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## 'Surprise' Question Found Effective As Screening Tool for Identifying Cancer Patients with Poor Prognosis

A physician's answer to the question "Would I be surprised if this patient died in the next year?" during a clinical encounter can be more predictive of death within 12 months in cancer patients than the type of cancer, the stage of cancer, or patient age, a team of West Virginia researchers has found.

"Taken together, our findings show that the surprise question is a simple, feasible, and effective tool to identify patients with cancer with a greatly increased risk of one-year mortality," write the authors of a report published in the *Journal of Palliative Medicine*.

The team analyzed outcomes of oncologists' use of the surprise question among 826 patients with breast, lung, or colon cancer during follow-up visits at a university cancer center. The physicians had not been trained in the use of the question, and used their clinical judgment to make their "Yes" or "No" classifications, which they did not share with the patients/families.

### KEY FINDINGS INCLUDE:

- After 12 months, 41% of the "No" patients had died, while 3% of the "Yes" group had died.
- In both univariate and multivariate analyses, the physician's "No" response was more predictive of patient death than were type of cancer, stage of cancer, or age.
- The "No" response identified patients with a 7.78 times greater risk of death in the next year than "Yes" group patients.
- "No" group patients were older than those in the "Yes" group, more likely to have Stage IV disease, more likely to have lung cancer, and more likely to have completed an advance directive (71% vs 44%).

The ability to estimate prognosis is key

*"Physicians do not need to definitely conclude...that a patient is dying. The question forces them to consider whether the patient might be dying. It is an intuitive tool... a feasible tool."*

—Moss et al, *Journal of Palliative Medicine*

to the timing of communication regarding end-of-life care preferences, but research has shown that oncologists consistently overestimate survival, the authors note. "A failure to estimate prognosis may lead to a delay in communication and in identifying the patient's values and wishes for subsequent treatment, which may include a preference for palliative care and hospice referral rather than continued aggressive therapy."

Incorporating the surprise question into an integrated prognostic model combining clinical predictions and prognostic factors "may improve prognostic accuracy, because it requires physicians to frame prognosis in a broader perspective and allows physicians to think in a new way about their patients," investigators suggest.

Source: "Prognostic Significance of the 'Surprise' Question in Cancer Patients," *Journal of Palliative Medicine*; July 2010; 13(7):837-840. Moss AH, Lunney JR, Culp S, Auber M, Kurian S, Rogers J, Dower J, Abraham J; West Virginia University, Morgantown, West Virginia.

# Patients Who Die in Hospitals Have Worse Quality of Life Than Those Dying with Hospice Care at Home

*Caregivers of hospitalized decedents have higher odds of developing bereavement-related psychiatric illness*

The place of death and type of medical care received by cancer patients near the end of life significantly affect the lives of both patients and their bereaved caregivers, a team of Boston researchers has found. Not only do those who die in hospitals have lower quality of life, but their caregivers have a five-fold greater risk of developing post-traumatic stress disorder (PTSD) following the death of their loved one.

“Where cancer patients die really does matter, not only for them, but for their family caregivers as well,” remarks lead author Alexi A. Wright, MD, instructor in medicine, Harvard Medical School and Dana-Farber Cancer Institute, Boston.

“This study provides evidence that patients with cancer who die at home have better quality of life at the end of life than patients who die in hospitals,” Wright and colleagues state in their report in the *Journal of Clinical Oncology*. “Patients’ experiences at the end of life have lasting effects on how their caregivers live after they are gone.”

The investigators conducted a prospective multisite study of 342 dyads of patients with advanced cancer (mean age, 58.0 years) and their caregivers (mean age, 51.3 years), as part of the larger Coping with Cancer study. Patients were followed from enrollment to death (median period, 4.5 months), with patient quality of life based on caregiver reports made within two weeks of death. Caregivers’ mental health was assessed from interviews conducted at baseline and again six months following the loss.

## **KEY FINDINGS AMONG CANCER PATIENTS:**

- There was no difference in patient survival by location of death.
- Patients who died in an ICU or hospital had lower quality-of-life scores than those who died at home with hospice services.
- Hospital and ICU decedents had higher scores for both physical and emotional distress. These patients also had lower mean scores for physical comfort and for psychological well being.
- ICU decedents were less likely to have had an end-of-life discussion with a physician than were those who died at home.

## **KEY FINDINGS AMONG CAREGIVERS:**

- Caregivers of patients who died in ICUs had a heightened risk of developing PTSD compared with caregivers of patients who died at home with hospice (21.1% vs 4.4%; adjusted odds ratio [AOR], 5.00; 95% confidence interval [CI], 1.26 to 19.91).

