HOSPICE MATTERS for physicians

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Women Far Likelier Than Men to Prefer Palliative Care When Facing Advanced Cancer

Gender disparities reported in the receipt of palliative care (PC) and hospice services near the end of life may be partially explained by the discrepancy in preferences for PC between men and women with advanced cancer. Women were found to be three times more likely than men to prefer PC, according to a report published in the *Journal of Pain and Symptom Management.*

"Our study findings suggest that there is a need to promote palliative care services among men," write the authors. "[C]linicians may wish to consider gender differences while discussing palliative care option/referral with their patients."

Patients with advanced cancer participating in the Values and Options in Cancer Care (VOICE) clinical trial (n = 383) were asked to consider their preferences for PC if their oncologist were to tell them that "there is no further anticancer treatment available that would be helpful." Subjects included those with Stage IV non-hematologic cancer or those with Stage III cancer whose oncologists reported they would not be surprised if the patient died within 12 months.

OVERALL:

- Most participants (79.1%) reported they would definitely (45.2%) or possibly (33.9%) want PC if told no further anticancer treatment would be helpful; 14.9% were unsure.
- Patient age was almost equally divided between those aged < 65 years and those aged ≥ 65 years and ranged from 22 to 90 years.
- A majority of participants were women (55.1%), white (89.3%), and had attended at least some college (71.3%).

KEY FINDINGS:

- Women were more likely than men to prefer PC (odds ratio [OR], 3.07; 95% confidence interval [CI], 1.80 to 5.23; $P < 0.0001$).
- Older adults were less likely than younger ones to prefer PC (OR, 0.54; 95% CI, 0.31 to 0.94; $P = 0.03$).
- Education level had no significant effect on PC preferences (OR, 0.85; 95% CI, 0.48 to 1.48; $P = 0.55$).

Gender differences in end-of-life (EOL) care choices may be explained by differences in social norms for men and women, suggest the authors. "If there is a 'war' on cancer, and treatments and hopes for cures are portrayed as 'fights' in media, then societal beliefs may push men, in particular, to fight the disease over receiving palliative care," they write.

"Distinct, gender-specific communication skills and techniques might be needed to facilitate EOL discussions," suggest the authors. "For example, helping men understand that PC can benefit not only themselves but also other family members may increase their receptivity toward PC."

Source: "Preference for Palliative Care in Cancer Patients: Are Men and Women Alike?" Journal of Pain and Symptom Management; *Epub ahead of print, March 23, 2018; DOI: 10.1016/j.jpainsymman.2018.03.014. Saeed F et al; Department of Medicine, Division of Nephrology and Division of Palliative Care, University of Rochester School of Medicine and Dentistry, Rochester, New York.*

Surgeons Favor Palliative/End-of-Life Care, but Identify Multiple Critical Barriers to Ensuring Its Provision

Surgeons caring for patients with advanced colorectal cancer (CRC) report encountering major barriers to providing appropriate palliative and end-of-life care. Aside from serious patient/family and system barriers, the most important barrier identified was their own lack of formal training in palliative care, particularly in the area of communication, according to a study published in the *Journal of Palliative Medicine.*

"In contrast to the notion that surgeons are primarily technicians, these data indicate that surgeons act as guides and recognize that the patient-surgeon relationship is based on empathic communication, and not simply the procedures performed," write the authors.

In the U.S., 135,000 patients are diagnosed with CRC every year, 20% of whom have potentially incurable (Stage IV) disease, note the authors. Despite support in the emerging literature for "the integration of palliative care into standard care for individuals with serious illness such as metastatic CRC ... surgical patients in particular are less likely to receive palliative care than medical patients," they write, noting that little prior research exists on how surgeons caring for CRC patients approach end-of-life care.

Investigators analyzed responses (n = 131) to an online survey of non-retired members of the American Society of Colon and Rectal Surgeons. The questionnaire was modified from a previously validated physician survey regarding barriers to optimal end-of-life care, then supplemented to include open-ended questions on surgeons' end-of-life care attitudes and experiences.

Five themes emerged regarding major barriers to palliative care: surgeon knowledge and training, communication challenges, difficulty with prognostication, patient and family factors, and systemic issues. Responses were dichotomized by the proportion of surgeons who characterized these barriers as major ("large/huge") as opposed to minor ("none/small/medium").

CLINICIAN BARRIERS

Surgeons identified a number of clinician barriers, including:

- No formal training in palliative care (76%)
- Insufficient training in communication about end-of-life care issues (42.7%)
- Lack of training in the management of seriously ill patients' distressing symptoms (40.3%) or in forgoing life-sustaining treatment without patient suffering (37.9%)
- Inadequate communication between care teams and patients/families (51.6%)
- Challenges with communication across care teams (47.6%)
- Unrealistic clinician expectations about prognosis or the effectiveness of treatment (45.2%)

Lesser clinician barriers included psychological and/or emotional stress (30.6%); fear of legal liability for forgoing life-sustaining treatments (25.0%); insufficient attention to diverse culture norms and customs surrounding death, dying, and grief (21.8%); and hesitance to prescribe opioids and sedatives due to concerns about side effects (21.0%).

