

Doing Palliative Care in the Oncology Office

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As palliative care specialists in oncology, we are used to the questions: Why palliative care? Shouldn't the palliative care types be doing the palliative care? As Abraham points out, most oncologists think they already do palliative care,¹ although when measured, their performance needs significant improvement.²

We have some good answers for these questions now. As defined by the Center to Advance Palliative Care,^{2a} palliative care is "specialized medical care for people with serious illnesses, focused on providing patients with relief from the symptoms, pain, and stress—whatever the diagnosis," with an explicit goal to "improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support, and can be provided together with curative treatment."

Palliative care concurrent with usual oncology care is now endorsed by ASCO because it results in better quality of life, better quality of care, improved symptom management, and equal or better survival, at an affordable cost.³ The enhanced survival of patients who receive palliative care^{4,5} or hospice care^{6,7} is an unexpected benefit. For years we have heard, "Hospice will just give them morphine to make them comfortable and they'll die sooner." But the data suggest otherwise.

There are three types of palliative care.⁸ Primary palliative care is delivered every day in the oncology office. Secondary palliative care is delivered by specialized teams at specific programs or inpatient units. And tertiary palliative care is delivered by specialized teams with expertise in advanced pain and symptom management, such as implantable drug delivery systems, palliative sedation, or advanced delirium management. In this article, we show what we have done in our oncology office that has effectively integrated palliative care into the treatment of patients with incurable cancer.

How to Do Palliative Care in the Office

Table 1 shows a list of components that must be in place for successful palliative care. As the table shows, much of our new learning is about communication.^{9,10}

Ask, Tell, Ask (and ask again)

In the Temel et al study of patients with lung cancer, longer survival was linked to a better understanding of the incurable nature of the disease, and those who understood their disease received less intravenous chemotherapy in the last 60 days of life.¹¹ The improved survival of the concurrent care group makes sense given the 2% and 0% response rate for third- and

fourth-line chemotherapy in patients whose lung cancer has progressed on a platinum and a taxane drug^{12,13} (but with preserved possibly fatal adverse effects). The palliative care team met with the patients every 3 or 4 weeks to discuss symptoms, disease understanding, and coping.

This is not a one-time conversation. Nearly all oncologists tell patients when they have an incurable illness, but then most of the remaining conversation is about chemotherapy, and the coping part is neglected.¹⁴ This has to be a repeating conversation,¹⁵ and there are some excellent triggers: when the disease grows, when the prognosis changes, when the performance status declines. In these cases, when the patient may be on second- or third-line chemotherapy, there are some important questions that should be asked: "Do you have a will? Do you have a living will? What does it say about CPR? Who do you want to make medical decisions, if you can't? Have you discussed this with her or him? Are there spiritual issues? Are there family issues? Have you met with hospice yet? [3-6 months before death] Have you thought about where you would like to be for your death? Let's start with you doing a life review; what you want people to remember about you. Oncologists need a script for this conversation as much as one for adjuvant chemotherapy. These are learnable skills, as shown by results of programs such as Oncotalk, a program designed to teach oncologists better communication skills, including challenging topics such as recurrence of cancer and code status discussions. After participation, providers made significantly more use of the skills needed to discuss end-of-life issues, deliver bad news, and discuss transitions in care goals.¹⁶

Always Do a Symptom Assessment

It likely does not matter which symptom assessment scale is used, and we like a simple one¹⁷ as shown in Table 2. The key is to remind ourselves to ask about more than just pain, since most patients with cancer have multiple symptoms—if we notice. Some areas that we have learned to focus on include delirium in the hospital,^{18,19} and depression in the outpatient setting. For outpatients, the simple question "Are you depressed?" has excellent reliability, especially if we prompt them with "yes, no, or possibly" as possible answers.²⁰ For inpatients, small daily doses of haloperidol (1 to 3 mg) help delirium,²¹ but only if it is diagnosed. We have learned from our nursing colleagues to do the relatively simple Confusion Assessment Method for the Intensive Care Unit for monitoring delirium^{22,23} assessment. Issues involved in getting the symptom assessments into the electronic medical record and acted on are beyond the scope of

Table 1. Components of Office-Based Primary Oncology Palliative Care

1. Ask, tell, ask. Always ask people how much they want to know, and what they do know. Then tell them, in understandable words. Ask "What is your understanding of your situation now, after our discussion? What are some key points you take away from our conversation?"
2. At each transition point (when changing treatments or prognosis) ask, "What are you hoping for?" and "What is your understanding of your situation?"
3. Always do a symptom assessment.
4. At least some of the time, do a spiritual assessment.
5. Make a hospice information referral when the patient still has 3-6 months left to live.
6. Audit hospice referrals, as QOPI does.
7. Set up best practices for seriously ill patients who have less than 1 year to live.
8. Take advantage of decision aids to provide accurate prognosis to patients who want to know their prognosis.
9. Use some palliative care "pearls" in your practice, such as olanzapine for nausea, ginger for nausea and fatigue, and dexamethasone for fatigue and better quality of life.

