breakfast
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Durham North Carolina

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# Outline

- A brief introduction to Palliative Care

We just have 10 minutes! ☺

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# "Oncodoxes": The catch 22's of oncology (Mintzer.JCO. 2013; 31:393-394)

- Be optimistic/ be honest
- Be aggressive /Be careful
- Prolong survival/Refer to hospice sooner

**"It is easy for the those working in hospice and palliative medicine to criticize the oncologist for continuing with chemotherapy. They are not the ones who have to make the call."**

Mintzer. JCO. 2013. p. 394.

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# Palliative Care: What it is not

- End of life care only
- Hospice
- Abdication of the patient

# Palliative Care: What it is

- Symptom management
- Unbound by point in the trajectory, eg, from time of diagnosis to bereavement
- Communication: goals of care
- *"And/with" and NOT "either/or"*

# What is Palliative Care?

- Specialized medical care for people with serious illness
- Relief from symptoms, pain and stress – ***whatever the diagnosis***
- Improve quality of life for both patient and family
- A team that provides an ***extra layer of support***
- Appropriate at any age and at any stage of illness
  - ***Can be provided together with curative treatment***

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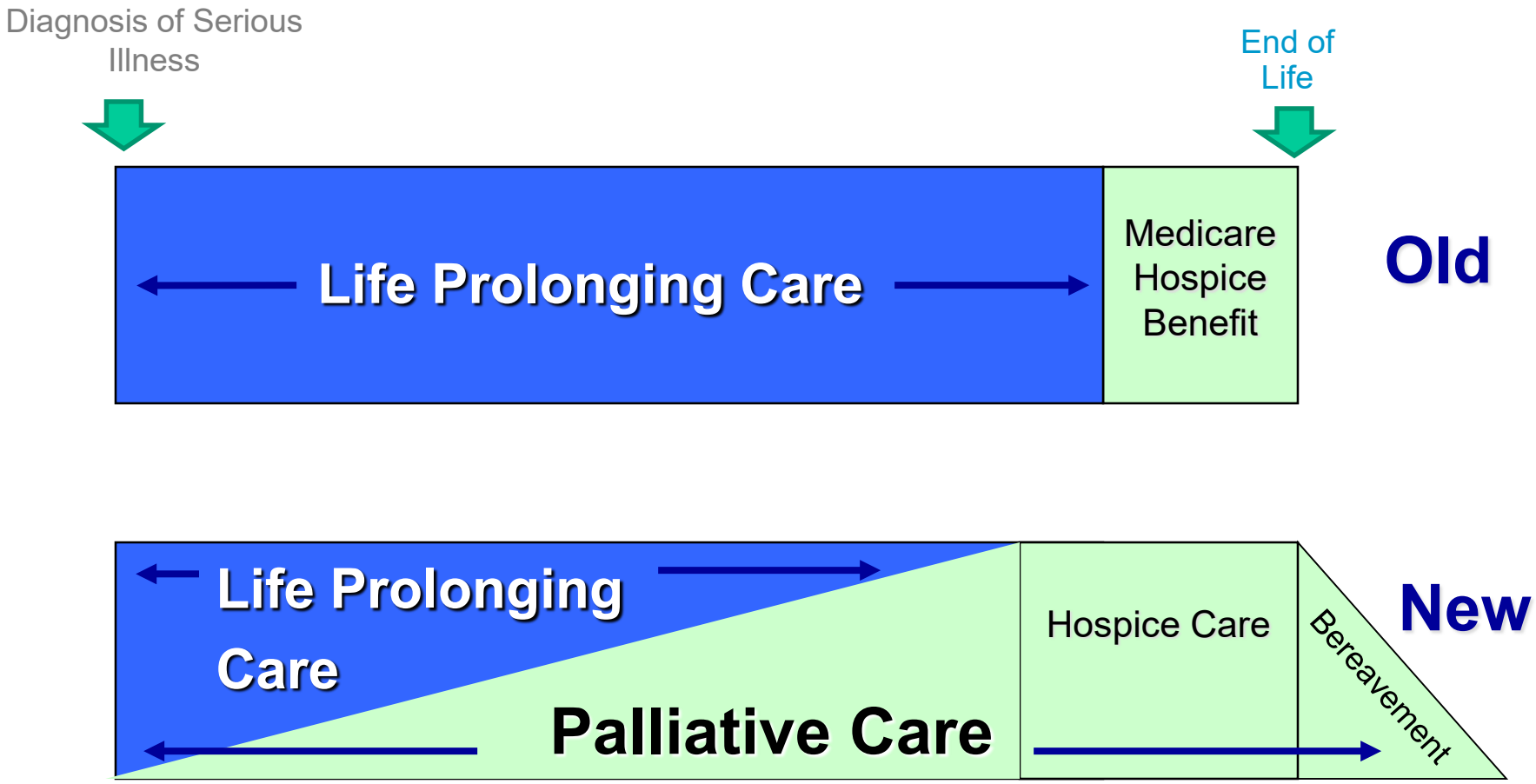
# Palliative Care Models

