Palliative Care
What do you need to know?

Vicki Jackson, MD, MPH
Chief, Division of Palliative Care
Massachusetts General Hospital
Associate Professor of Medicine
Co-Director HMS Center for Palliative Care
Harvard Medical School

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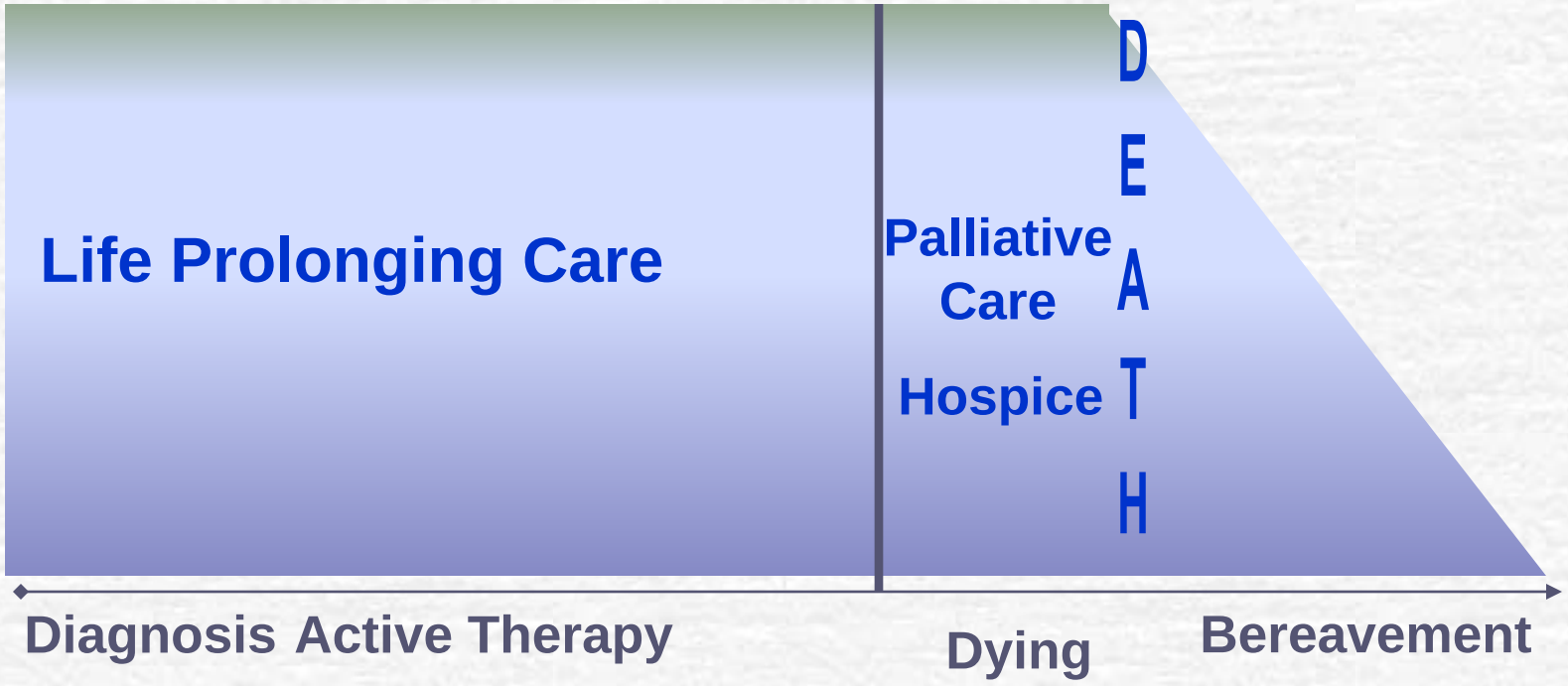
Learning Objectives

- Define palliative care, and how it differs from the traditional hospice model
- Better understand how palliative care is beneficial for patients
- Gain skills in managing common symptoms encountered in palliative care patients
- Identify opportunities to improve the care for patients and families with serious illness through the provision of prognostic data
- Learn who to refer to palliative care and how to introduce the referral to the patient