PATIENT AND FAMILY BARRIERS:

- Unrealistic patient and/or family expectations about prognosis or effectiveness of treatment (61.8%)
- Disagreements between patient/family and care teams (43.5%) or within families (48.9%)

Respondents shared experiences when disagreements reduced quality of life ("... I attempted to convince him to do hospice .... Unfortunately, by the time he was discharged he was [unable to perform] activities he might have been able to do had he decided quickly to accept the inevitable ..."), as well as when agreement helped provide a positive end-of-life experience ("The patient and his family ... had a chance to spend their remaining days together at home ...").

SYSTEMIC BARRIERS:

- Lack of advance directives (43%)
- The absence of surrogate decision makers (39.7%)
- Competing demands for clinicians' time (53.2%)
- The healthcare culture of adding or continuing all life-sustaining therapies (51.2%)
- Insufficient recognition of the importance of end-of-life care (38.3%)

"In my opinion, the biggest gap is that our country views death as a taboo subject and as a failure, instead of treating it like another part of life that has its own value and meaning," commented a respondent.

Lesser barriers included inadequate support services (34.9%), a lack of experts to consult regarding distressing symptoms (32.8%), and a lack of palliative care services for dying patients (25.6%). Respondents who were able to collaborate with specialists recalled positive experiences ("smooth transition from acute care to palliative care").

The study findings support the need for surgical education that includes better end-of-life and palliative care training, note the authors, as well as reinforcing the value of a multidisciplinary, team-based approach for quality end-of-life care. "Most surgeons recognized that both surgeons and palliative care specialists are essential for patients with end-stage CRC and cannot exist without the other."

Source: "Surgeons' Perceived Barriers to Palliative and End-of-Life Care: A Mixed Methods Study of a Surgical Society," Journal of Palliative Medicine; *Epub ahead of print, March 13, 2018; DOI: 10.1089/jpm.2017.0470. Suwanabol PA et al; Division of Colorectal Surgery, Department of Surgery, University of Michigan, Ann Arbor, Michigan; Division of Colorectal Surgery, Department of Surgery, Allegheny Health Network, Pittsburgh; Department of Surgery, S-SPIRE Center, Stanford University, Stanford, California.*

Major Delays in Hospice Referrals of Patients Receiving Hemodialysis Demonstrate Need for Integrated Palliative Care

Hospice care has the potential to greatly benefit patients with end-stage renal disease (ESRD) receiving maintenance hemodialysis, because of their high symptom burden and limited life expectancy. Yet, enrollment rates of these terminally ill patients have remained relatively low, with very late referrals compared with hospice users with other terminal illnesses, according to a report published in *JAMA Internal Medicine.*

"Almost two-thirds (64.0%) of hospice users in our study received one week or less of hospice care compared with 39%, 36%, and 34% reported for Medicare hospice beneficiaries with heart failure, colorectal cancer, and dementia, respectively," write the authors. "This is concerning, because short hospice stays have been associated with inadequate pain control and unmet emotional needs."

The late referral of ESRD patients can be partially explained by Medicare's requirement that enrollees agree to forgo curative treatment for their primary terminal admitting diagnosis, note the authors. Unfortunately, maintenance hemodialysis for patients admitted with renal failure is considered by Medicare strictures to be "curative."

Investigators analyzed the results of a cross-sectional, observational study of 770,191 Medicare beneficiaries with ESRD in the United States Renal Data System registry who were receiving maintenance hemodialysis (mean age, 74.8 years; male, 53.7%) and died between 2000 and 2014.

OVERALL:

- 20.0% of ESRD patients were enrolled in hospice at the time of death, with a median length of stay of 5 days (interquartile range, 2 to 12 days).
- Fully 41.5% of enrollees received hospice services for ≤ 3 days prior to death, a percentage that remained stable over the study period, despite a doubling of the percentage of hemodialysis patients using hospice during that time period (from 11.0% in 2000 to 21.7% in 2014).

KEY FINDINGS:

- Patients in hospice for ≤ 3 days were less likely than those with no hospice to die in the hospital (13.5% vs 55.1%; $P < 0.001$) or to undergo an intensive procedure in the last month of life (17.7% vs 31.6%; $P < 0.001$).
- However, those in hospice for ≤ 3 days had higher rates of hospitalization (83.6% vs 74.4%; $P < 0.001$) and ICU admission (54.0% vs 51.0%; $P < 0.001$) than non-hospice patients, most likely reflecting "a crisis-driven approach to hospice referral" in which hospice serves as a last-minute "add-on," note the authors.
- Hospitalization rates in the last month of life were lowest for those in hospice ≥ 15 days (35.1%) and highest among those in hospice for ≤ 3 days (83.6%).
- Findings were similar for ICU admission in the last month of life for ≥ 15-day hospice stays vs ≤ 3-day stays (16.7% vs 54.0%).
- Both hospice and non-hospice groups incurred similar Medicare costs in the last week of life, although costs and all healthcare utilization rates for ESRD patients decreased progressively for longer lengths of hospice stays, especially for those ≥ 15 days.

