How to ease a terminal patient's stress with earlier end-of-life care talks

APR 5, 2019

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For people living with advanced cancer, conversations about prognosis, priorities and end-of-life care may be difficult, but research shows they can also be vitally important in reducing moderate to severe symptoms of anxiety and depression. An editorial highlights the findings and offers suggestions to oncologists for ways to more effectively incorporate these discussions into clinical practice.

The editorial, published in *JAMA Oncology*, is based on studies that looked separately at 278 patients and 91 clinicians who participated in the Serious Illness Care Program (SICP), at the Dana-Farber Cancer Institute and two affiliated satellite clinics, over nearly four years. The results, published in *JAMA Internal Medicine* and *JAMA Oncology*, detailed patient outcomes and process outcomes, respectively.

The AMA Code of Medical Ethics provides additional guidance on end-of-life care, such as Chapter 5, "Opinions on Caring for Patients at the End of Life," which covers topics including advance care planning, advance directives and orders not to attempt resuscitation.

Improved symptoms, fewer harms

Typically, end-of-life care conversations take place in the last month of a patient's life, in unfamiliar settings and with unfamiliar physicians, with potentially serious negative ramifications.

"Poor communication about these issues is associated with greater suffering and exposure to unpleasant, futile treatments," wrote Drs. Belinda E. Kiely, PhD, and Martin R. Stockler, of the University of Sydney, Australia, in their JAMA Oncology editorial.

The Dana-Farber SICP combines information for patients, their families and their caregivers with tools and guidance for oncologists in identifying suitable patients and prompting conversations, as well as a mechanism for documenting discussions in the patient's electronic medical record (EMR).

While the program showed substantial improvements in process outcomes—including cutting the median time between identifying a patient and having a conversation by more than 50 percent—patient outcomes were less affected.

"There were no demonstrable effects on the coprimary outcomes (care concordant with goals and peacefulness)," the study authors wrote, "or the main secondary outcome (therapeutic alliance)."

Still, patients assigned to the SICP had half the frequency of moderate to severe symptoms of anxiety and depression compared with the control group at 14 weeks after baseline. In addition, the authors wrote, the data "provide strong evidence that these conversations did not increase symptoms of anxiety or depression."

Key suggestions

Drs. Kiely and Stockler make several recommendations for changes to clinical practice based on this research.

Start talking sooner. "Oncologists should initiate conversations about serious illness with patients who have a significant risk of dying in the foreseeable future. Not because this will necessarily improve outcomes, but because patients want, require and deserve to know what is coming."

Think broadly. Conversations should be about more than ceilings of care. They should include values, priorities and preferences.

Connect with the rest of the care team. "The conversations should be documented, accessible and flagged in the EMR to increase the accessibility to others involved in the patient's care."

Be confident. Having these conversations is unlikely to increase anxiety or depression in patients.

Have realistic expectations. "Initiating and documenting these discussions is an important start," they noted, "but the results of this trial suggests that it may be insufficient to improve other patient outcomes."

The authors of each study cited several limitations, including, regarding patient outcomes, a smaller sample size than expected for primary outcomes and the variation in timing of outcome assessment, and, regarding process outcomes, the examination of documented discussions, not actual

discussions. Both studies noted limited generalizability because they were conducted at a single oncology institution with a relatively homogenous population.