

CONQUERING THE CANCER CARE CONTINUUM™

Hospice Care: Providing Critical Support to Patients and Families

Lillie D. Shockney, RN, BS, MAS

It is my privilege to bring to you the next edition of *Conquering the Cancer Care Continuum* series. This issue, which focuses specifically on hospice options, is one I believe to be vitally important to read. Hopefully, concepts addressed here will be adopted as new and better ways of supporting our terminally ill cancer patients and their families.

I recall several years ago getting an e-mail from a man named Bill. He had found me via the Internet and wrote to me stating that his young wife, Mary, had metastatic breast cancer that had progressed to her liver, lungs, bone, and now brain. She was currently in the hospital and sleeping more than she was awake, confused at times, losing weight, but “had still been receiving chemotherapy until yesterday.” He wrote that the doctor who had taken care of her for the last 4 years had asked him to come and meet him this morning in her room to talk about next steps. He said that usually the oncologist would linger for a while whenever these types of discussions were taking place, but this time he was very brief. The doctor said that treatments were no longer working, so he was “going to put my wife on hospizz.” The husband then went on to write, “I found the drug Herceptin but I can’t find the drug Hospizz. Can you tell me anything about how effective this drug is for brain, liver, and lung mets?”



Lillie D. Shockney, RN,
BS, MAS

My heart sank. I wrote him back asking him to call me. He did soon after that and said how surprised he was for me to respond at all and to even request that we talk by phone. I reiterated all of the information he had told me about the long journey he and his wife had endured together since her initial diagnosis at age 30. Based on his description of her clinical condition and limited alertness, it was evident that she was gravely ill. I told him that I thought the doctor was so distressed himself that he found it difficult to linger after his brief conversation regarding this next step for Mary. And that what he is now placing her on is not a drug but a special program called hospice. (He had not heard this term before either.) As I began to explain some of the key benefits of hospice care, he got very upset and said, “Lillie, my wife cannot die. We have 2 sons, 6 and 8 years old. I cannot raise them alone.” I then told him that she would die but that hospice staff and I would work with him to prepare these children for losing their mom and help him identify family members and friends who would help him raise these boys. I emphasized the importance of getting all the ducks in a row now – advance directive, will, power of attorney, etc. Though he was obviously overwhelmed, he realized that this did have to happen very soon. Though she died just 5

days later, the hospice experience was a positive one. It was not the Grim Reaper coming to their door. It was a philosophy of dying with dignity, having your wishes known and carried out, getting closer with family, and preparing family for moving forward after she was gone.

What was unfortunate, however, was the brief time they had to truly benefit from hospice care and services. Mary as well as her family could have gained more benefit and probably experienced better quality of life at end of life had chemotherapy not still been infused into her weekly during the last 3 months of her life, while the doctors watched her scans show consistently progressing growth of the tumors everywhere.

It also worries me that if Bill hadn't "found me" on the Internet, how much more time would have been lost in getting Mary the palliative care she needed and getting the emotional support he and their young sons needed.

After Mary died, Bill called me to thank me for my help. He had done as I had asked, which was to get cards for the boys' birthdays, communion, high school

graduation, marriage, and when they have their own first-born child so that he could help Mary record (or record on her behalf) what she wanted to tell them on each milestone day. In doing so, Mary would still be there instilling her values in her children and being an active part of their lives as they grow into adulthood.

We need to have more thoughtful discussions with our patients and not equate hospice care to throwing in the towel, giving up, bringing the Grim Reaper to stand at the foot of the patient's bed. Some of the best weeks and months of truly "living" can be achieved for the patient by engaging hospice care sooner rather than later. If I had a nickel for every time a family said to me, "I wish we had learned about hospice sooner," I could likely retire early.