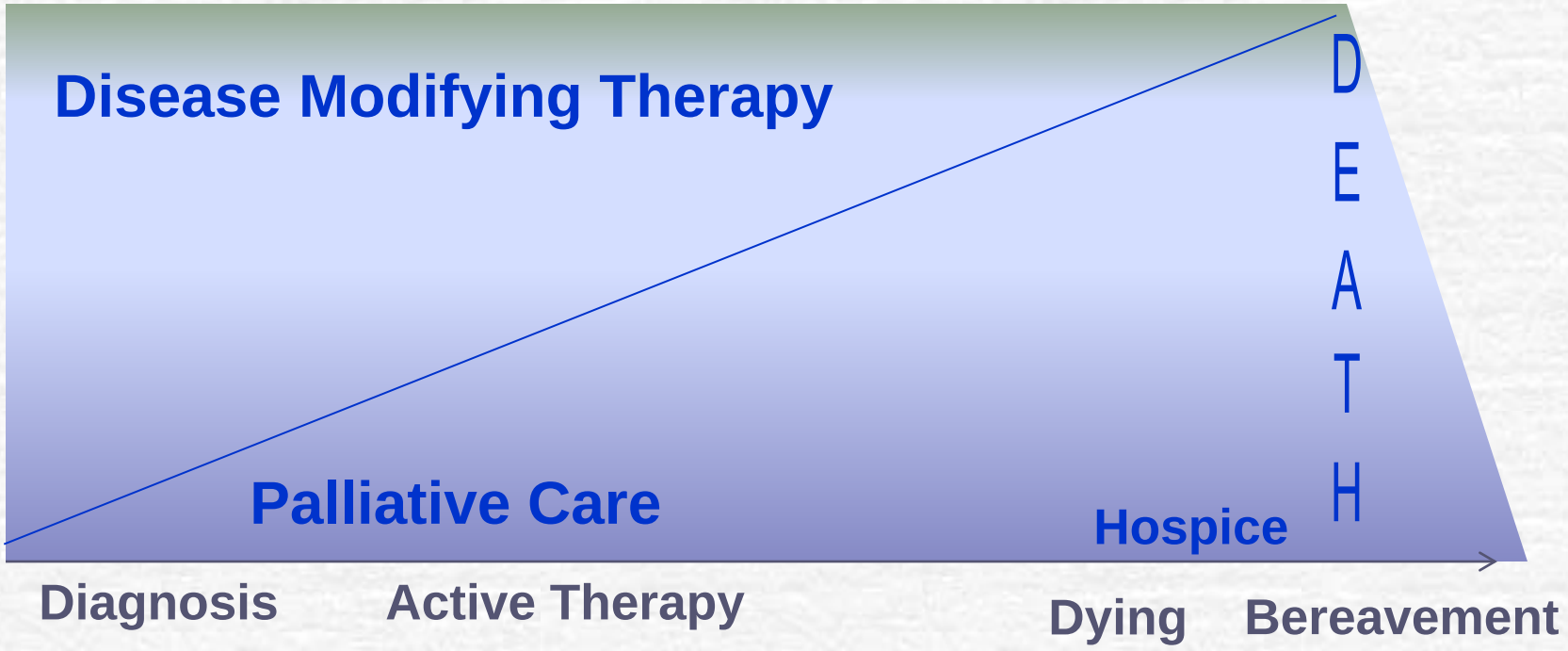
Subspecialty of Palliative Care

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis or prognosis. It is an extra layer of support to the patient's other clinicians.

Traditional model of care at the end of life



Palliative Care for Quality of Life "Upstream"



What palliative care is…

- Excellent, evidence-based medical treatment
- Vigorous care of pain and symptoms throughout illness
- Care that patients want *at the same time* as efforts to cure or prolong life

What palliative care is not…

- Not "giving up" on a patient
- Not in place of curative or life-prolonging care
- Not the same as hospice

Demand for improved care: What patients and families want

- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of control
- Relieve burdens on family
- Strengthen relationships with loved ones

Steinhauser, et al. Ann Intern Med 2000; 132: 825-32

Singer et al, JAMA 1999

A 59 year old woman with metastatic cancer presents to her primary care physician

Julie Murphy

- 59 yo former nurse with metastatic lung cancer
- Receiving chemotherapy
- Prescribed oxycodone 5mg/acetaminophen 325mg every 4 hours prn
- Complaining of:
  - back pain
- She is married and has 3 college-age children

Pain and symptom assessment

- Pain is deep, aching her back and R hip
- She is taking 5 mg oxycodone/ 325mg acetaminophen of every 3 hours
- Pain intensity 8/10 with 50% relief from current opioid regimen that lasts 2 hours
- Unable to sleep or function normally
- Normal neurologic exam , Spine MRI negative for cord compression but shows L4 bony metastases

Provide sustained pain relief for constant cancer pain

KEY POINT

Since she is using short acting opioids around the clock,

add a sustained-release opioid

Which long acting agent?

- Long acting opioids
  - Consider route of administration
  - Cost
  - Availability
  - Efficacy
  - Contraindications
- For Julie...we choose morphine

Calculate the sustained-release dose using 24h total of short acting

- Each tablet of 5mg/325mg has 5 mg oxycodone
- 5 mg x 2 tablets = 10 mg/dose
- Every 4 hours = 6 doses/24 hours
- 10 mg x 6 doses = 60 mg oxycodone/ 24 hour

Use the equi-analgesic table when switching to another opioid

Opioid	Oral	IV
Morphine	30mg	10mg
Oxycodone	20mg	N/A
Hydromorphone	7.5mg	1.5mg

Morphine 50 mg/24 hours orally = Fentanyl patch 25 mcg/hour

Equianalgesic Dose Calculation: When converting from oxycodone to morphine

From equianalgesic chart:

20 mg oxycodone = 30 mg oral morphine

If the patient, for example, was taking 60mg of oxycodone in 24 hours-

$$\frac{\text{20 mg oxycodone}}{\text{30 mg oral morphine}} = \frac{\text{60 mg oxycodone}}{\text{x mg oral morphine}}$$

x = 90 mg oral morphine/24 hours

New dose must account for incomplete cross tolerance

A patient who is tolerant to the effect and side effects of one opioid may not be equally tolerant to the effects and side effects of another opioid.