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Slide courtesy of R. Morgan Bain, MD

# Toward Individualized Care for Patients with Advanced Cancer. J Clin Oncol. 2011; 29: 755-60.

- The Domains of Care in the Palliative care model are congruent with the American Society of Clinical Oncology Statement: physical, psychological, social and spiritual consequences of cancer.

- "There is a need to change the paradigm for advanced cancer care to include an earlier and more thorough assessment of patients' options, goals, and preferences, and to tailor the care that we deliver to those individual needs *throughout the continuum of care*."

J Clin Oncol.2011.29:pg 756.

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# Is a marriage possible between Oncology and PC?

*"By all means marry:*

*If you get a good wife , you will become happy.*

*If you get a bad one, you will become a philosopher."*

Socrates (c. 470-399 BC)

# Landmark Study

ORIGINAL ARTICLE

## Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

ABSTRACT

BACKGROUND

Patients with metastatic non–small-cell lung cancer have a substantial symptom burden and may receive aggressive care at the end of life. We examined the effect of introducing palliative care early after diagnosis on patient-reported outcomes and end-of-life care among ambulatory patients with newly diagnosed disease.

METHODS

We randomly assigned patients with newly diagnosed metastatic non–small-cell lung cancer to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone. Quality of life and mood were assessed at baseline and at 12 weeks with the use of the Functional Assessment of Cancer Therapy–Lung (FACT-L) scale and the Hospital Anxiety and Depression Scale, respectively. The primary outcome was the change in the quality of life at 12 weeks. Data on end-of-life care were collected from electronic medical records.

RESULTS

Of the 151 patients who underwent randomization, 27 died by 12 weeks and 107 (86% of the remaining patients) completed assessments. Patients assigned to early palliative care had a better quality of life than did patients assigned to standard care (mean score on the FACT-L scale [in which scores range from 0 to 136, with higher scores indicating better quality of life], 98.0 vs. 91.5; P=0.03). In addition, fewer patients in the palliative care group than in the standard care group had depressive symptoms (16% vs. 38%, P=0.01). Despite the fact that fewer patients in the early palliative care group than in the standard care group received aggressive end-of-life care (33% vs. 54%, P=0.05), median survival was longer among patients receiving early palliative care (11.6 months vs. 8.9 months, P=0.02).

CONCLUSIONS

Among patients with metastatic non–small-cell lung cancer, early palliative care led to significant improvements in both quality of life and mood. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival. (Funded by an American Society of Clinical Oncology Career Development Award and philanthropic gifts; ClinicalTrials.gov number, NCT01038271.)

- 151 patients
- Newly dx met NSCLC
- Randomized
  - Standard oncologic care (SOC)
  - SOC + early palliative care
- Primary outcome: QOL