So read these case studies and see how they apply to your patient population. Treatment for treatment's sake is bad medicine. Supporting patients so that their pain is controlled and their wishes carried out, while providing them quality-of-life time spent with those they love and helping them experience a peaceful death, is far better medical care. ■

Hospice Care Options: A Pharmacist's Perspective

Steve Stricker, PharmD, MS, BCOP

HW is a 71-year-old male diagnosed with a recurrence of colorectal cancer in the spring of 2012 with radiographically confirmed metastases bilaterally in his lungs and throughout his liver. Palliative chemotherapy was undertaken at that time with initial response documented by CT scan and serum CEA monitoring. However, within the past 2 months HW has experienced progressively worsening pain (rated 8/10 on a numeric pain scale) in his right side (consistent with progressive liver metastases) and today is severely jaundiced (total bilirubin has increased from 8 mg/dL to 26 mg/dL in the past 2 weeks). The decision is made to transition HW to hospice care.

In the case described above, it is evident that HW is experiencing hepatic failure at a rapidly progressing rate consistent with extensive liver metastases. At this point, his prognosis is poor, and he likely would not be considered a candidate for additional chemotherapy or other

life-prolonging treatment. For patients like this, hospice care often becomes an appropriate option for consideration as it focuses on ensuring that the patients' basic needs and comfort are addressed during their

final days of life. These decisions are a daily occurrence in oncology practice but are often fraught with emotional difficulty and uncertainty for patients and their families. The transition to hospice care and away from the traditional medical establishment represents more than a change in philosophy of care, it represents a change to unfamiliar healthcare providers, questions related to insurance coverage or financial costs, new medications, and sometimes a change in the setting where care will be provided. As such, hospice programs employ large multidisciplinary teams to attend to the potential barriers that

would prevent a patient from dying a dignified death, free of unnecessary pain and suffering. Many reviews



Steve Stricker, PharmD,
MS, BCOP

of hospice are available in the medical literature. Here, we will focus on describing the role of the pharmacist within the interdisciplinary hospice team (IDT).

In the first installment of this series on *Conquering the Cancer Care Continuum*, we discussed the difference between palliative care delivered concurrently with interventional cancer therapy versus palliative care in the setting of hospice. Here, it was essential to emphasize that good supportive care should be introduced as early in a patient's diagnosis as possible, as studies have shown that it can ease the burdens of patients with cancer and allow them to focus their attention and energy on the management of their diagnosis, leading to improvement in cancer outcomes and quality of life. However, once a patient meets the criteria for hospice, ie, a terminal illness with less than 6 months to live if the disease runs its normal course, good palliative care should not stop; rather it should become the sole focus for that patient.¹

Here lies one of the primary pitfalls and greatest misunderstandings of the hospice movement. All too often, even as healthcare providers, we speak of hospice as a place where patients with terminal illnesses go to die. Instead, we should stress that hospice represents a philosophy of care that is most simply stated as "caring, not curing."² When teaching pharmacy and medical students and residents, I additionally emphasize the World Health Organization (WHO) definition of palliative care as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering..."³ While this definition is pertinent in all stages of illness, I often feel that it is most applicable for patients and their families as they prepare for hospice care.

Hospice and the Role of the Pharmacist

As of 2012, it was estimated that 5300 hospice programs provided care to more than 1.65 million patients, approximately 37% of whom had a diagnosis of cancer, in the United States alone.² Each of these hospice programs is required by Medicare regulations to maintain an IDT composed of a physician, a registered nurse, a social worker, and a pastor or other counselor in order to deliver the goals of palliative care described by the WHO. In addition, Medicare requires that a pharmacist be employed by or contracted with the hospice agency to ensure appropriate drug ordering, storage, administration, etc. While there is a necessary drug dispensing role filled by pharmacists who work with hospice programs, many pharmacists

in this setting function in an advanced practice role that involves the 7 key responsibilities identified in a vision statement first formalized in a 2002 publication from the American Society of Health-System Pharmacists (ASHP).⁴ They include:

1. Assessing the appropriateness of medication orders and ensuring the timely provision of effective medications for symptom control.
2. Counseling and educating the hospice team about medication therapy.
3. Ensuring that patients and caregivers understand and follow the directions provided with medications.
4. Providing efficient mechanisms for extemporaneous compounding of nonstandard dosage forms.
5. Addressing financial concerns.
6. Ensuring safe and legal disposal of all medications after death.
7. Establishing and maintaining effective communications with regulatory and licensing agencies.

