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# Palliative Care in the Care of Patients with Cancer

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# Disclosures

No relevant Financial Relationships with  
Commercial interests

No conflicts of Interests

# Objectives

- Define Palliative Care
- Factors influencing growth in past few years
- Models of Palliative Care
- Define Hospice in relation to Palliative Care
- Questions

Life is pleasant.

Death is peaceful.

It's the transition that's troublesome.

-Isaac Asimov

# Palliative Care

Interdisciplinary care that aims to relieve suffering and improve quality of life for patients with advanced illness and their families.

It is offered simultaneously with all other appropriate medical treatment.

# Definitions

- **CAPC:** Palliative care is an Interdisciplinary specialty that aims to relieve suffering and improve quality of life for patients with advanced illness, and their families. It is provided simultaneously with all other appropriate medical treatment.
- **NCP:** The goal of palliative care is to prevent and relieve suffering and support the best possible quality of life for patients of all ages and their families. Palliative care is both a philosophy of care and an organized program for delivering care to persons of all ages with life threatening conditions. This care focuses on enhancing quality of life for patient and family, optimizing function, helping with decision-making, and providing opportunities for personal growth. As such, it can be delivered concurrently with life prolonging care or as the main focus of care.
- **National Quality Forum:** Palliative care refers to patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.



# The Nature of Suffering and the Goals of Medicine

The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians' failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself.