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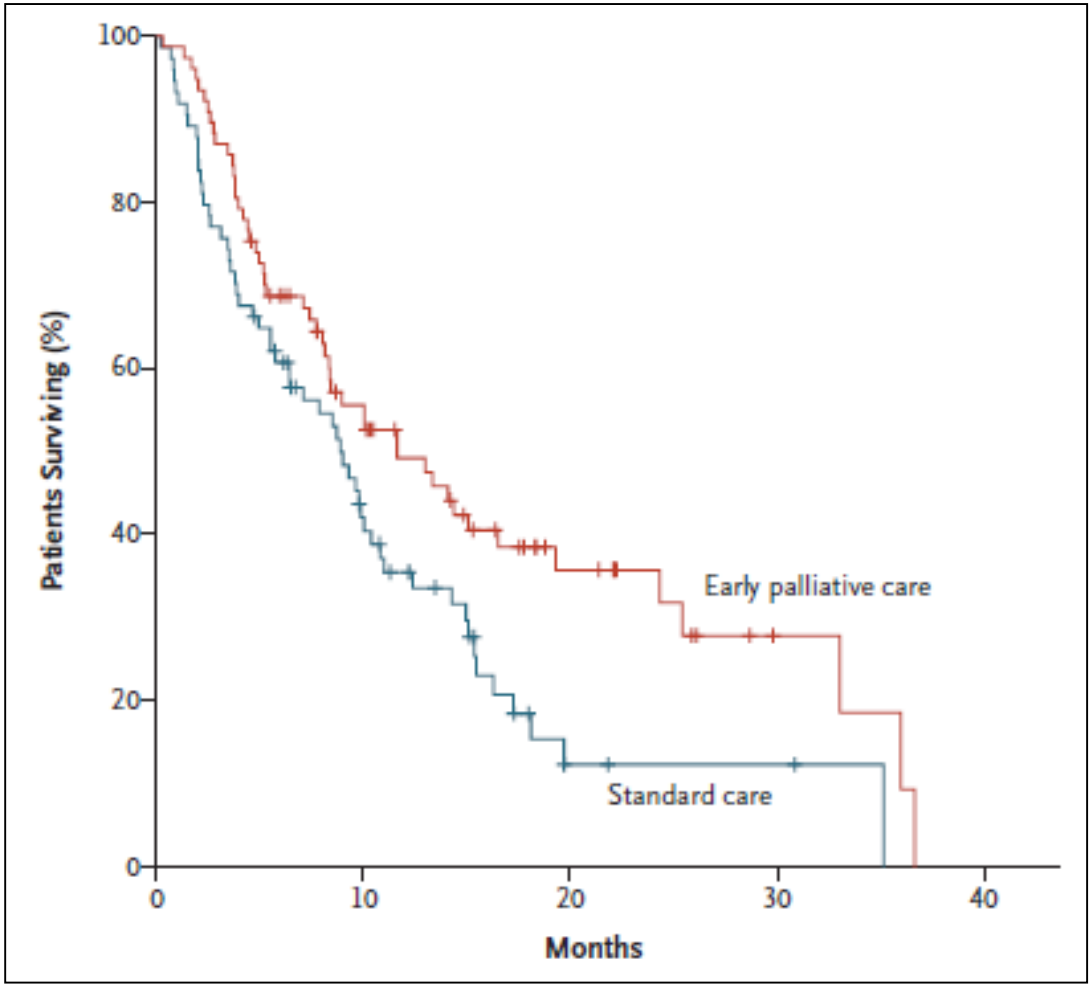
Temel, JS et.al. N Engl J Med 2010;363:733-42.

# Palliative Care Improves Survival

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Temel, JS et.al. N Engl J Med 2010;363:733-42.