Hospice programs employ large multidisciplinary teams to attend to the potential barriers that would prevent a patient from dying a dignified death.

Now more than a decade after the publication of this position statement, it is worthwhile to evaluate how successful ASHP was in advocating for the role of the pharmacist as an integral member of the hospice IDT. A recent study by Latuga and colleagues attempted to address this issue by surveying hospice pharmacists and administrators who are members of the National Hospice and Palliative Care Organization.⁵ Following the trend of pharmacists who have completed extensive clinical training and assumed more clinical responsibilities in other areas of medicine, this study noted that >50% of pharmacists involved in hospice care maintained clinical activities including "development of drug use protocols, formal and over-the-counter recommendations for symptom management, development of the hospice's standing orders, ability to initiate standing orders, on call for consultation, and provision of drug information." It is important to note that there was widespread agreement on the role of the pharmacist between hospice administrators and what was self-reported by the pharmacists surveyed. These findings serve to reinforce the expanding role of the pharmacist on multidisciplinary teams across medical specialties as the drug therapy expert.

The inclusion of a pharmacist on the hospice IDT to manage medication-related issues allows other healthcare providers to focus principally on the roles they have been trained to perform rather than having to take on this additional responsibility. This is important in light of a Medicare policy requiring patients enrolled in hospice care to undergo medication reviews upon admission and every 14 days in order for the program to continue receiving reimbursement for services provided.⁶ Interestingly, Medicare does not require these medication reviews to be conducted by pharmacists, only requiring that this rule is met by any individual who has “education and training” in medication management.⁵ In hospice programs where a pharmacist is not available on a daily basis, this role is most commonly fulfilled by nurse case managers whose time may be better utilized in a direct patient care capacity.

Pharmacists also have a notable impact on drug accountability within hospice care organizations. Given that many patients nearing the end of life are receiving treatment with narcotic medications to manage pain and discomfort, FDA oversight requires records to be meticulously maintained regarding the acquisition and dispensing of these controlled substances. Furthermore, after death these medications must be disposed of in a way that is appropriate, given their hazardous waste category, and in full compliance with state and federal law. Pharmacists are the most educated healthcare providers with regard to laws providing oversight of medication usage and thus should be administratively responsible for drug accountability in a hospice organization.

With HW's complaints of severe pain, he was prescribed fentanyl transdermal patches and concentrated oral morphine sulfate liquid. The family was instructed on dose titration by hospice nurses and pharmacists, and HW peacefully passed away 10 days after enrollment in hospice.

Along with success achieved related to clinical practice responsibilities, it is important for pharmacists involved in palliative care and hospice to recognize that a broader impact can still be achieved by becoming a more integrated member of the IDT. One of the greatest barriers for pharmacists in this setting, as identified in the study by Latuga and colleagues, is in the area of education. Most pharmacists identified a lack of postgraduate training (23% completing postgraduate year 1 [PGY-1] residencies and 5% complet-

ing PGY-2 residencies in palliative care). In addition, very few pharmacists had attained board certification (an additional measure of expertise not required for licensure), and few had completed certification programs in geriatric medicine. There has been a marked increase in the number of physicians seeking board certification in palliative care over the past decade, and if pharmacists wish to further expand their role in this area, additional training will be essential.

In our practice, we often define 3 categories of cancer patients. Category 1 involves patients treated with intent to cure. Some category 1 patients become category 2 patients, whose goal shifts from cure to living longer and better. All category 2 patients ultimately become category 3 patients, for whom our job is to ensure that resources are available, including hospice, to allow them to be made comfortable and their supportive care needs addressed. As an oncology clinical pharmacist, I am not directly involved in hospice care, but I am occasionally called upon by colleagues working with hospice organizations to provide information on specific patients to allow for continuity of care. More commonly, I am involved in the initial medication management planning so that a patient's needs are addressed to the best of our ability before admitting that patient to hospice care. I consider it a great honor and privilege as a member of a multidisciplinary cancer care team to be invited into one of the most intimate moments of a patient's life when end-of-life planning is being undertaken. If our job is done well, these moments should focus not only on the life of the patient we have treated but also on attending to the needs of the family so that they may later feel peace knowing that all reasonable treatment options were considered and their family member was treated with dignity until the last moments of life. ■