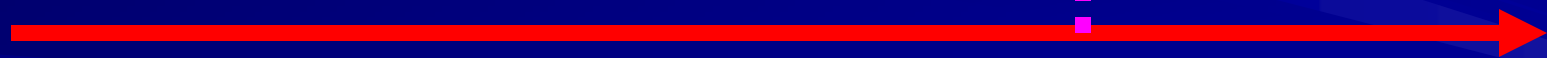
# The Cure - Care Model: The Old System

Life  
Prolonging  
Care



Palliative/  
Hospice  
Care

D  
E  
A  
T  
H

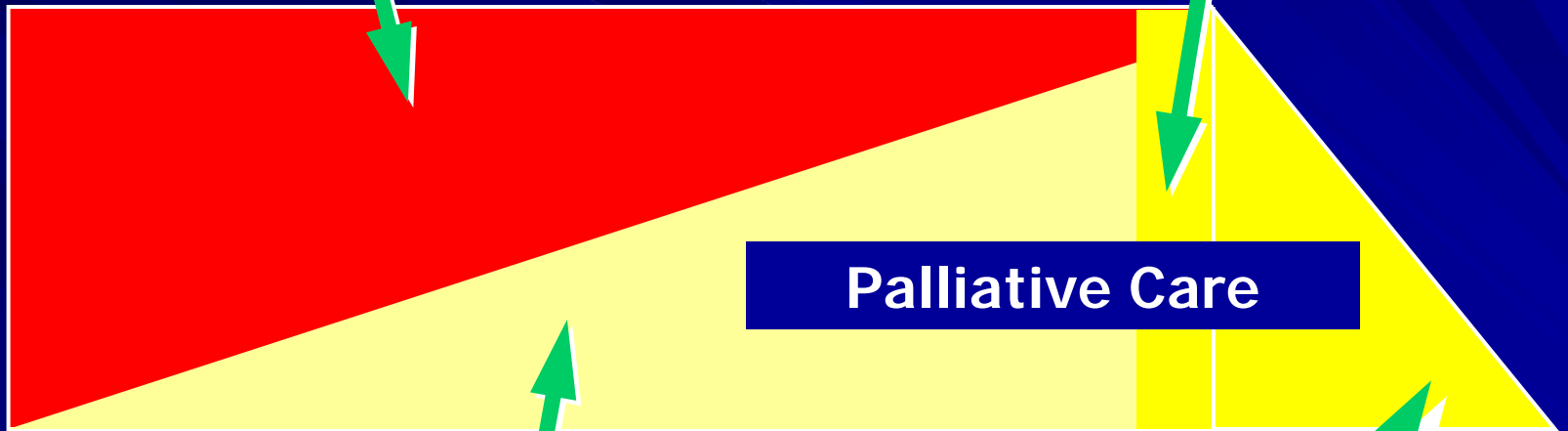


Disease Progression

# Palliative Care

Therapies to modify disease

Hospice



Palliative Care

6m Death

Bereavement  
Care

Presentation

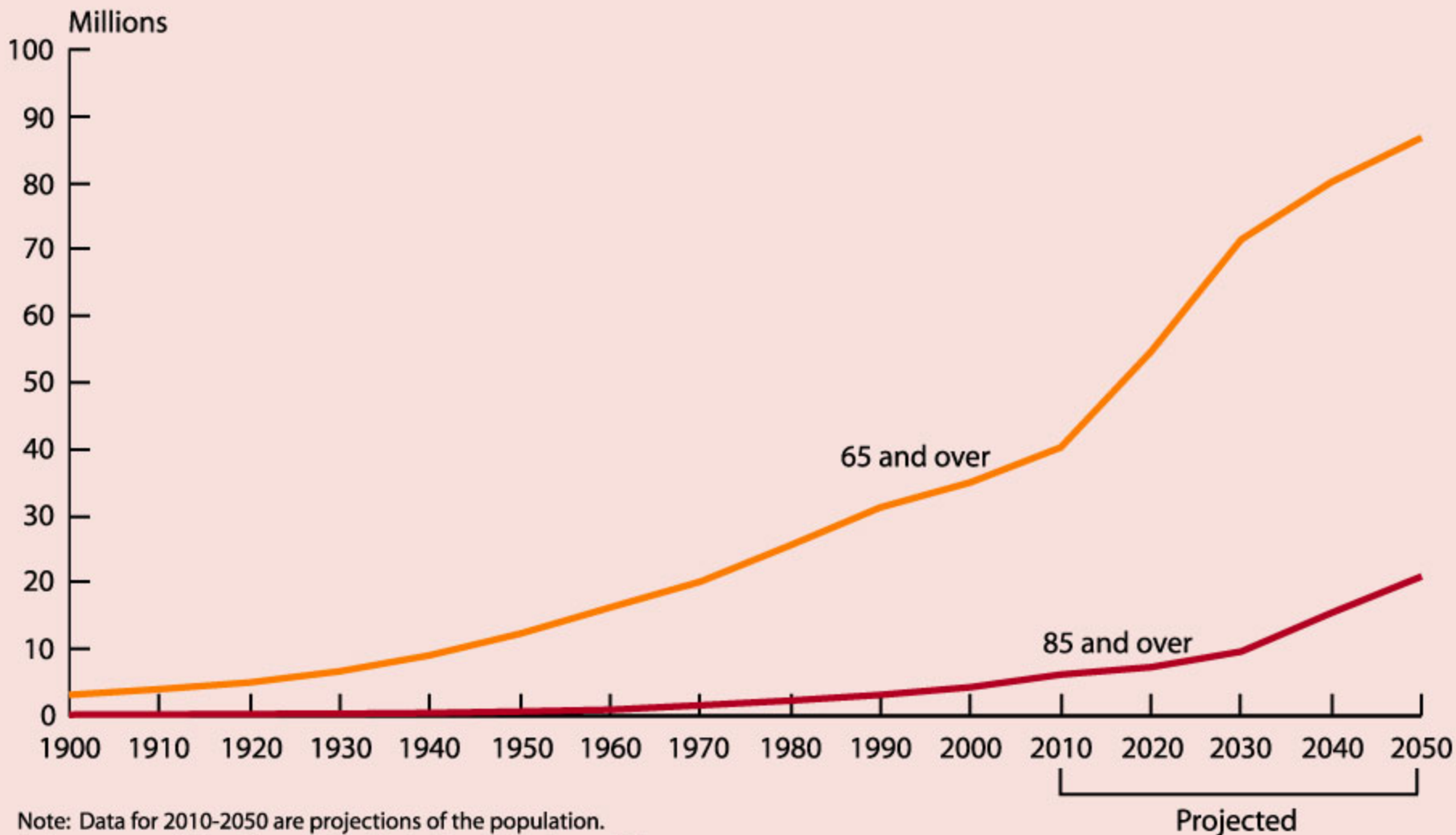
Therapies to relieve  
suffering and/or  
improve quality of  
life

# Palliative care-

## Predisposing environmental factors

- Aging population, chronic disease demographics
- Payment system mismatch to need
- AIDS epidemic early 1980s
- Quinlan, Cruzan, and later, Schiavo
- We have a quality problem: Kevorkian 1990; SUPPORT 1995; Oregon 1997.
- Moyers *On Our Own Terms*, popular media 2000-
- Private sector investment: RWJF, PDIA >\$250 million
- Baby boomers with authority/leadership positions in healthcare
- Baby boomers with aging parents
- Healthcare cost emergency

## Number of people age 65 and over, by age group, selected years 1900-2000 and projected 2010-2050



Note: Data for 2010-2050 are projections of the population.  
Reference population: These data refer to the resident population.  
Source: U.S. Census Bureau, Decennial Census and Projections.

