Palliative Care and Oncology: Data and a Discussion

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Why I Am Here Today: Thank you, Justin

“Not only so, but we also rejoice in our sufferings, because we know that suffering produces perseverance.”
- Romans 5:3

Justin Walter Lee Straus
(8/12/1995 - 9/17/2008)

Our beloved Justin, We will persevere with you in our thoughts and hearts forever.
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
Palliative Care: What it is not...

- End of life care only
- Hospice
- Hand holding and nonaggressive
- Abdication of the patient
How Does Palliative Care Differ From Hospice?

- **Non-hospice palliative care** is:
  - Appropriate at any point in a serious illness
  - Provided at the same time as life-prolonging treatment
  - Without prognostic requirement
  - No need to choose between treatment approaches

- **Hospice is a form of palliative care** that:
  - Provides care for those in the last weeks/few months of life
  - Requires a 2 MD-certified prognosis of <6 months
  - Necessitates giving up insurance coverage for curative/life prolonging treatment
It is not “Either/Or” but “And/With”

“Offering palliative care ... is a challenge for the team and family because it is perceived as ‘giving up hope’ for recovery or cure.

This occurs because the term palliative care is often used by health care providers as synonymous with end-of-life care...” pg. 917

Palliative Care Models

Old

Diagnosis of Serious Illness

Life Prolonging Care

Medicare Hospice Benefit

End of Life

New

Diagnosis of Serious Illness

Life Prolonging Care

Palliative Care

Hospice Care

Bereavement
NQF Framework for Quality Palliative Care
Eight Domains

1. Structure and Process of Care
2. Physical Aspects of Care
3. Psychological and Psychiatric Aspects of Care
4. Social Aspects of Care
5. Spiritual, Religious and Existential Aspects of Care
6. Cultural Aspects of Care
7. Care of the Imminently Dying Patient
8. Ethical and Legal Aspects of Care

http://www.nationalconsensusproject.org/AboutGuidelines.asp
NQF: Core Elements of Palliative Care

- Debilitating chronic or life-threatening illness, condition or injury
- Patient- and family-centered care
- Begins at the time of diagnosis of a life-threatening or debilitating condition
- Comprehensive care
- Interdisciplinary team
- Attention to relief of suffering
- Communication skills

http://www.nationalconsensusproject.org/Guidelines_Download.asp
Duke Inpatient Palliative Care: What We Do

- Serve as a resource for ALL patients
- Provide an extra layer of support and availability
- Build upon care treatments plans outlined by primary providers
- Provide all treatments, interventions, and diagnostics available within Duke Medicine
Duke Inpatient Palliative Care: What We Do **NOT** Do

- Discuss domains of palliative medicine not requested by the consulting provider
- Talk only about hospice
- Create a self-fulfilling prophecy
- De novo recommend against disease-directed therapies
- **Take away** patient .... *hope*, options, or relationship with primary physician
Inpatient Introduction

- “To best meet some of the goals we’ve been discussing...I would like to have some consultants from the Palliative Care Team visit with you”

- “They can help with the symptom you have been experiencing...They are also good at helping your family deal with all of the changes brought on by your illness...”
Inpatient Introduction

Emphasize the positive aspects of what palliative care can do, eg, pain and sx management.

- Emphasize that this is a good team to have on board if/as the disease progresses and goals of care change

- The palliative care team is equally comfortable with both aggressive care and the issues surrounding end of life

Reasons for Palliative Care Consultation

- Communication
- Symptom
- Dispo
- EOL
"There's no easy way I can tell you this, so I'm sending you to someone who can."
Communication

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

Rudyard Kipling
1865-1936
Communication

- “What do you understand about where your Brother is right now in his illness?” (AnnInternMed.1999;130:744-749)
- Listen...be curious...tell yourself a good story about this patient and family...maybe it’s not guilt but “control” over a bad situation (Science. October 2008. pgs 115-117)
- Studies confirm that when families speak more than the doctor, they have more productive meetings and much greater satisfaction (NEJM. 2007.356:513-515. and Crit Care Med. 2004.32:1484-1488.)
Symptom Management

“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.”

It Is Not Just Symptom Management...

“...what may be most difficult is moving through the transition from gravely ill and fighting death to terminally ill and seeking peace...

shifting the goals of treatment from cure or longer survival to preservation of comfort and dignity.”