References

- Centers for Medicare & Medicaid Services. *Medicare Hospice Benefits*. www.medicare.gov/Pubs/pdf/02154.pdf. Accessed April 6, 2013.
- National Hospice and Palliative Care Organization. *NHPCCO Facts and Figures: Hospice Care in America*. www.nhpcco.org/sites/default/files/public/Statistics_Research/2012_Facts_Figures.pdf. October 2012. Accessed April 1, 2013.
- World Health Organization. WHO Definition of Palliative Care. www.who.int/cancer/palliative/definition/en/. Accessed April 6, 2013.
- American Society of Health-System Pharmacists. ASHP statement on the pharmacist's role in hospice and palliative care. *Am J Health Syst Pharm*. 2002;59:1700-1703.
- Latuga NM, Wahler RG, Monte SV. A national survey of hospice administrator and pharmacist perspectives on pharmacist services and the impact on medication requirements and cost. *Am J Hosp Palliat Care*. 2012;29:546-554.
- Department of Health & Human Services. Centers for Medicare & Medicaid Services. *Medicare and Medicaid Programs: Hospice Conditions of Participation*. <http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf>. Accessed April 7, 2013.

Hospice Care Options: A Nurse's Perspective

Beth Faiman, PhD(c), MSN, APRN-BC, AOCN

Linda is a 62-year-old nonsmoker who eats a vegetarian diet and walks 3 miles 3 days a week. Despite her healthy lifestyle, Linda developed a nonproductive cough in May 2012 that kept her up at night. The coughing became progressively worse, so she was evaluated by her primary care provider. A chest x-ray was performed that showed a suspicious right upper lobe mass. A positron emission tomography/computed tomography (PET/CT) test was performed that showed "a hypermetabolic (SUV max 27), 6-cm right upper lobe lung mass consistent with malignancy and abuts the mediastinal pleura." Metastases to left upper lobe and right adrenal gland were also noted. A biopsy was positive for non-small cell lung carcinoma (NSCLC). Linda was referred to a local medical oncologist for evaluation and staging. She was diagnosed with T3 N2 M1/stage IV metastatic lung cancer.

At diagnosis Linda began carboplatin and pemetrexed chemotherapy for her locally advanced NSCLC and completed 3 cycles of chemotherapy. The medical oncologist suggested that Linda and her family meet with the hospice and palliative medicine team at the local hospital due to the advanced stage at diagnosis. She declined, citing strong faith and "the hope for a cure." Linda wanted to "fight for her life" and thought that meeting with the hospice and palliative medicine team would be like "giving up the fight." The physician planned to further discuss the issue of palliative medicine at a later date.

After cycle 3 of chemotherapy, Linda developed progressive shortness of breath. A CT scan of the chest revealed a moderate loculated pleural effusion and worsening mediastinal involvement of the tumor. Linda was admitted to the hospital for palliative radiation and thoracentesis to control her symptoms. Despite best supportive care efforts, Linda continued to become progressively weaker and eventually nonresponsive. She was referred to the local community hospice and passed away 3 days later, just 5 months after the initial diagnosis of lung cancer was made.

Hospice and Palliative Medicine: Is There a Difference?

In the first installment of this *Conquering the Cancer Care Continuum* series, Dr Lederman provided an overview of palliation in cancer. The article made clear the benefits of palliative care for cancer patients. The

article and commentaries also illustrated that palliative services are underutilized for a number of reasons. Two key reasons patients and caregivers do not opt for palliative services are a lack of understanding of the benefits of palliative care and too few qualified practitioners to administer the services. Similar issues are seen with hospice. The **Table** outlines key concepts that differentiate palliative and hospice care.