Decrease dose of new drug for incomplete cross tolerance

- Decrease equi-analgesic dose by 1/4 to 1/3 because of incomplete cross tolerance
- In the example, 90 mg oral morphine – 30 mg = 60 mg oral morphine/24 hours
- New dose: **30 mg SR Morphine q12h**

Provide a short-acting opioid for break through pain

- Use 10-20% of the total opioid dose every 2-3 hours prn
- Use adjuvants such as NSAIDS round the clock for improved pain control
- Avoid using combination preparations (e.g. Oxycodone 5mg/Acetaminophen 325mg) for breakthrough dosing
  - Can lead to overdosing of acetaminophen
- Prevent opioid-induced constipation

Case

- Pain regimen prescribed
  - Morphine sustained release 15mg every 12hours
  - Morphine immediate release 7.5mg every 2 hours prn pain
  - Ibuprofen 600mg every 8 hours scheduled round the clock
  - zoledronic acid monthly
  - Omeprazole prophylaxis
  - Stool softeners and laxatives

Case

- Today she asks you about what she should expect as her illness progresses
- You don't feel like you know her prognosis and are not really sure what she is asking.
- You have as many questions about her illness as she does.
- You tell her that you will get more information from her oncologist and plan to discuss prognosis at the next appointment

Case

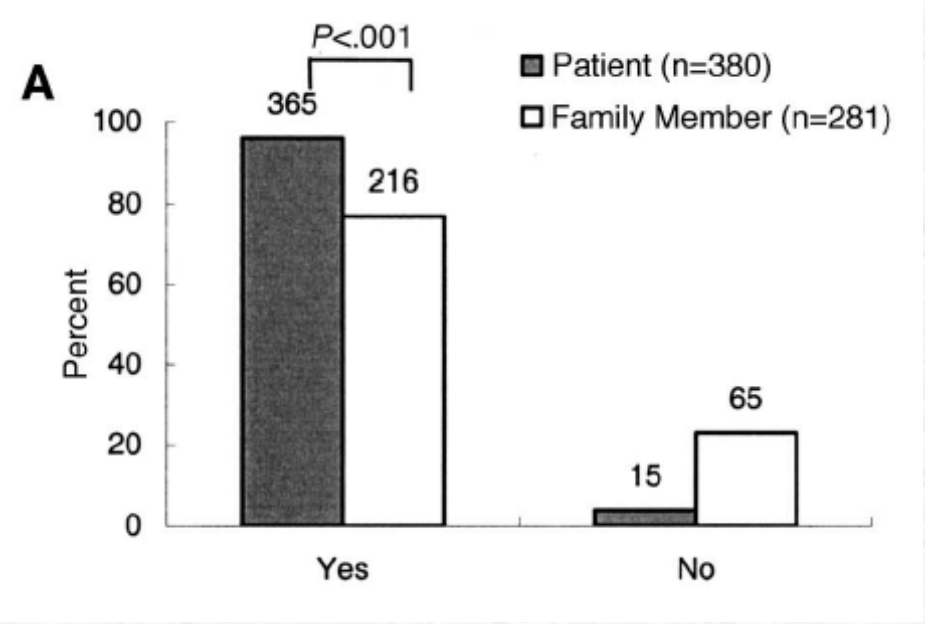
- You speak to the oncologist caring for your patient. He states that the median life expectancy for patients with metastatic non-small cell lung cancer is on the order of 9-12 months. Your patient was diagnosed 3 months ago
- He expects that she will slowly dwindle over the next 6-9 months. Her cancer has not responded to the first 2 lines of chemotherapy.
- You worry that telling your patient will make her give up and maybe die sooner
- You have not had many other patients die of cancer in your practice. You decide to go to the literature to better understand what is helpful to patients and their families with serious illness and how to have these conversations

Seriously ill patients want to feel close to their physician, family, and friends

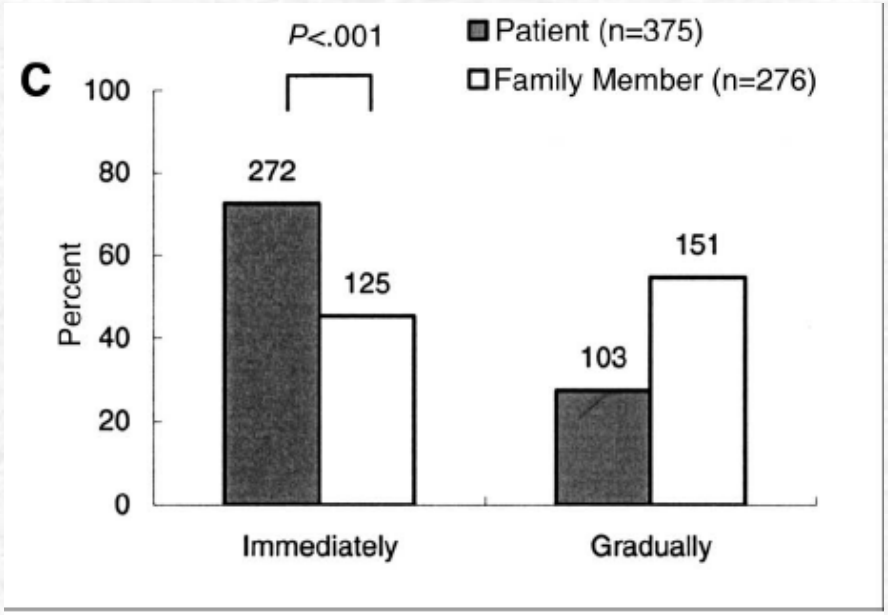
- Over 85% of patients report
  - Wanting a physician who knows them as a whole person
  - Having a physician with whom they can discuss their fears
  - Wanting to resolve unfinished business with family and friends
  - Wanting to share time with close friends

Steinhauser et al, JAMA 2000

Patients with advanced cancer want to know prognosis, early in the course of illness



Do you want to be informed the truth?