Sharing The Sandbox: Implementation And Results From A Fully Integrated Palliative Care/Medical Oncology Rounding Model For Inpatient Cancer Care

Christopher Jones, Richard F. Riedel, Kim Slusser, Devi Desai, Anthony N. Galanos
Duke University Medical Center, Durham, NC

Annual Assembly of American Academy of Hospice and Palliative Med
March 16, 2013
9300 Oncology Attending Survey

- Since palliative care started on service:
  - Rounding on 9300 more enjoyable (100%)
  - More willing to round (87%)
  - I have learned new ways to manage cancer symptoms (87%)

- Palliative care:
  - Is necessary component of comprehensive cancer care (100%)
  - Should have outpatient presence (100%)

“I feel more comfortable admitting my patients with supportive care needs and EOL issues because I know they’ll be addressed”

Leblanc T, in preparation
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.’

Framework: Integrated Palliative Care

- Disease Modifying Treatments
- Hospice

Diagnosis
- Treatments to Relieve Suffering/Improve QOL

6Mo
- Death

Bereavement
Toward Individualized Care for Patients with Advanced Cancer


- 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.**”
Early Palliative Care for Patients with Metastatic Non-Small Cell Lung Cancer


# Early Palliative Care Study Procedures

## Palliative Care Guidelines

### Illness understanding and education
- Inquire about illness and prognostic understanding
- Offer clarification regarding treatment goals

### Symptom management
- Pain
- Pulmonary symptoms
- Fatigue and sleep disturbance
- Mood
- Gastrointestinal

### Decision-making
- Assess mode of decision-making
- Assist with treatment decision-making

### Coping with life-threatening illness
- Patient
- Family/family caregivers

[www.nationalconsensusproject.org](http://www.nationalconsensusproject.org)
Kaplan-Meier Estimates of Survival According to Study Group

Median Estimates of Survival

11.6 mos early palliative care
8.9 mos standard care

p = 0.02
Early Palliative Care in Advanced Lung Cancer

A Qualitative Study

Jaclyn Yoong, MBBS, FRACP; Elyse R. Park, PhD, MPH; Joseph A. Greer, PhD; Vicki A. Jackson, MD, MPH; Emily R. Gallagher, RN; William F. Pirl, MD, MPH; Anthony L. Back, MD; Jennifer S. Temel, MD

Background: Early ambulatory palliative care (PC) is an emerging practice, and its key elements have not been defined. We conducted a qualitative analysis of data from a randomized controlled trial that demonstrated improved quality of life, mood, and survival in patients with newly diagnosed metastatic non-small cell lung cancer who received early PC integrated with standard oncologic care vs standard oncologic care alone. Our objectives were to (1) identify key elements of early PC clinic visits, (2) explore the timing of key elements, and (3) compare the content of PC and oncologic visit notes at the critical time points of clinical deterioration and radiographic disease progression.

Methods: We randomly selected 20 patients who received early PC and survived within 4 periods: less than 3 months (n=5), 3 to 6 months (n=5), 6 to 12 months (n=5), and 12 to 24 months (n=5). We performed content analysis on PC and oncologic visit notes from the electronic health records of these patients.

Results: Addressing symptoms and coping were the most prevalent components of the PC clinic visits. Initial visit
ts focused on building relationships and rapport with patients and their families and on illness understanding, including prognostic awareness. Discussions about resuscitation preferences and hospice predominantly occurred during later visits. Comparing PC and oncologic care visits around critical time points, both included discussions about symptoms and illness status; however, PC visits emphasized psychosocial elements, such as coping, whereas oncologic care visits focused on cancer treatment and management of medical complications.

Conclusions: Early PC clinic visits emphasize managing symptoms, strengthening coping, and cultivating illness understanding and prognostic awareness in a responsive and time-sensitive model. During critical clinical time points, PC and oncologic care visits have distinct features that suggest a key role for PC involvement and enable oncologists to focus on cancer treatment and managing medical complications.

“We observed that the specific content of the early PC visits varied according to timing along the trajectory...rather than following a ...prescribed checklist.” pg E4

“Early involvement of PC does not imply a presumed discussion about EOL care and hospice...This may allay patient and oncologist concerns that early PC may ask patients and families to discuss and make decisions about EOL care early in the disease process before they are ready to address such challenging topics” pg E6

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Duke Cancer Institute Palliative Medicine and Supportive Care Clinic

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“Oncodoxes”

- Being pushed and pulled in two opposite directions
- Be Optimistic/Be Honest
- Be aggressive/Be careful (narrow therapeutic index)
- Prolong survival/Refer to hospice sooner
- Be close/Keep your distance
- Hurry up/Take your time
- Seeking Balance... help pts navigate difficult issues
Comprehensive, Integrated Palliative Care Ensures that Patients Receive...

The **Right** care at the **Right** time in the **Right** place
Thank you

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Resources

- www.getpalliativecare.org
- PalliativeDoctors.org
- Aahpm.org
- Pallimed.org
- http://www.capc.org/forums/