# Leading Causes of Death: 77% not due to Cancer

Diseases of the Heart	27%
Malignant Neoplasm	23%
Cerebrovascular Disease	6%
COPD	5%
Accidents	4%
Diabetes Mellitus	3%
Alzheimer's Disease	3%
Influenza/pneumonia	3%

# Better Care Needed From the Day of Diagnosis of Any Serious Illness

- People need better care throughout the **multi-year** course of advanced illness.
- Medicare Hospice Benefit developed to care for those dying soon: payment regulations require 6 month prognosis and decision to forego insurance coverage for life prolonging care.
- Additional approaches are needed for much larger numbers of persons with chronic, progressive illness, years to live, continued benefit from disease modifying therapy, and obvious palliative care needs.

# Pain Data from SUPPORT

% of 5176 patients reporting moderate to severe pain between days 8-12 of hospitalization:

Colon cancer	60%
Liver failure	60%
Lung cancer	57%
MOSF & cancer	53%
MOSF & sepsis	52%
COPD	44%
CHF	43%



# SUPPORT STUDY

- 40% DNR orders written 2 days before death
- 47% of physicians knew when their patients wanted to avoid CPR
- 38% of patients spent 10+ days in the ICU
- 50% suffered severe pain
- High hospital resource use

# Symptoms Prevalence

<b>SYMPTOMS</b>	<b>CANCER (%)</b>	<b>AIDS (%)</b>	<b>HD (%)</b>	<b>COPD (%)</b>	<b>RD (%)</b>
Pain	35-96	63-80	41-77	34-77	47-50
Depression	3-77	10-82	9-36	37-71	5-60
Anxiety	13-79	8-34	49	51-75	39-70
Confusion	6-93	30-65	18-32	18-33	---
Fatigue	32-90	54-85	69-82	68-80	73-87
Breathlessness	10-70	11-62	60-88	90-95	11-62
Insomnia	9-69	74	36-48	55-65	31-71
Nausea	6-68	43-49	17-48	---	30-43
Constipation	23-65	34-35	38-42	27-44	29-70
Diarrhea	3-29	30-90	12	---	21
Anorexia	30-92	51	21-41	35-67	25-64

# Place of Death Desire vs. Reality

- 90% of respondents to US survey desire death at home
- Death in US Institutions
  - 1949- 50% of deaths
  - 1958- 60%
  - 1980 to present- 75%
    - 57% hospitals, 17% NH, 20% home, 6% other

## If people wish to die at home, why do most die in the hospital?

Forces exist in our health care delivery system together with the values related to health and illness, that propel the physician, patient, family towards aggressive, life prolonging care far longer than is medically appropriate; such care typically is provided in the hospital environment, up until shortly before death.

# 1. Physician Forces

- MD's personal fear of death and fear of failure
- Identification with patient
  - viewing patient as a friend pushes towards continued aggressive care
- Fear of missing a “treatable” problem

# 1. Physician Forces (cont.)

- Uninformed about prognostic factors
- Uninformed about pain treatment
  - e.g. how to assess pain, use opioids
- Poor or no training in end-of-life communication skills
- Cultural insensitivity

# 1. Physician Forces (cont.)

- Lack of knowledge about ethical principles, laws and regulations concerning treatment decisions at end of life.
  - Fear of ethical, legal, or religious impropriety
  - Fear of accelerating death



# 1. Physician Forces (cont)

- Fear of litigation
  - Not “doing everything”
  - Fear of going against family wishes
- Personality deficiencies
  - Ego, arrogance, abuse of power

## 2. Patient and Family Forces

- Difficulty accepting impending death
  - Expectation of miracles
  - Inability to “give up hope”
  - Fear of talking about death
  - Fear that “giving up” = personal weakness
- Fear of the impact of a death at home
- Failure to discuss advance care plans

# 3. System Forces

- Increased number of hospital beds correlates to increased hospital deaths.
  - *“if you build it, they will come!”*
- Lack of organizational structure to support excellent end of life care in all care settings.
- Financial disincentives exist that force care toward aggressive orientation.

# How can you move forward ..

- Recognize who is dying!
  - This is the single most important issue in end-of-life care—unless you can recognize and name the process, there will be no timely transition away from curative or life-prolonging care, towards palliative care.
- Understanding disease trajectories can assist in determining when someone is dying.