When is the appropriate time to be informed the truth?

Yun, JCO 22 (2) 2004

Provision of prognostic information changes medical decision-making

- Patients who expected 6-mo survival are 2.5 times more likely to choose and receive aggressive therapy, but did not have longer survival
- Patient understanding of a 10% chance of dying in 6 months led to less aggressive treatment decisions

Weeks JC et al. JAMA 1998;279: 1709-1714

Discussions of prognosis improve outcomes

In Coping with Cancer study, 37% of patients reported having prognosis discussion at baseline

- These patients had lower use of aggressive treatments, better quality of life, and longer hospice stays
- Not associated with more worry or depression
- Family after-death interviews showed better psychological coping for those with conversations as compared to those without

Wright et al. JAMA 2008 300(14):1665-1673.

You learn that patients develop prognostic awareness slowly, over time

- Patients and families have two main tasks
  - Understand the illness and its likely trajectory
  - Become aware of the prognosis and integrate that reality
- You learn that this is an iterative process so don't plan to discuss it all in one visit

Provide prognostic information to help patients make informed decisions

- Patients can ask for two different types of prognostic information
  - “Doc, how much time do I have left?”
  - “What is going to happen to me with this illness?”
    - Both kinds of information tell the patient something about prognosis
    - But we will answer the questions differently

Experts use specific skills to address patient ambivalence

- ASK-TELL-ASK
  - Assess what patients really want to know
    - Why is the patient asking?
    - What do they want to know?
    - Permission that there are no right answers here
  - Avoids giving too much information
  - Allows honest discussion at the level the patient needs

Back, 2005

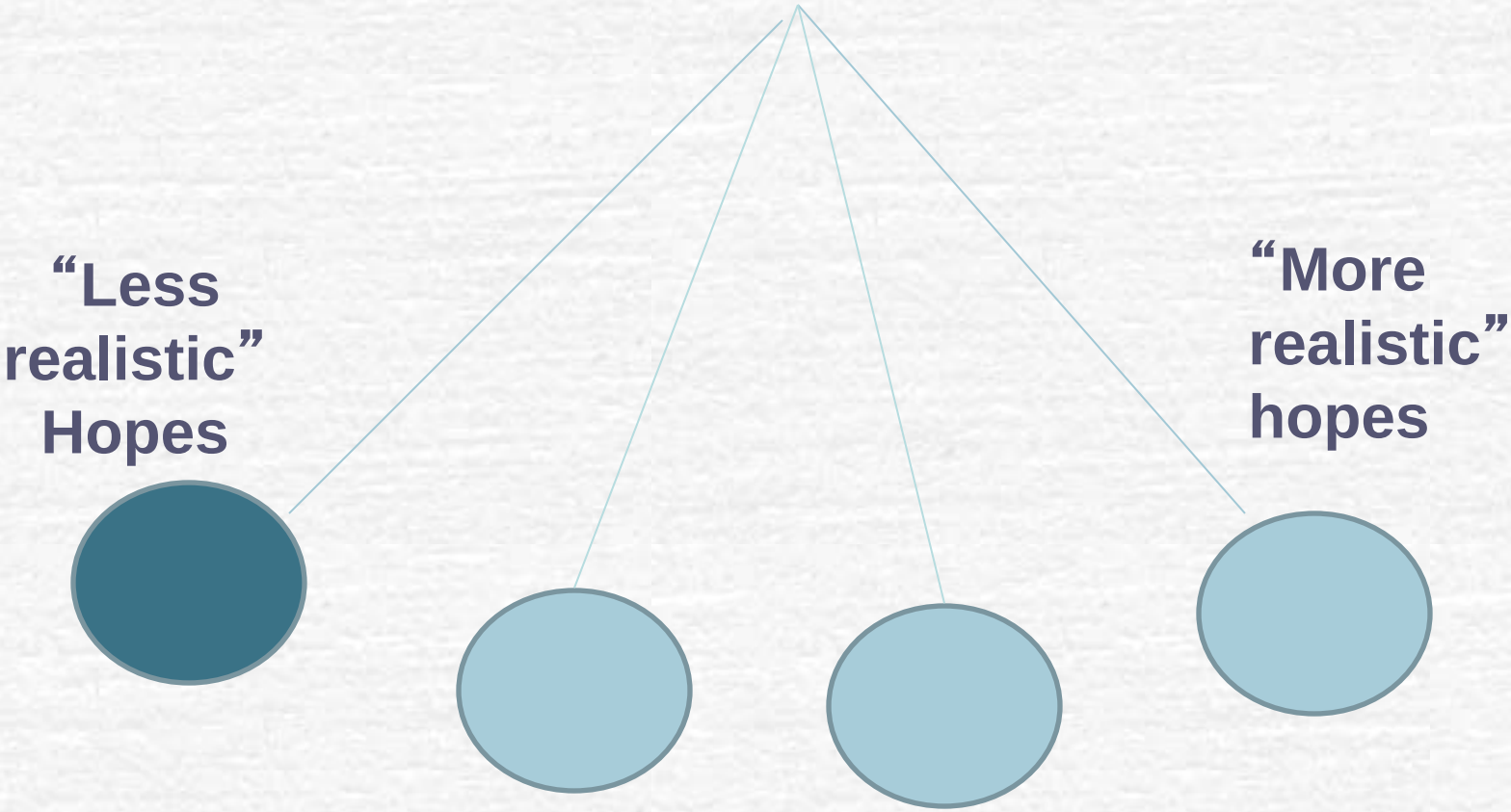
Some patients want to know life expectancy