Dame Cicely Saunders learned of surveys in the United Kingdom (UK) conducted during the 1950s that identified the appalling conditions in which patients were dying of cancer. Dame Saunders had experience as a wartime nurse in the 1940s and later in the 1950s caring for patients at the end of life.¹ She identified the concept of "total pain," which described one's physical symptoms of pain, mental distress, and social and spiritual problems that may go unresolved at the end of life. Multidisciplinary teams of nurses, social workers, spiritual advisers, and physicians were drawn toward the ideas. Thus, the movement toward comprehensive symptom management and services to address basic and advanced needs at the end of life was conceived. The National Health Service of the UK opened the first of many hospice centers with the goals of alleviating patient suffering and providing end-of-life support.^{1,2}

Hospice programs are comprehensively designed to provide physical, emotional, legal, and social support at the end of the cancer continuum. The multidisciplinary team of doctors, nurses, pharmacists, social workers, financial counselors, and clergy are equipped to address the specialized issues associated with end of life. Legal counsel in terms of advanced care directives, living wills, and durable power of attorney services are also offered.³

Hospice Care Options

Individuals within the United States who are entitled to Part A of Medicare services have access to the Medicare hospice benefit. The benefit allows individuals with a terminal illness (life expectancy of less than 6 months) the opportunity to forgo curative treatment for the incurable illness and to transition



Beth Faiman, PhD(c),
MSN, APRN-BC, AOCN

Table. Differentiating Hospice and Palliative Services

Type of Service	When Appropriate	Notes
Palliative	At any point in the cancer diagnosis	Best to initiate services early on in the disease process for surveillance of symptoms and to form a relationship with family and patient prior to hospice transition
Hospice	Life expectancy <6 months	The final phase of palliative care; referrals are often made too late in the diagnosis for patients to receive a benefit

the goals of care toward symptom management. The benefit covers a comprehensive range of services. Even the most basic of services includes nursing and physician care, medical supplies, equipment, pain management, and emotional support. Many cancer patients have symptoms such as pain, nausea, dyspnea, or other side effects of the disease or treatment that need to be controlled. Eligible patients who agree to proceed with hospice will be referred to a hospice center. Four different levels of hospice care exist and can be used to address the spectrum of needs a patient may have. The levels include routine care, continuous care, inpatient care, and respite care.⁴

Nurses and physicians must possess adequate knowledge about the benefits of and barriers to hospice, which includes pain management and supportive care.

Routine care is generally the first step toward hospice. Routine care services include nurse and nursing assistant visits 1 to 3 times or more per week based on the patient’s needs. Physician and specialist visits for symptom management are also included. Medical equipment and counseling services are available as needed.⁴

Continuous care is the escalated level in which a nurse and/or a home health aide will provide care to the patients for a minimum of 8 and up to 24 hours per day. In addition to the routine care, nurses administer medications and treatments and support the patient and family until symptoms of pain, nausea, or emotional distress are under control.

Inpatient and respite care services are available to patients who require advanced services that the caregivers and continuous support staff are unable to provide. Inpatient hospice stays can range from days to weeks. According to the Centers for Medicare &

Medicaid Services, general inpatient care is for pain control or symptom management that cannot be managed in other settings. Respite care may be provided only on an occasional basis and may not be reimbursed for more than 5 consecutive days at a time.⁴ Individuals who are the principal source of care for the patient may require a break for a variety of reasons but are primarily able to meet the patient’s needs. It is important to note that patients can transition through all levels of hospice care if initiated early. Understanding the levels of hospice and what the services entail is a first step toward the hospice transition.⁵

Benefits and Barriers to Hospice

Nurses and physicians must possess adequate knowledge about the benefits of and barriers to hospice, which includes pain management and supportive care. The lack of understanding of what hospice services entails prevents patients from opting for hospice services. In the United States, patients are not referred for hospice care until it is too late. As a result, patients will not receive the full benefit of all the services that are available. It is estimated that only 30% of patients are enrolled in hospice at the time of death, and most patients die within 7 days of admission to hospice. The median (50th percentile) length of service in 2010 was 19.7 days, a decrease from 21.1 days in 2009. The average length of service dropped to 67.4 days in 2010 from 69 days in 2009.⁶

Nurses and physicians must be adequately prepared to discuss the topic of hospice and administer hospice services. The services primarily consist of pain management and supportive care for nausea, vomiting, and respiratory or cardiac symptoms. However, major barriers to effective hospice management include a lack of qualified practitioners to administer services and a lack of education of pain management in academics.^{7,8}