BARRIERS TO HOSPICE REFERRAL

The authors urge that barriers to hospice referral — particularly to the earlier timing of referral — need to be addressed. Barriers can include:

- The Medicare payment plan, which does not reimburse for maintenance hemodialysis when ESRD is the primary hospice diagnosis. This can be a disincentive to the consideration of hospice for both physicians and patients.
- An unrealistic, "life at any cost" view of the prognosis among ESRD patients who have already been drawn into the highly medicalized treatment pattern of hemodialysis.
- The view by both physicians and patients that renal failure is a problem that can be "fixed" with hemodialysis.
- Prognostic uncertainty. Illness trajectories in patients with organ failure tend to be less predictable than those for patients with advanced cancer, although the ESRD patients in this study were referred to hospice much later in the illness course than referrals reported for other patients with organ failure, such as heart failure and chronic lung disease.

"Earlier and more frequent integration of palliative care services into the care of patients receiving hemodialysis is an intervention that could potentially target a number of these barriers," write the authors. Early palliative care integration could also address the "substantial and often unrecognized" symptom, functional, and caregiving burdens faced by these patients and their families, they add.

"Concurrent receipt of hemodialysis and palliative care services earlier in the illness trajectory could perhaps also allow for a smoother, less crisis-driven transition to hospice closer to the end of life," the authors conclude.

Source: "Association Between Hospice Length of Stay, Health Care Utilization, and Medicare Costs at the End of Life Among Patients Who Received Maintenance Hemodialysis," JAMA Internal Medicine; *Epub ahead of print, April 30, 2018; DOI: 10.1001/jamainternmed.2018.0256. Wachterman JW, Halpern SM, Keating ML, Kurella Tamura M, O'Hare AM; Section of General Internal Medicine, Veterans Affairs Boston Healthcare System, Boston; Division of General Internal Medicine and Primary Care, Department of Medicine, Brigham and Women's Hospital, Boston; Department of Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, Boston; Division of Nephrology, Kidney Research Institute, Department of Medicine, University of Washington, Seattle; Department of Health Care Policy, Harvard Medical School, Boston; Division of Nephrology, Department of Medicine, Stanford University, Palo Alto; Geriatric Research and Education Clinical Center, Veterans Affairs Palo Alto Health Care System, Palo Alto; and Hospital and Specialty Medical Service, Veterans Affairs Puget Sound Health Care System, Seattle.*

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WHEN TO REFER TO HOSPICE

Call us if your patient exhibits the following indicators:

- Physical / functional decline
- Weight Loss >10% in last 6 months
- Multiple comorbidities

*When life expectancy can be measured in weeks or months, hospice is usually the best option. For patients with **pulmonary disease (COPD),** look for the following indicators:*

- Dyspnea at rest
- Poor response to bronchodilators
- Recurrent pulmonary infections
- Right heart failure
- Unintentional weight loss
- Bed to chair existence

Call us any time, any day.

Geoffrey Coleman, MD
Medical Director
Montgomery Hospice

'The Pause' Honors a Life Lost and the Care Team's Efforts at the Bedside

Stopping for a moment immediately following a patient's death, and standing silently together to pay respect for the value of the life just ended can bring closure and create an uplifting, reflective experience for the care team, according to the emergency room nurse who initiated the ritual several years ago at his medical center and published his thoughts in *Critical Care Nurse.*

"I would stand, ask that no one leave, and invite my peers to bear witness with me ... to offer silent recognition of the lost human life ... and to acknowledge that our own efforts, too, were worthy of honor," writes Jonathan B. Bartels, RN, CHPN, who is now palliative care liaison at the University of Virginia Medical Center in Charlottesville.

The practice was soon picked up by other departments in the medical center, and has since been spreading across the country, adopted by hospices and other facilities in their hospital emergency departments, ICUs, and other settings.

A recent investigation of the impact on the attitudes and practices of the hospital care team when using "the pause" in the ICU setting found that utilizing the brief ritual provided emotional support and a sense of professional satisfaction, according to a report published in the *American Journal of Hospice and Palliative Medicine.*

Researchers conducted an online anonymous survey in July 2017 of ICU physicians and nurses (n = 34) at a tertiary care hospital where the practice of stopping immediately after a patient's death to honor and recognize the lost human life and acknowledge the team's efforts had been adopted the year before, and named "sacred pause."

FINDINGS:

- 79% of respondents felt that performing the ritual brings closure and helps them overcome feelings of grief, disappointment, distress, and failure.
- 82% reported that the ritual makes their efforts feel appreciated.
- 73% agreed that the practice has encouraged a sense of team effort.
- 85% thought the ritual should be a universal phenomenon in all ICUs.

Source: "The Pause," Critical Care Nurse; *February 2014; 34(1):74–75. Bartels JB; University of Virginia Medical Center, Charlottesville. "'Sacred Pause' in the ICU: Evaluation of a Ritual and Intervention to Lower Distress and Burnout,"* American Journal of Hospice & Palliative Medicine; *Epub ahead of print, January 1, 2018; DOI: 10.1177/1049909118768247. Kapoor S et al; Department of Pulmonary, Critical Care, and Sleep Medicine, Baylor College of Medicine, Houston.*