- Use a standard method to provide prognostic information about length of time the person has to live
  - Days to weeks
  - Weeks to months
  - Months to years

Some patients want to know what the future will be like

- Patients do not know what it looks like to be ill and eventually die from a terminal illness
- They are often surprised that the decline is slow
- They want us to tell them what the illness trajectory will look like

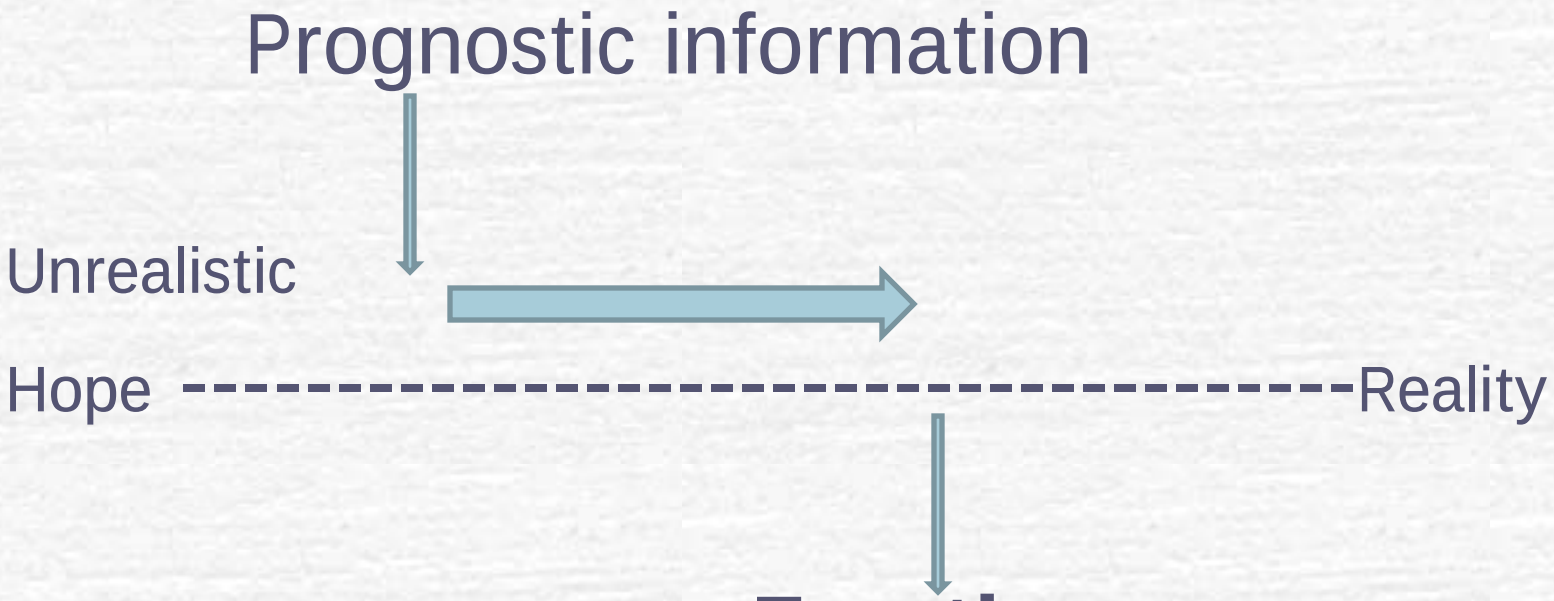
Patients and families struggle to understand their own prognosis



Pairing hope and worry is a good way to deliver prognostic information

- Patients want to know that we **hope** they will do well.
- The HOPE/WORRY technique
  - “I hope that you do well for a long time, but I worry that it could be as short as a few months”
  - “I hope that you regain some function in your legs, but I worry that you may not”
  - Acknowledges uncertainty
  - Aligns with the patient
  - Allow physician to be honest about prognosis

Honest information precipitates emotion



Sadness, anger, or disbelief.

Emotions should be expected The key is what you say next

- Clinicians often struggle with what to say next
  - Common Pitfalls to Avoid
    - Reassurance about clinical possibilities
    - Offer unhelpful treatments
    - Retreat into medical details
    - Take back what was said

Acknowledge the emotion- but don't take back information

- Identify the emotion and let the patient know we heard it
  - "I bet this is really sad to hear. I am sorry I don't have better news."
- Allow space without taking back prognostic information
  - I wish statement
  - *"I wish I had different information to share with you. I wish it wasn't true."*
  - Allows clinician to empathize with patient disappointment

Partner with patients on hoping for things that are likely attainable

- I HOPE....
  - Focus on things that can be controlled
  - “*I am hoping that we can get you feeling better so you can spend good time with your son.*”

Julie's next appointment

- She is accompanied by her husband.
- You assess what information would be helpful to her. She wants information about her likely illness trajectory and her likely survival.
- You inform her that likely survival is on the order of months and that, at some point, she will become weaker and be less interested in eating and drinking.
- She had read this on the internet and is not surprised but her husband becomes angry stating, "I just think we should be hopeful!"