# Integration and Impact of Palliative Care on an Oncology Inpatient Ward: The Duke 9300 Experience

*Medicine Grand Rounds*
*September 5, 2014*

Richard F. Riedel, MD
Kim M. Slusser, MSN, RN, CHPN
Anthony N. Galanos, MD

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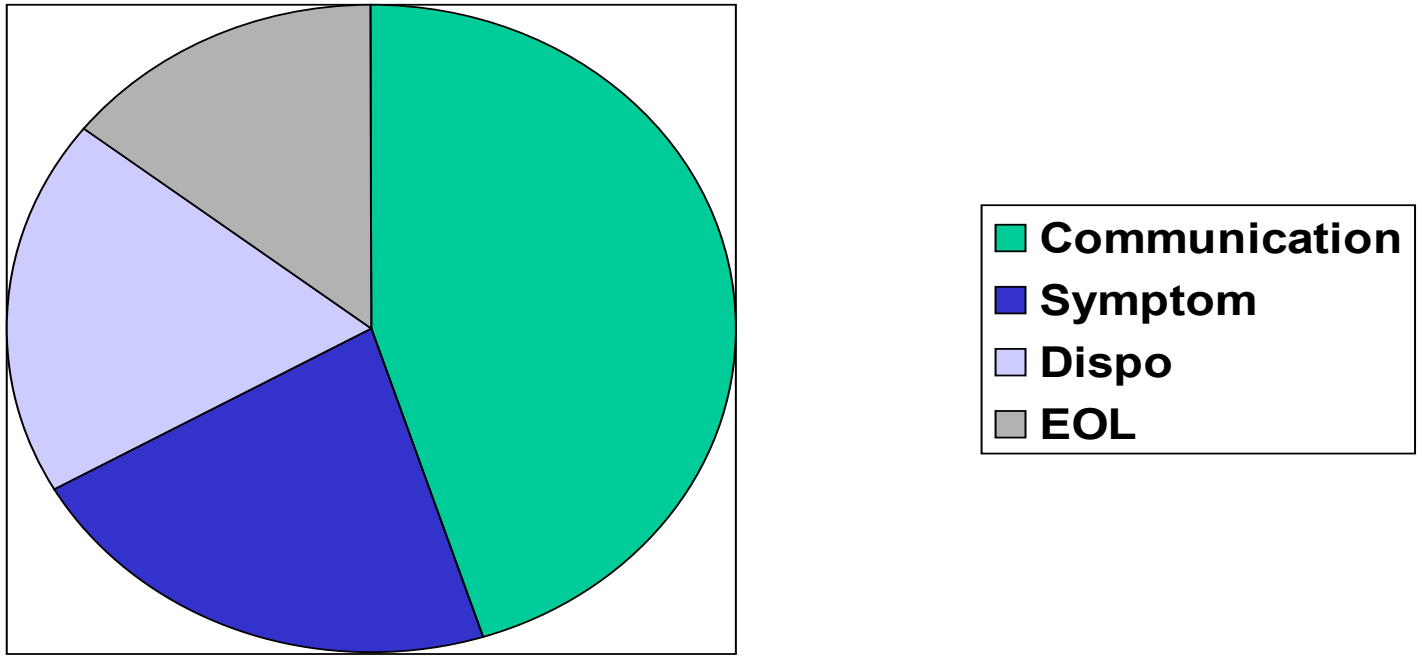
**"An Integrated Oncology and Palliative Medicine Approach on a Solid Tumor Service"** Rich Riedel et al. J of Oncology Practice. 2017.13 (9):e738-746.

- Retrospective cohort study at Duke. Pre and post intervention patients admitted to the solid tumor inpatient service
- Cancer dx and stage; LOS; ICU transfer rate; discharge dispo; time to readmit: 7 and 30d. Nursing and MD satisfaction surveys.
- Lower LOS and 7 day readmission rates
- Increasing hospice referrals and 15% decrease in ICU transfers.
- Physicians and nurses universally favored the model.

# Reasons for Palliative Care Consultation

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# Manage the Symptoms First

"No man can be rendered pain free whilst he still wrestles with his faith. No man can come to terms with his God when every waking moment is taken up with pain or vomiting."

Oxford Textbook of Palliative Medicine. 1998. pg 6.

# Communication

“Words are, of course, the most powerful drug used by mankind.”

Rudyard Kipling

1865-1936

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JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

# Patient-Clinician Communication: American Society of Clinical Oncology Consensus Guideline

*Timothy Gilligan, Nessa Coyle, Richard M. Frankel, Donna L. Berry, Kari Bohlke, Ronald M. Epstein, Esme Finlay, Vicki A. Jackson, Christopher S. Lathan, Charles L. Loprinzi, Lynne H. Nguyen, Carole Seigel, and Walter F. Baile*

Author affiliations and support information (if applicable) appear at the end of this article.

Published at jco.org on September 11, 2017.

T.G. and W.F.B. were Expert Panel co-chairs.

Clinical Practice Guideline Committee approved: May 18, 2017.

Editor's note: This American Society of Clinical Oncology (ASCO) Clinical Practice Guideline provides recommendations, with comprehensive review and analyses of the relevant literature for each recommendation. Additional information, including a Data Supplement, a Methodology Supplement, slide sets, clinical tools and resources, and links to patient information at www.cancer.net, is available at www.asco.org/supportive-care-guidelines and www.asco.org/guidelineswiki.

Reprint requests: 2318 Mill Road, Suite 800, Alexandria, VA 22314; guidelines@asco.org.

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## ABSTRACT

### Purpose

To provide guidance to oncology clinicians on how to use effective communication to optimize the patient-clinician relationship, patient and clinician well-being, and family well-being.

### Methods

ASCO convened a multidisciplinary panel of medical oncology, psychiatry, nursing, hospice and palliative medicine, communication skills, health disparities, and advocacy experts to produce recommendations. Guideline development involved a systematic review of the literature and a formal consensus process. The systematic review focused on guidelines, systematic reviews and meta-analyses, and randomized controlled trials published from 2006 through October 1, 2016.

### Results

The systematic review included 47 publications. With the exception of clinician training in communication skills, evidence for many of the clinical questions was limited. Draft recommendations underwent two rounds of consensus voting before being finalized.