- Similarly, these caregivers had higher odds of meeting criteria for prolonged grief disorder (PGD) — a period of intense, disabling grief lasting six months or more following loss — compared with caregivers of patients who died at home (21.6% vs 5.2%; AOR, 8.83; 95% CI, 1.51 to 51.77).

*“Interventions aimed at reducing terminal hospitalizations or increasing the utilization of hospice services may improve the quality of life of patients with advanced cancer at the end of life and reduce the risk of psychiatric illness in bereaved caregivers.”*

—Wright et al,  
*Journal of Clinical Oncology*

“Our study demonstrates that patients with advanced cancer who die in a hospital or ICU have worse quality of life at the end of life, and their caregivers have higher odds of developing bereavement-related psychiatric illnesses compared with those who die at home with hospice,” write the authors. “**These findings are important because patients with advanced cancer are receiving increasingly aggressive care at the end of life.**”

## **RECOMMENDATIONS: INCREASED END-OF-LIFE DISCUSSIONS AND IMPROVED PATIENT EDUCATION**

“If patients are aware that the intensity of care that they receive near death may affect their quality of life — and that of their loved ones after they are gone — they may make different choices...so that they are protected against futile aggressive care,” observes Wright.

“Our findings suggest that interventions aimed at reducing hospital deaths or increasing hospice use may improve cancer patients’ quality of life near death, while also reducing the risk that caregivers will develop mental illness during bereavement.”

A member of the American Society of Clinical Oncology’s Cancer Communications Committee agrees. “As physicians, we can do a much better job of discussing end-of-life options for patients with advanced cancer,” says Jennifer C. Obel, MD. “These results show that there are real consequences to the choices made, in terms of quality of life for both patients and caregivers.

“We must approach educating patients about choices near the end of life with the same rigor that we approach educating them about treatment options like chemotherapy and surgery.” Obel practices hematology and oncology at NorthShore University HealthSystems, Evanston, Illinois.

*Source: “Place of Death: Correlations with Quality of Life of Patients with Cancer and Predictors of Bereaved Caregivers’ Mental Health,” Journal of Clinical Oncology; October 10, 2010; 28(29):4457-4464. Wright AA, Keating NL, Balboni TA, Matulonis UA, Block SD, Prigerson HG; Department of Medical Oncology and Center for Psycho-Oncology and Palliative Care Research, Dana-Farber Cancer Institute, Boston; Brigham and Women’s Hospital, Boston.*

# COPD Patients Have Symptom Burden and Palliative Care Needs Similar to Patients with Advanced Cancer, International Study Finds

*COPD patients experience these symptoms and needs much earlier and for a longer time*

As part of a wider study on the course of breathlessness, researchers from three nations determined and compared the symptom burden, palliative care needs, and survival among breathless patients with either COPD stage III/IV (n = 60) or advanced lung cancer (n = 49) being cared for in one of three major hospitals, by a hospice home care service, or at one of two outpatient clinics in Munich, Germany, from June 2006 to November 2007.

## KEY FINDINGS:

- Patients from both the COPD and cancer groups reported a similar number of symptoms (median, 14).
- Moderately high symptom distress was measured in both groups.
- Shortness of breath caused the highest

distress in both patient groups, and this distress was higher in COPD patients.

- Depression scores were higher than anxiety scores in both groups.
- Median survival was significantly longer among COPD patients than among those with cancer (589 days [range, 8-692] vs 107 days [range, 4-671]). Thus, COPD patients cope with these symptoms and palliative care needs from a much earlier point in their disease trajectory.

“As symptom burden and palliative care needs in patients with severe COPD seem to be very similar to patients with cancer, lessons can be learned from the palliative care model for patients with cancer, such as: the need for symptom control, attention to psychosocial issues, and advance care planning,” write the authors of the re-

port, which was published in the *Journal of Palliative Medicine*.

“Regular symptom assessment is paramount in hospice and palliative care services, but should also be integrated into respiratory medicine as it has in other areas, such as renal medicine,” they suggest. **“Late referral of a patient in the last weeks of life will not meet the patients’ and families’ needs sufficiently. Therefore, palliative rather than only end-of-life care is needed for these patients.”**

Source: “Understanding Breathlessness: Cross-Sectional Comparison of Symptom Burden and Palliative Care Needs in Chronic Obstructive Pulmonary Disease and Cancer,” *Journal of Palliative Medicine*; September 10, 2010; 13(9):1109-1118. Bausewein C, et al; Department of Palliative Care, Policy, & Rehabilitation, King’s College London, London, United Kingdom; and Munich University, Munich, Germany.

## Optimal End-of-Life Communication Can Give Patients What They Want: ‘Truth, Touch, and Time’

Asking oneself what dying people want can be a clinician’s first step toward improving end-of-life communication, a skill often marred by such barriers as personal discomfort with the subject, a focus on other clinical care duties, or lack of intuition or training in such discussions. “So what *do* dying people want?” asks the author of an editorial published in the *Canadian Medical Association Journal*. “In short: truth, touch, and time.”