Case

- Your patient has had a difficult few weeks with a new diagnosis of spinal cord compression from a metastasis in her lumbar spine. She is undergoing radiation and despite treatment with opioids, her pain is very difficult to manage. You are not sure what to do next and wonder who could help you and the oncologist treat your patient's symptoms
- You remember reading something about Palliative Care recently and how it differs from hospice. You decide to learn more about it.

You find this definition of Palliative care on a patient website

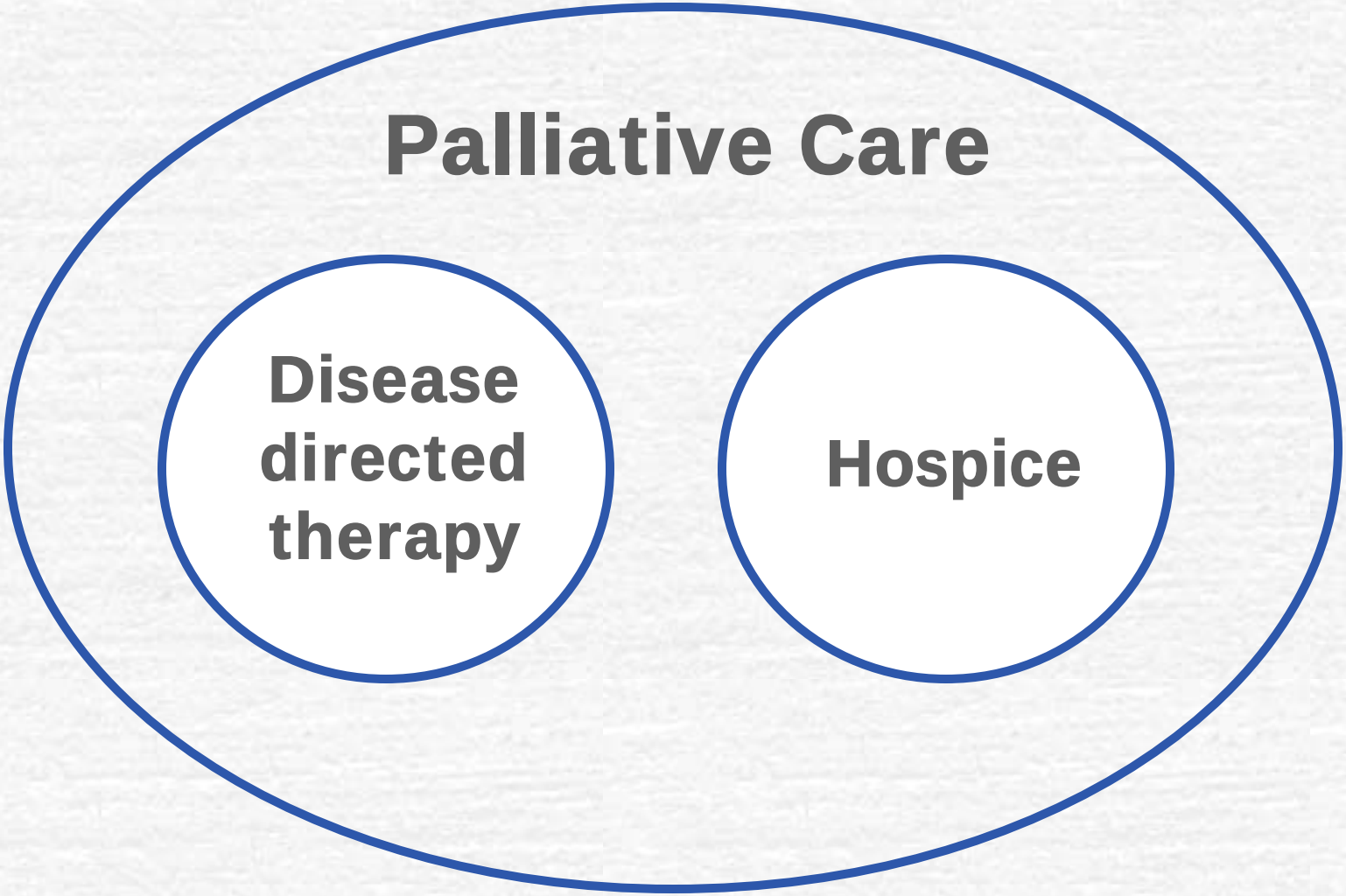
Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis or prognosis. It is an extra layer of support to the patient's other clinicians.