The 2010 Patient Protection and Affordable Care Act (PPACA) is legislation originally signed by President Barack Obama in 2010. The legislation initially

included a provision by which voluntary end-of-life counseling would become a reimbursable service under Medicare. However, the provision was withdrawn. Recognizing the need to improve physician education, President Obama will provide governmental grants to teaching hospitals and institutions. The grants are to be directed toward additional medical training for hospice and palliative medicine programs.^{8,9}

Early use of hospice and palliative services are supported by a randomized study by Temel et al.¹⁰ Investigators demonstrated a survival benefit in patients who received early palliative care versus those who did not (11.6 vs 8.9 months; $P=.02$). The 2.7-month improved overall survival is better than that achieved with most new therapies and illustrates the importance of the supportive care services that palliative medicine provides.¹⁰ In another study, Bakitas et al.¹¹ randomized terminally ill patients to a nurse-led intervention that focused on a multicomponent, psycho-educational intervention (Project ENABLE [Educate, Nurture, Advise, Before Life Ends]) conducted by advanced practice nurses consisting of 4 weekly educational sessions and monthly follow-up sessions until death or study completion ($n=161$) versus usual care ($n=161$).¹¹ Also, a recent study of individually tailored hospice supportive services from an interdisciplinary team are associated with improved health-related quality of life in a group of patients.¹²

It is clear that better patient and family education about hospice is necessary. Fear of dying and hope for a “cure” are cited as reasons why patients do not transition to hospice sooner,¹³ as evidenced in the case study with Linda. Therefore, it is recommended to allow patients a natural transition to first start with palliative services and follow with hospice. Optimally, the palliative care services should be initiated in patients with incurable cancer at the time of diagnosis or soon after.^{12,13}

How Could Linda’s Course Have Been Changed?

Linda was a young lady with a terminal diagnosis. Her goals of care at diagnosis were to extend her life (“I want to fight”). This would be an opportunity for the physician or nurse to intervene and begin to counsel Linda regarding the natural history of the diagnosis and discuss short-term and long-term goals of care.

In general, healthcare providers can assist in the decision-making process by offering support and resources at each office visit. It is difficult to predict with relative certainty the life expectancy of patients

with advanced illness or cancer, but in Linda’s case example, with the diagnosis of metastatic lung cancer, early discussion with Linda and her family about the benefits of hospice might have provided better quality of care and quality of life.

Optimally, the palliative care services should be initiated in patients with incurable cancer at the time of diagnosis or soon after.

Conclusion

The decision to accept hospice services remains in the hands of the patient and the family or significant others. All patients should have access to hospice services when appropriate. Therefore, nurses and clinicians are integral to the education process. Palliative medicine and hospice services are well poised to address the needs of cancer patients across the continuum. Selecting hospice and/or palliative services as a treatment option can be distressing for the patient and family. Providers must highlight supportive research findings and include comprehensive education that highlights the benefits of the multidisciplinary services to the patient. ■

References

1. Saunders C. The treatment of malignant disease. *Prescribers J*. 1964.
2. Saunders C. The evolution of palliative care. *J R Soc Med*. 2001;94:430-432.
3. Capaso J, Kim R, Perret D. Hospice for the terminally ill and end-of-life care. In: Vadivelu N, Kaye AD, Berger JM, eds. *Essentials of Palliative Care*. New York, NY: Springer; 2013:49-71.
4. Department of Health & Human Services. Centers for Medicare & Medicaid Services. CMS 42 CFR § 418.302(b)(4). 2012.
5. Jenq G, Tinetti ME. Changes in end-of-life care over the past decade: more not better. *JAMA*. 2013;309:489-490.
6. National Hospice and Palliative Care Organization. *NHPCO Facts and Figures: Hospice Care in America*. www.nhpco.org/hospice-statistics-research-press-room/facts-hospice-and-palliative-care. October 2012.
7. Plaisance L, Logan C. Nursing students’ knowledge and attitudes regarding pain. *Pain Manag Nurs*. 2006;7:167-175.
8. Bui T. Effectively training the hospice and palliative medicine physician workforce for improved end-of-life health care in the United States. *Am J Hosp Palliat Care*. 2012;29:417-420.
9. US Senate. Patient Protection and Affordable Care Act. <http://democrats.senate.gov/pdfs/reform/patient-protection-affordable-care-act-as-passed.pdf>. Accessed April 4, 2013.
10. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010;363:733-742.
11. Bakitas M, Lyons KD, Hegel MT, et al. Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the project ENABLE II randomized controlled trial. *JAMA*. 2009;302:741-749.
12. Daly BJ, Douglas SL, Gunzler D, et al. Clinical trial of a supportive care team for patients with advanced cancer [published online ahead of print March 22, 2013]. *J Pain Symptom Manage*.
13. Finestone AJ, Inderwies G. Death and dying in the US: the barriers to the benefits of palliative and hospice care. *Clin Interv Aging*. 2008;3:595-599.

