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American Medical News

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Oncologists shouldn't delay frank talk with patients

Candid conversations about treatment options and palliative care benefit patients most, says the American Society of Clinical Oncology.

By KEVIN B. O'REILLY, amednews staff. *Posted Feb. 14, 2011.*

Oncologists caring for patients with incurable cancer should have realistic conversations about treatment options and refer patients for palliative care services earlier, according to a new policy statement by the American Society of Clinical Oncology.

The recommendations come on the heels of research showing that fewer than 40% of oncologists have such candid talks with their patients and that patients who receive palliative care live longer than those who receive only oncologic care.

Honest conversation with patients whose cancer cannot be cured is "happening far less often than it should," said Allen S. Lichter, MD, CEO of ASCO, which has more than 30,000 oncology professionals as members. "It should happen 100% of the time."

When dealing with cases of metastatic cancer, oncologists know that a cure usually is not possible and owe it to their patients to be forthcoming about that, said Thomas J. Smith, MD, co-author of the ASCO policy statement published online Jan. 24 in the *Journal of Clinical Oncology*.

"It's important to mention to people that there will come a time when anti-cancer treatment won't be helpful -- and to say that up front, so that when you do get to that point it doesn't come as a complete shock to the patient," said Dr. Smith, professor of medicine and palliative care research at Virginia Commonwealth University Massey Cancer Center.

The notion that it is better for patients to be shielded from this bad news is misguided, Dr. Smith said.

"Being honest with people in fact engenders hope rather than takes it away, and helping people plan for their life -- whether there is long-term survival or not -- avoids depression," he said.

Earlier palliative care

A more comprehensive approach to treating patients with incurable cancer also means involving palliative care sooner, Dr. Smith said.

"Oncologists have tended to hold palliative and hospice care back until someone is really sick and even near death, and that's the wrong approach," he said. "More and more data show that if you work closely with palliative care you can help people adjust to their illness, help with their symptoms a lot and even potentially make people live longer."

Cancer patients who receive palliative care live longer than those who don't.

A study in the April 19, 2010, *New England Journal of Medicine* found that 74 patients who received standard oncologic care at Massachusetts General Hospital for metastatic, non-small-cell lung cancer had a median survival time of nine months, compared with nearly a year for the 77 patients who received standard care and visited the hospital's outpatient palliative care service within three months of diagnosis. The patients getting palliative care lived longer despite spending more time in hospice care and receiving less chemotherapy.

The study's lead author, Jennifer S. Temel, MD, said ASCO's new policy could result in earlier referrals to palliative care.

"Oncologists really look toward ASCO as an important, practice-changing organization, so their coming out with a statement like this will get the message across to the academic community and the practicing community that focusing on quality of life needs to be part of cancer care, and has to be integrated and moved up to the forefront while patients are getting cancer-directed therapy," said Dr. Temel, a thoracic surgeon at Massachusetts General Hospital and an assistant professor of medicine at Harvard Medical School in Boston.

Palliative care is getting a push from another direction. The Commission on Cancer, a multidisciplinary organization convened by the American College of Surgeons that sets standards for cancer centers, has proposed requiring that cancer centers make palliative care services available to patients on site or by referral. The proposal is part of a working draft that could take effect Jan. 1, 2012. The commission accredits more than 1,500 hospitals.

Under the plan, the palliative care team should consist of at least one physician board-certified in hospice and palliative medicine as well as one nonphysician member such as a nurse, pharmacist, social worker or chaplain.

Yet outpatient palliative care services can be hard to come by, experts said. More than 80% of 300-plus bed hospitals have palliative care programs, but outpatient services are less common, said Diane E. Meier, MD, director of the Center to Advance Palliative Care, a New York nonprofit that helps hospitals develop palliative care programs.

Finding a way to finance outpatient palliative care services is a challenge, said Anthony L. Back, MD, an oncologist at the Fred Hutchinson Cancer Center, part of the Seattle Cancer Care Alliance.

"The cancer center where I work has a very established inpatient palliative care service, and we are now thinking about how to use outpatient palliative care effectively," he said. "The business model of how to structure consultants so we can make reimbursement work in this setting is generally not clear."

This content was published online only.

ADDITIONAL INFORMATION:

Conversations about cancer

Too often, oncologists fail to have forthright, comprehensive discussions about care choices with patients who have incurable cancer, according to the American Society of Clinical Oncology. The organization's new policy statement says physicians should:

- Inform patients about their prognosis and treatment options, ensuring that they have opportunities to discuss their preferences and concerns regarding treatment and supportive care.
- Offer anti-cancer therapy when evidence supports a reasonable chance that it will provide meaningful clinical benefit.
- Discuss options to enhance patients' quality of life when incurable cancer is diagnosed and throughout the course of the illness.
- Tell patients the likelihood and nature of response to anti-cancer interventions as well as their toxicity, adverse effects, risks and financial costs.
- Give patients the opportunity to participate in clinical trials that could improve their outcomes or care for future patients.
- Encourage patients to transition to symptom-directed palliative care alone when disease-directed options are exhausted.

Source: "American Society of Clinical Oncology Statement: Toward Individualized Care for Patients With Advanced Cancer," *Journal of Clinical Oncology*, Jan. 24 (**www.ncbi.nlm.nih.gov/pubmed/21263086**)

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"American Society of Clinical Oncology Statement: Toward Individualized Care for Patients With Advanced Cancer," *Journal of Clinical Oncology*, Jan. 24 (**www.ncbi.nlm.nih.gov/pubmed/21263086**)

"Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer," *The New England Journal of Medicine*, Aug. 19, 2010 (**www.ncbi.nlm.nih.gov/pubmed/20818875**)

"Working Draft: Cancer Program Standards 2012: Ensuring Patient-Centered Care," American College of Surgeons Commission on Cancer, February (**www.facs.org/cancer/coc/cps2012draft.pdf**)

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