Abbreviation: QOPI, Quality Oncology Practice Initiative.

this review, but should be no different than for performance status.

Do a Spiritual Assessment

Our patients want us to be aware of their spirituality, even if they do not expect us to engage in it. One of the key parts of palliative care is to involve spiritual care specialists such as chaplains for patients facing challenging existential adjustments. There is accumulating evidence that programs that do spiritual assessments and have active chaplaincy programs have better patient satisfaction²⁴ and fewer in-hospital deaths.^{25,26} In fact, if spiritual care is provided by the medical team, rather than by community services, patients with terminal illness are five time more likely to use hospice and have better quality-of-life scores.²⁷ We use the Faith, Importance, Community, Address (FICA) tool,²⁸ the FICA Spiritual History Tool,^{28a} or simply ask, "Is religion or spirituality important to you?" Have established links to

chaplains available if the person responds, "Yes...I have neglected that part of my life."

Make a Hospice Information Referral When the Patient Still Has 3 to 6 Months to Live

This is one of the key practical points of the ASCO Provisional Clinical Opinion, and it is endorsed by the ASCO University Top Five choices in oncology practice.²⁹ Oncologists who say they cannot predict the future course of patients have excellent tools to help improve their prognostic forecasting, which most patients want. It is relatively easy to predict which patients have less than 6 months to live³⁰: decline in performance status, weight loss/anorexia, any malignant effusion, or hypercalcemia should all trigger discussion about hospice. It is especially important to have a frank discussion about prognosis when the time is short, and there are excellent prognostic scales well validated in cancer patients.^{30a} The use of scales is critical because the closer oncologists are to the patient, the more they tend to overestimate survival. Oncologists have been found to overestimate survival by a factor of 5.3.³¹

The advantages to this hospice information visit are several. First, it brings hospice into the picture as part of best practices if and when it is needed (and hospice has been endorsed by ASCO for at least 15 years³²) Second, it tells the patient and the family that there will indeed be care for them when it is needed, rather than just being told "there is nothing more we can do." Third, it reinforces that the patient has an illness that will lead to the need for hospice and eventual death, which will help that patient and their family start planning for the future. It moves the anguish of facing a terminal illness way upstream, when patients and families are not in extremis, and makes eventual transitions easier. Finally, it allows the hospice team to get to know the patient and family before an imminent death and crisis. In US Oncology practices that adopted hospice information referrals as part of their clinical pathways project, patients with lung cancer spent more than a month in hospice have better patient (Roy Beveridge, MD, and J. Russell Hovermann, MD, PhD, personal communication, November 2012). This is compared to the 0 to 4 hospice days in the usual oncologic care arm of Temel's trial (without palliative care intervention). An earlier

Table 2. The Memorial Symptom Assessment Scale Condensed Rounding Tool

MSAS-C: 0 = none, 1 = a little bit, 2 = somewhat, 3 = quite a lot, 4 = very much, 7 = refused										
Reported by: Patient/Caregiver/RN/MD										
Unable to respond: Yes No										
Delirious: Yes No [N.B. Use haloperidol or Seroquel (Quetiapine), NOT BENZODIAZEPINE.]										
	Pain	Tiredness	Nausea	Depression	Anxiety	Drowsiness	Anorexia	Constipation	Dyspnea	Secretions
0										
1										
2										
3										
4										
7										

Abbreviation: MSAS-C, Memorial Symptom Assessment Scale Condensed.