Patients rarely initiate conversations about their wishes using words “like ‘resuscitation,’ ‘inotropes,’ or ‘levels of care’ — words that are best used to communicate concepts among health professionals,” observes David Kuhl, MD, PhD, associate professor, Department of Family Practice, Faculty of Medicine, the University of British Columbia, Vancouver.

Rather, patients tend to speak of: Rela-

tionships; what life means to them; how they might be remembered; their hopes; their worries; and their fears.

### PATIENTS WANT TRUTH

People nearing the end of life want their family and physicians to be truthful with them, while still providing hope and reassurance, Kuhl notes. Hope can be about savoring final moments with loved ones, while reassurance can involve alleviating fears about pain, suffering, and loneliness.

### PATIENTS WANT TOUCH

Terminally ill patients want to be touched, emotionally as well as physically. Kuhl suggests that touch serves as a reminder to patients that they are still here at a time when relatives and friends may begin to distance themselves from someone who is dying.

### PATIENTS WANT TIME

Knowing that death is unlikely to occur

for most patients in the next minutes or hours following a discussion provides reassurance about timing, and hope. “Time is key for patients to come to terms with their illness, losses, and unresolved issues, as well as remaining hopes, so that their minds have time to change their hearts.”

Kuhl, a key participant in the design and development of one of the early palliative care programs in North America, at St. Paul’s Hospital in Vancouver in 1988, concludes: “With proper support, awareness, and training, all of us will be able to connect with terminally ill patients and their loved ones, so that they feel sustained — rather than abandoned — at a time of great need.”

Source: “What People Want at the End of Life,” *Canadian Medical Association Journal*; November 9, 2010; 182(16):1707. Kuhl D, Stanbrook MB, Hébert PC; Department of Family Practice, St. Paul’s Hospital, University of British Columbia, Vancouver, British Columbia, Canada.

## MONTGOMERY HOSPICE CORE VALUES:

- **UNCONDITIONAL COMPASSION:** Compassionate care, partnered with professional excellence, is the heart of our service.
- **DIGNITY OF THE DYING:** We affirm the right of our patients to be treated with respect, and to be honored as unique individuals.
- **DEDICATION:** We are committed and privileged to ease the burdens and challenges that our patients and families face.
- **COLLABORATION:** Mutual respect, empathy and trust unite us in providing care.



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## Patient-Reported End-of-Life Preferences Are Rarely Documented in Their Medical Records

Despite the wide acceptance of advance care planning and advance directives in the care of older patients, there is a disconnect between the stated wishes of patients for end-of-life care and the type of care actually received. Researchers in Los Angeles have found that this problem may be due to a lack of information flow from patient to medical record.

“Preferences for end-of-life care among community-dwelling elders are often not available in medical record documentation” according to a report published in the *Journal of Palliative Medicine*. “In addition, patients do not consistently discuss end-of-life issues with their providers, even if they have thought about such issues.”

The researchers examined data from two previous quality of care evaluations, the Assessing Care of Vulnerable Elders (ACOVE)-1 and ACOVE-2, consisting of a total of 811 community-dwelling elders (mean age, 81 years).

### KEY FINDINGS INCLUDE:

- The vast majority of patients participating in the survey said they preferred to die rather than remain permanently unconscious (93%), indefinitely attached to a ventilator (90%), or fed through a tube (88%).
- 38% said they had thought about limiting the aggressive care they would receive at the end of life, and 24% said they had spo-

ken to their physician about this.

- Despite these stated preferences, only 15% to 22% of respondents had such preference information in their medical records.
- Among those who reported having completed an advance directive and given it to their health-care team, only 15% (ACOVE-1) and 47% (ACOVE-2) had such information in their medical record.

“The uniqueness of patients’ preferences, coupled with the frequent desire to avoid certain medical interventions, reinforce the need to assess older adults’ preferences regularly and to document them,” comment the authors.

“Documentation is...critical in a health care system that relies on teams of providers in different settings,” they assert. “Future research should address whether electronic health records and/or a structured approach to documenting patients’ preferences, such as the Physician Orders for Life-Sustaining Treatment, could reduce these problems...”

Source: “Documentation of Advance Care Planning for Community-Dwelling Elders,” *Journal of Palliative Medicine*; July 2010; 13(7):861-867. Yung VY, et al; David Geffen School of Medicine, University of California, Los Angeles; Health Services Research & Development Center of Excellence and Geriatric Research, Education, and Clinical Center, Veterans Affairs Greater Los Angeles Healthcare System; University of California, Los Angeles Healthcare Ethic Center, Los Angeles, California.