# Hospice

- Concept/Philosophy of care
- Insurance product
  - Medicare/Medicaid

# Hospice Requirements

- Six months or less to live
- Multidisciplinary care

# Medicare Hospice Levels of Care

## ■ Routine Home Care

- Whether a private home, a nursing facility, or prison, the benefit does not cover the cost of a patient's room and board in a nursing home.

## ■ Continuous Home Care

- For crisis management of acute symptoms to maintain the patient at home.
- Required intensive nursing care to achieve
- Must be provided for a minimum of 8 hrs during each 24 hour day

## ■ General Inpatient Care

- For control of acute pain or other symptoms that cannot be adequately managed in the patient's home

## ■ Respite Care

- For patients whose caregivers need relief
- Respite care is reimbursed for no more than 5 days at a time



# Comparison of the Medicare Hospice Benefit & the Medicare Home Care Benefit

Service	Medicare Hospice	Medicare Home Health
100% coverage of medications	Yes	No
100% coverage of durable medical equipment	Yes	No
Homemakers & home health aides	Yes	Yes, if short term
Inpatient respite care	Yes	No
Inpatient care, no deductible	Yes	No
Counseling in home	Yes	Limited
Bereavement support	Yes	No
Trained volunteers	Yes	No

# Comparison of the Medicare Hospice Benefit & the Medicare Home Care Benefit

Service	Medicare Hospice	Medicare Home Health
Ongoing pastoral counseling & spiritual support	Yes	No
Payment of consulting physicians fees at 100%	Yes	No
MD, Nurse, SW & counselor on-call 24/7	Yes	No
Family supportive care	Yes	No
Patient must be homebound	No	Yes

Why is **non hospice** palliative care  
necessary?

I don't want to achieve immortality  
through my work. I'd rather achieve  
it by not dying.

*Woody Allen*

# Models of Palliative Care

- Primarily hospital based
- Different Models
  - Physician model
  - Multidisciplinary
  - Nurse model
  - Hospice run

# Comprehensive Palliative Assessment

Dame Cicely Saunders' concept of "Total Pain and Suffering"

4 domains:

- 1) **Physical Pain** –easily treated by trad medical model
- 2) **Psychological Pain** – often manifest as depression, anxiety, or agitation
- 3) **Social Pain** – results from the change in relationships and role that occur with progressive disease
- 4) **Existential or Spiritual Pain** – deals with larger questions of the meaning of pt's life, their legacy, and the "why" of dying

# Comprehensive Palliative Assessment

- Forces one, to bear witness to another's suffering
  - Diagnostic listening is often therapeutic
- Consults often start with an admission of the inability to change the underlying diseases' course
- “Patient” is the family unit



The Germans dumped a young Soviet prisoner in my ward late one night. The ward was full, so I put him in my room as he was moribund and screaming and I did not want to wake the ward. I examined him. He had obvious gross bilateral cavitation and severe pleural rub. I thought the latter was the cause of the pain and the screaming. I had no morphia, just aspirin, which had no effect. I felt desperate. I knew very little Russian then and there was no one in the ward who did. I finally instinctively sat down on the bed and took him in my arms, and the screaming stopped almost at once. He died peacefully in my arms a few hours later. It was not the pleurisy that caused the screaming but the loneliness. It was a wonderful education about the care of the dying. I was ashamed of my misdiagnosis and kept the story secret.

Excerpt from A.L. Cochrane's autobiography, *One Man's Medicine*. Memoir Club, 1989. pg 82. London. BMJ



# Palliative Care

## Levels of Expertise

### ■ Primary Palliative Care

- Basic knowledge and skills for all physicians

### ■ Specialist Palliative Care

- Physicians with specialized training and experience in the care of seriously ill and dying patients