You also find this short video clip about a patient's experience with palliative care

http://www.youtube.com/watch?v=XHtHXGhTIC4

Hospice differs from palliative care. It is an insurance benefit

- It requires patients to have a likely life expectancy of less than 6 months
- It is interdisciplinary care that is most often provided in the patient's home but can also be provided in a facility or residential hospice
- It is the gold-standard for care of the end- of-life


Palliative Care
Disease directed therapy
Hospice

Case

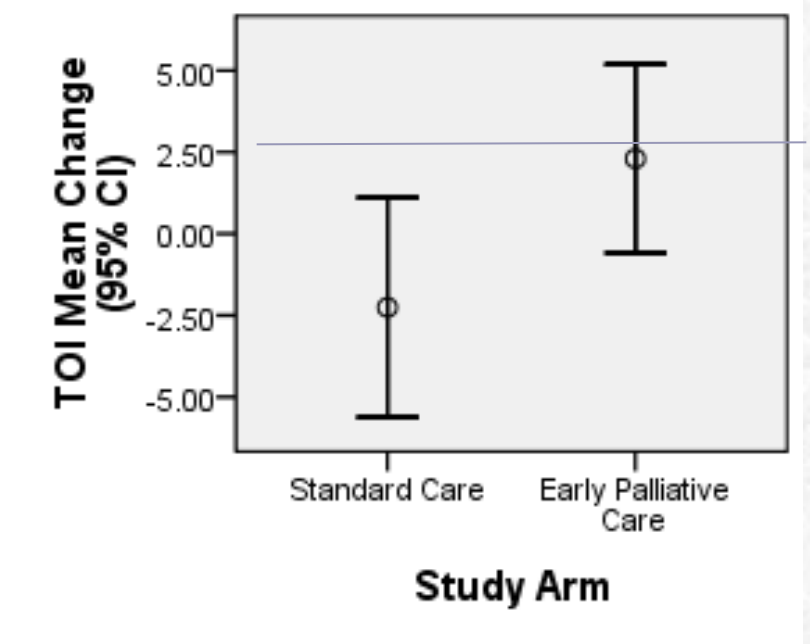
- Palliative care sounds, in theory, like it might be useful
- You look for any evidence that Palliative care might change outcomes for your patient
- You find several studies that show that palliative care can improve quality of life.
- You find one randomized clinical trial in patients with lung cancer just like your patient.

Early intervention palliative care study

- Randomized controlled trial of 151 patients
- Comparing standard oncology care plus early referral to palliative care to standard oncology care
- Population: patients with newly diagnosed metastatic non small cell lung cancer
- Intervention: At least monthly visits with the palliative care team
- Primary outcomes: Quality of life
- Secondary outcomes: Mood, end of life outcomes