Hospice Care Options: A Physician's Perspective

Jeffrey A. Meyerhardt, MD, MPH

Each year in the United States, over 1.5 million people are diagnosed with cancer and nearly 600,000 will die of cancer. While cure rates for certain cancers have increased over the decades and survival has lengthened for many incurable cancers, ultimately the vast majority of patients with metastatic disease from most solid tumors and some hematological malignancies will not survive their cancer. As providers for patients with cancer, our aggressiveness toward the care of a patient at the end of life should match the aggressiveness of our attempts to treat patients with surgery, radiation, chemotherapy, or other modalities. Hospice provides that level of aggressiveness at the end of life. However, as Ms Faiman notes, many patients in hospice do not experience the full benefits of hospice care, with 30% admitted to hospice for a less than 1 week and over half of patients in hospice for less than 3 weeks.

As discussed in earlier articles in this series, *Conquering the Cancer Care Continuum*, palliative care should be integral throughout the care of patients with cancer, whether curable or incurable. However, as patients with incurable cancer move along their treatment continuum, at some point either treatment options may be exhausted or patients' appropriateness (or desire) for further therapy is lessened. Thus, a shift to a supportive-care-only approach is critical. Such conversations with patients or families are not always easy. Indeed, I will treat patients who have very clear goals from the onset that they do not want to just prolong their time if they do not have quality time. They provide clear direction when they do not want further chemotherapies. On the other side of the coin will be patients with metastatic disease who go from treatment to treatment and, in their cancer life, do not view any other options. In both cases, as well as cases in between, discussion of hospice care becomes critical. When I was in training, one senior physician used to say that just as patients seek a good life, we should help them seek a good death. Patients,



Jeffrey A. Meyerhardt,
MD, MPH

and family members, sometimes consider the mention of hospice as an indication of an inevitable end. Given the statistics that Ms Faiman pointed out, it is understandable where that perception is derived from. However, I try to discuss with patients and family that we do not institute hospice early enough, leading neither the patient nor the family to derive the true benefits of hospice. For patients who choose home hospice, having strangers come into their home at the very end, when they are so ill and at the most stressful time in their illness, is more discomforting for patients and family members than instituting hospice early so the hospice providers get to know the patient and family while the patient is well and more communicative. Family members of my patients who are in hospice longer typically provide considerably more positive feedback on the experience than family members of patients on for shorter times (though many who only have hospice for short periods are usually still very appreciative of the services).

The article by Dr Stricker brings forth the importance of considering hospice as team care. For my patients on home hospice, I find communications with the hospice nurse, hospice pharmacist, and hospice director to be critical in helping to best manage patients. Some patients develop more complex symptom management issues, and working together as a team is critical.

In conclusion, I very much concur with Ms Faiman and Dr Stricker that as providers of care for cancer patients, we need to work with patients and family members to dispel the perception that hospice is a place to die; rather it is a place to maximize quality of life for whatever time a patient has to live. Early discussions of the concept of hospice, even while patients are actively on therapy that is controlling their cancer, and reintroduction at different times during the continuum of their care may help patients understand and accept the value of hospice when relevant for their situation. ■

Supported through funding by  Oncology

GHC106-3