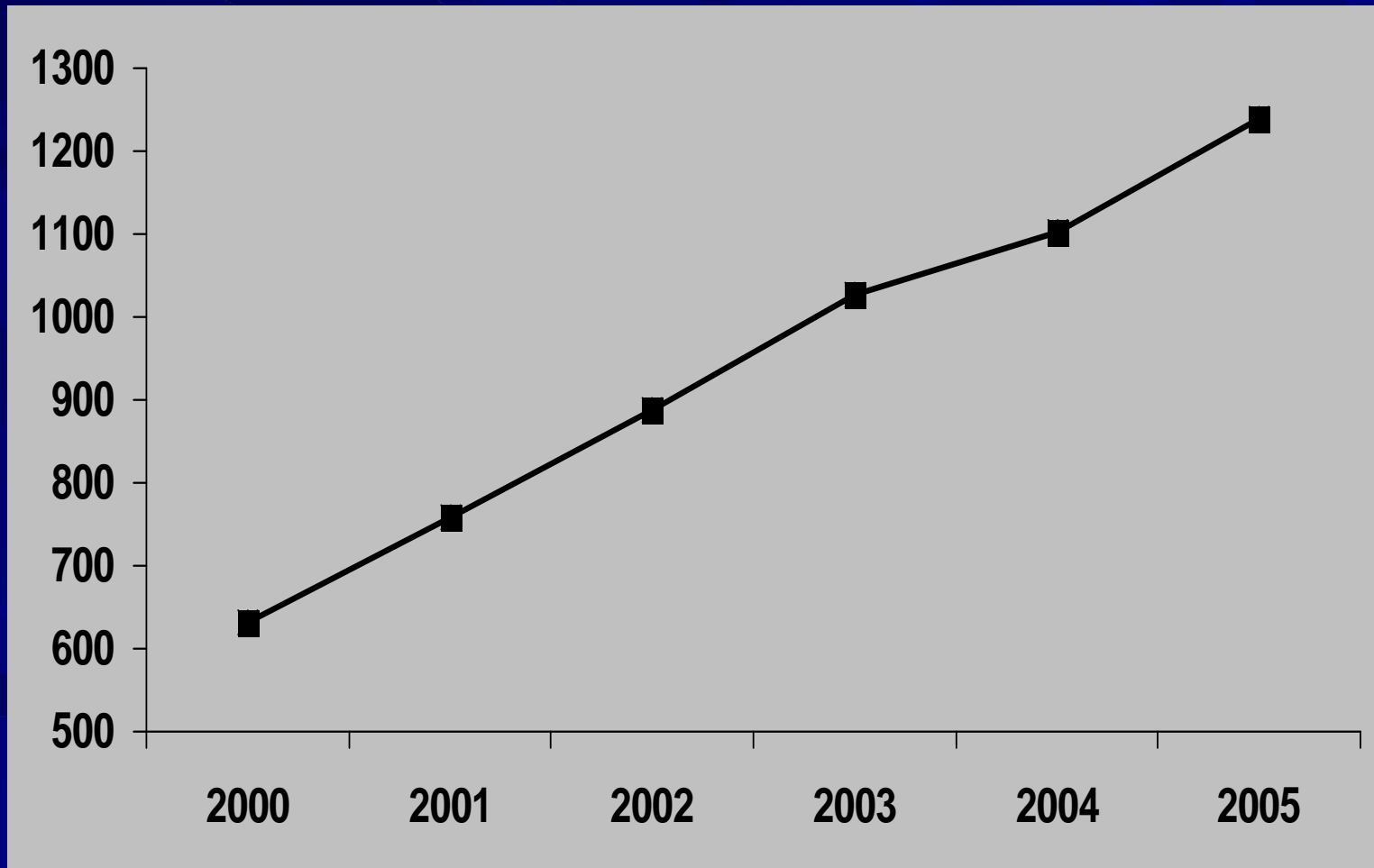
# Palliative Care is ...

- Pain and Symptom Management
- Prognostication
- Communication Skills
- Application of Bioethics/Law
- Community Resources/Hospice
- Psychosocial and Family Care
- After-Death Care/Grief

- Supportive Oncology: focus is to treat symptoms associated with cancer and its treatment

# # Hospital Palliative Care Programs 2000-2005

AHA Survey 2007



# Cost and ICU Outcomes Associated with Hospital Palliative Care Consultation

## 8-hospital study (adjusted results)

Morrison et al JAGS supplement April 2007

n>25,000 subjects

	Live Discharges			Hospital Deaths		
Costs	Usual Care	Palliative Care	P	Usual Care	Palliative Care	P
Per Day	\$867	\$684	<.001	\$1,515	\$1,069	<.001
Per Admission	\$11,498	\$9,992	<.001	\$23,521	\$16,831	<.001
Laboratory	\$1,160	\$833	<.001	\$2,805	\$1,772	<.001
ICU	\$6,974	\$1,726	<.001	\$15,531	\$7,755	.045
Pharmacy	\$2,223	\$2,037	.19	\$6,063	\$3,622	.002
Imaging	\$851	\$1,060	.03	\$1,656	\$1,475	.16
Died in ICU	X	X	X	18%	4%	<.001

# 8 Hospital Study: Costs/day for patients who died with palliative care vs. matched usual care patients