Temel et al NEJM, 2010

Early palliative care was associated with improved quality of life at 12 weeks

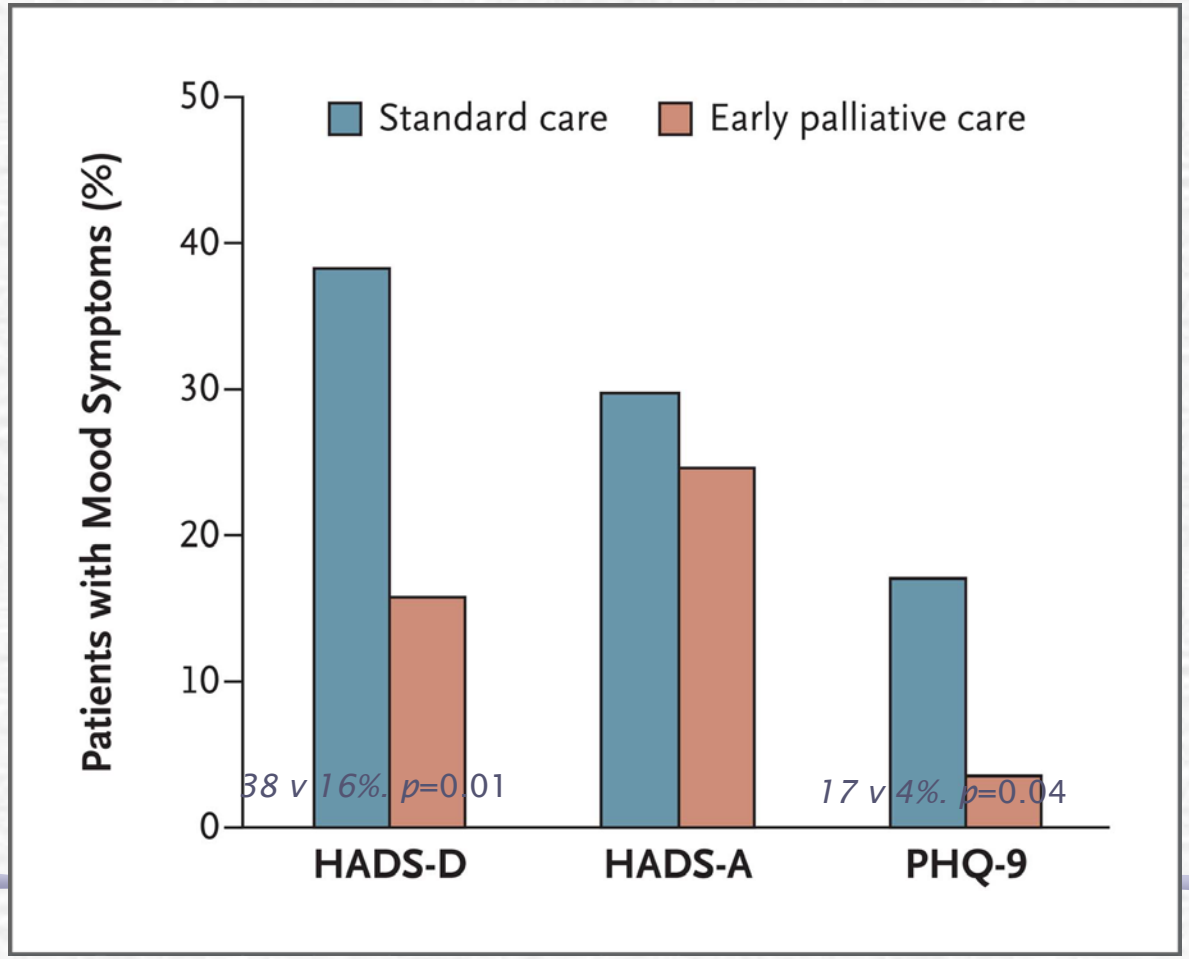


Mean change Standard Care = **- 2.3**

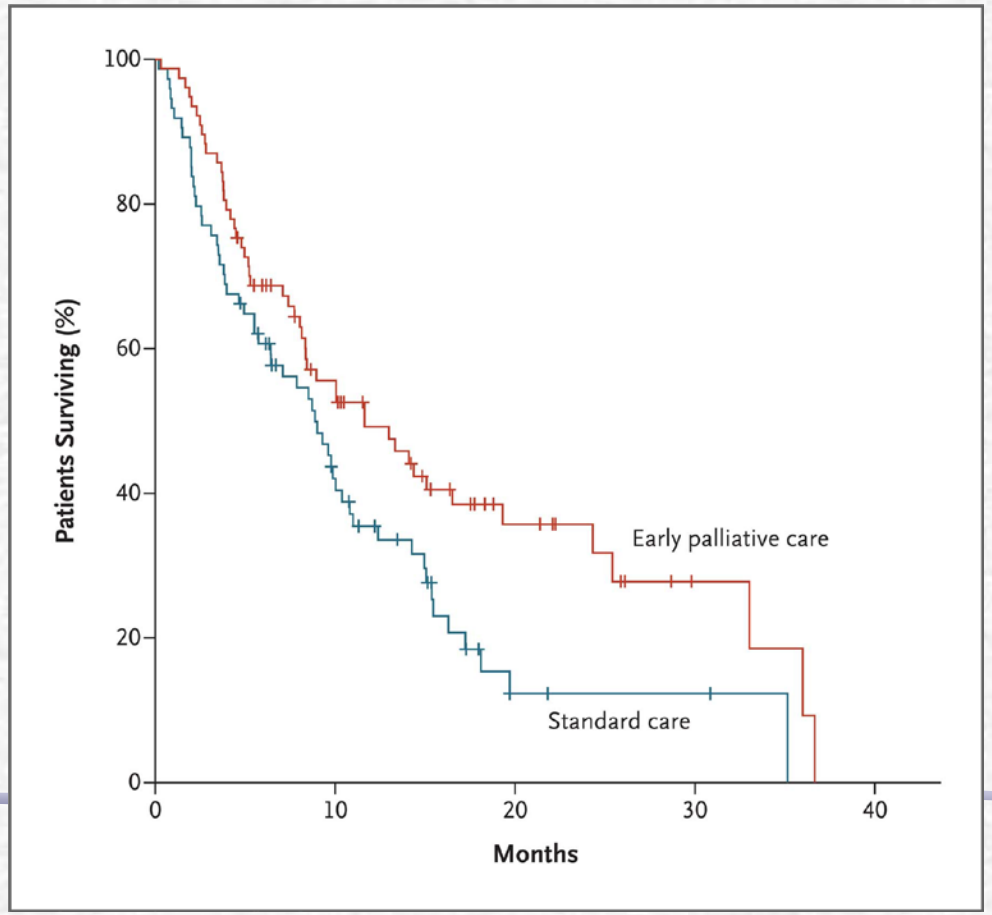
Mean change Early Palliative Care = **+ 2.3**

***p*=0.04**

Early palliative care was associated with a 50% lower rate of depression



Patients who received early palliative care had prolonged survival



Palliative Care=11.6 months

Standard Care=8.9 months

Entire Sample=9.8 months

*Log Rank p<.02

Controlling for age, gender and PS, adjusted HR=0.59 (0.40-0.88), p=0.01

Case

- The patient returns to clinic. Her pain is worse despite treatment with short and long-acting opioids
- She also reports that her husband and children are “breaking down”
- You recommend referral to Palliative Care...”They can help us manage your symptoms and support you and your family through this illness”
- The patient questions your plan for a palliative care referral. She says, “Listen I know I am not curable but I am not ready for hospice. I am not dying yet.”
- You respond, “You are right, they will help you live better.”

Once referred to palliative care, most wish it was done earlier

- Half of bereaved family members felt that timing of referrals to palliative care was too late.
- 87% of families reported that earlier cooperation of palliative care physicians with oncologists would be helpful.

Morita JCO, 2005

Most clinicians care for the seriously ill

- All clinicians who do direct patient care are likely to encounter patients with these complex issues
- The skills of symptom management, communication, and advance care planning can be learned
- Sometimes the care of seriously ill patients becomes complex and sub-specialty level help is appropriate

We all care for the dying- Our job as healers

- Aggressively treat suffering
  - physical, psychological, existential
- Get to know the patient's goals and values
- Provide prognostic information
- Prepare the patient and family
- Avoid prolongation of dying
- Employ the assistance of a team and partner in this care
- Refer to palliative care when needed

“..if we can learn to face death, we’ll learn how to face ourselves and come to terms with ourselves as human beings.”

Facing Death and Finding Hope