### Recommendations

In addition to providing guidance regarding core communication skills and tasks that apply across the continuum of cancer care, recommendations address specific topics, such as discussion of goals of care and prognosis, treatment selection, end-of-life care, facilitating family involvement in care, and clinician training in communication skills. Recommendations are accompanied by suggested strategies for implementation. Additional information is available at www.asco.org/supportive-care-guidelines and www.asco.org/guidelineswiki.

*J Clin Oncol 35:3618-3632.* 

# What patients (families) want

**Fogarty, et al. "Can 40 Seconds of Compassion Reduce Patient Anxiety?" *J Clin Onc*, 1999**

- **They want compassion and empathy**
  - Study design: RCT of videotaped intervention, with pre and post-test anxiety inventory and rating of MD
    - 123 breast cancer survivors and 87 healthy volunteers,
    - video of oncologist consultation …scripted but varied on degree of compassion demonstrated
  - Results: viewing the "enhanced compassion" video was associated with significantly **decreased anxiety**
    - Also a/w higher rating of physician on non-emotional topics

# Here's the "intervention"

- **It's only 40 seconds long!**

- *Segment 1: "*I know this is a tough experience to go through and I want you to know that I am here with you. Some of the things that I say to you today may be difficult to understand, so I want you to feel comfortable in stopping me if something I say is confusing or doesn't make sense. We are here together, and we will go through this together."

- *Segment 2:* I know this is a tough time for you and I want to emphasize again that we are in this together. I will be with you each step along the way.

**Fogarty, et al. "Can 40 Seconds of Compassion Reduce Patient Anxiety?" *J Clin Onc*, 1999**

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# What we do…we tend to…

- **…miss or ignore opportunities for empathy**

- (Suchman et al. JAMA.1997;277: 678-82**.** A model of empathic communication….
- Curtis et al. Missed opportunities during family conferences in the ICU. Am J Respir Crit Care Med. 2005;171:844-9.
- Pollak et al. "Oncologist Communication About Emotion During Visits With Patients With Advanced Cancer." J of Clinical Oncology, 2007)

  - Study design: audio-recorded clinic visits
    - 290 pts with advanced cancer, 51 oncologists
    - coded for the presence of empathic opportunities

  - Results: 37% of conversations contained at least one empathic opportunity
    - **oncologists responded empathically only 22% of time**
      - responses more prevalent among younger oncologists and those self-rated as "more socioemotional than technical"

JOURNAL OF CLINICAL ONCOLOGY ASCO SPECIAL ARTICLE

# Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update

*Betty R. Ferrell, Jennifer S. Temel, Sarah Temin, Erin R. Alesi, Tracy A. Balboni, Ethan M. Basch, Janice I. Firn, Judith A. Paice, Jeffrey M. Peppercorn, Tanyanika Phillips, Ellen L. Stovall,† Camilla Zimmermann, and Thomas J. Smith*

## ABSTRACT

**Purpose**

To provide evidence-based recommendations to oncology clinicians, patients, family and friend caregivers, and palliative care specialists to update the 2012 American Society of Clinical Oncology (ASCO) provisional clinical opinion (PCO) on the integration of palliative care into standard oncology care for all patients diagnosed with cancer.

**Methods**

ASCO convened an Expert Panel of members of the ASCO Ad Hoc Palliative Care Expert Panel to develop an update. The 2012 PCO was based on a review of a randomized controlled trial (RCT) by the National Cancer Institute Physicians Data Query and additional trials. The panel conducted an updated systematic review seeking randomized clinical trials, systematic reviews, and meta-analyses, as well as secondary analyses of RCTs in the 2012 PCO, published from March 2010 to January 2016.

**Results**

The guideline update reflects changes in evidence since the previous guideline. Nine RCTs, one quasiexperimental trial, and five secondary analyses from RCTs in the 2012 PCO on providing palliative care services to patients with cancer and/or their caregivers, including family caregivers, were found to inform the update.

**Recommendations**

Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services.

J Clin Oncol. 2017 Jan;35(1):96-112. Epub 2016 Oct 28; DOI: 10.1200/JCO.2016.70.1474

# Hospital Based Palliative Care

"**Palliative care** is not a way out but a way through…

Hospitals are a place of miracles and cures, but when that can not be the outcome, we

***'…palliate often and comfort always.' "***

Galanos, AN North Carolina Med Journal. July/August 2004, vol 65, #4. pg 218.

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