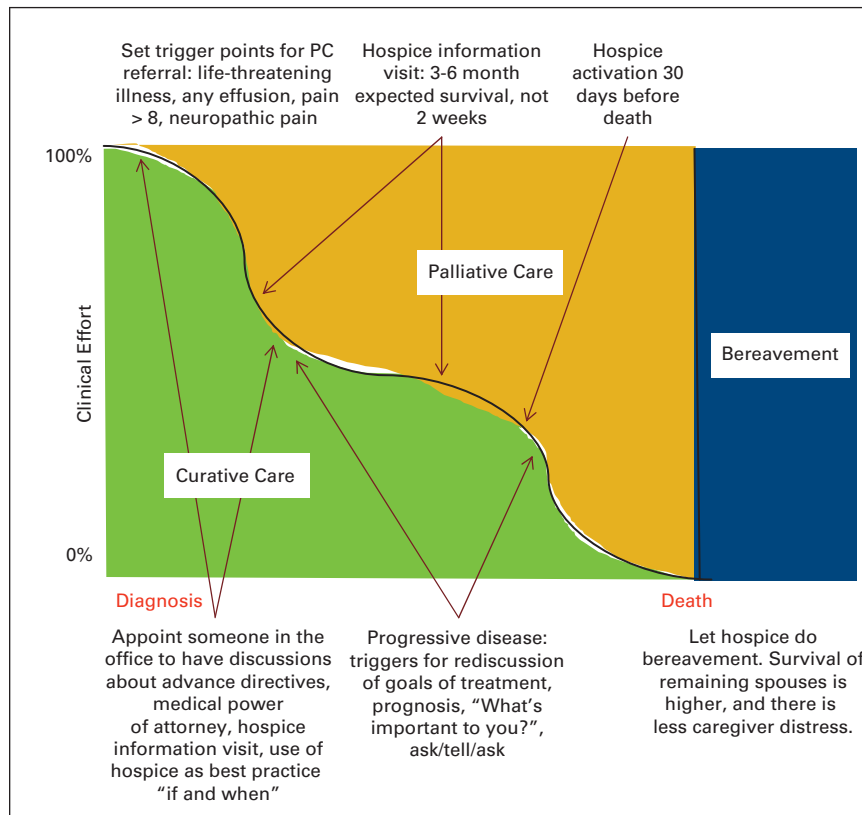


Figure 1. Diagram showing palliative care (PC) moved upstream.

study of concurrent care with upstream referral and the opportunity for patients to meet the hospice care team showed that hospice length of stay increased from 14 to 48 days.³³

Audit Hospice Referrals

ASCO's Quality Oncology Practice Initiative (QOPI) shows us what we do, not what we think we do. The average patient with cancer lives just 8 days in hospice nationwide,³⁴ and 20% of patients at Johns Hopkins Oncology live less than a week. Nationwide, only 2% of patients with hematologic malignancy ever use hospice. The way to change this is to have the hospice information visit, make the referral as soon as chemotherapy stops working, and audit our performance. Blayney showed that the use of chemotherapy in the last 2 weeks before death could be decreased from 50% to 20% in a month through QOPI audit and provision of feedback.³⁵ Hospices can also give feedback to physicians on our performance, but they may hesitate for fear of losing referrals.

Set Up Best Practices for Seriously Ill Patients Who Have Less Than a Year to Live

Nearly all of our practices have standard antiemetic orders, doses calculated from a spreadsheet, the available lines of chemotherapy, and so on. We can do the same standardization with integration of palliative care: build in the automatic referrals to hospice with second-line chemotherapy for solid tumors, malignant effusions/ascites/hypercalcemia, or decline in ECOG performance status to 2. Well-designed clinical path-

ways are not a panacea,³⁶ but they appear to improve care and reduce cost in patients with colon³⁷ and lung³⁸ cancer.

Take Advantage of Decision Aids

Decision aids can be used to provide accurate prognosis to those patients who want to know their prognosis. Most oncologists use Adjuvant!, which gives exact prognoses and improves decision making.³⁹ There are excellent decision aids for non-small-cell lung cancer on the ASCO Cancer.Net Web site that show the benefits of first-, second-, third-, and fourth-line chemotherapy.⁴⁰ Most important, they provide a set of transition prompts that allow clinicians to move from simply telling patients "there is nothing more I can do" to actively engaging them in taking ownership of their end-of-life process.

Use Palliative Care "Pearls"

To alleviate disease- or treatment-related symptoms, use metoclopramide, haloperidol, or olanzapine for cancer-related nausea⁴¹; ginger 0.5-1.0 g/d for nausea⁴²; American ginseng to improve fatigue,⁴³ and dexamethasone for both intestinal obstruction and to improve fatigue and quality of life.⁴⁴ Octreotide, long used for malignant bowel obstruction,⁴⁵ is not superior to placebo when dexamethasone and ranitidine are used for intestinal obstruction,⁴⁶ at a cost saving of \$25-\$100 a day. If your patient has an uncomplicated nonvertebral symptomatic bone metastasis, the American Society of Radiation Therapeutic Oncology recommends a single large fraction of radiation rather than 10; ask your radiation therapist to do this

as the default practice.⁴⁷ Make sure patients get into hospice within the last 30 days of life, to allow discussions that reduce caregiver distress,⁴⁸ as hospice increases the chance of survival of the remaining spouse.⁴⁹ These are some things we do as palliative care doctors that work, are incredibly simple, and usually inexpensive.

Yes, We Can Do This

Alesi documented several examples of practices that have fully integrated palliative care into oncology practice.⁵⁰ This improved symptom management and actual symptoms, mostly paid for itself, and was doable in typical cancer offices. Whether integrated (the same practitioners doing palliative and oncology care) or consultative (referral to specialists in or out of the practice) models are better cannot be answered at the present time.

Conclusions

Palliative care is increasingly cited as providing better communication, symptom control, and knowledge about treatment options and goals; not hastening death; and improving survival. ASCO recommends concurrent palliative care early in the cancer disease course for any patient with advanced cancer or high symptom burden. Primary palliative care skills should be part of any physician's armamentarium. Like any other clinical skills, they can be learned, and will improve with use and practice. These skills include ensuring accurate and multidirectional

communication by using techniques such as ask, tell, ask; performing symptom and spiritual assessments; recognizing triggers for palliative care and hospice referrals; and using evidence-based decision aids for prognostication. For patients with likely less than 6 months to live, normalizing hospice services through routine hospice information referrals can calm the often turbulent transitions from primarily disease-focused to symptom-focused management.

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