



Study: Early Palliative Care Helps Quality of Life

BY HOWARD GLECKMAN

For years, advocates for palliative care have argued that such programs are powerful tools for improving patients' quality of life. Careful research, including a new randomized trial, now seems to be supporting their claims.

This study, published in the Aug. 19, 2010, issue of *The New England Journal of Medicine*, found that patients with metastatic lung cancer who received early palliative care both lived longer and reported a better quality of life than similar patients who had standard cancer treatment alone.¹ Although the report did not look at costs, other recent studies have concluded that well-designed palliative care programs can reduce

Palliative care focuses on managing symptoms, although, unlike hospice, patients still receive treatment for their terminal disease if they wish.

hospital expenses. Taken together, these results suggest that more hospitals (as well as nursing homes) should be adopting palliative care programs.

Palliative care focuses on managing symptoms, although, unlike hospice, patients still receive treatment for their terminal disease if they wish. Indeed, palliative care is often appropriate for patients with chronic illness, even if they are not at end of life. Palliative care provides pain management as well as care coordination and social and spiritual assistance. By 2005, about 30 percent of all U.S. hospitals and 70 percent of hospitals with 250 beds or more had adopted such programs.²

The new study, done from 2006 to 2009 at Massachusetts General Hospital, found that while

palliative care patients often chose less aggressive treatment, they lived almost three months longer than those receiving standard cancer care only. They spent less time in the hospital, enrolled earlier in hospice and were more likely to inform their physicians of their end-of-life wishes. In addition, they were less depressed and reported a significantly higher quality of life.

The striking bottom line: "Despite receiving less aggressive end-of-life care, patients in the palliative care group had significantly longer survival than those in the standard care group." The difference, on average, was more than 11.5 months compared to less than nine months for those get-

ting usual care.

The authors concluded that a key to the success of the program was early enrollment. Participants began receiving palliative care within eight weeks of diagnosis.

Although the *New England Journal* study provides important evidence of the value of palliative care, it does not mean that all patients everywhere will do as well. The Massachusetts General program is well designed with interdisciplinary teams of both lung cancer and palliative care specialists. The study participants were well informed about how the program worked and what their care would be like.

Patients in other settings may not have these advantages. For example, other studies have found that palliative care programs are less successful



when patients enrolled later. One physician who frequently cares for terminally ill patients told me that many drop out of palliative care programs because medical professionals never take the time to fully explain how the program works. According to this physician, some patients fear they are being written off and will receive less attention while in the program.

For instance, a 2004 controlled trial of an outpatient palliative care program found some important benefits, including fewer doctor visits with no increase in hospitalizations or length of stay. However, it also found these patients had no significant reduction in pain.³ Why did this program fail to achieve one of the major goals of palliative care? Remarkably, the study concluded that primary care doctors prescribed recommended opiate pain drugs in only 8 percent of the cases where these medications were recommended by the care team.

Not surprisingly, that study recommended closer collaboration between care teams and primary care doctors. Other recent research seems to support this conclusion. It is critical for palliative care teams to establish good communications with physicians. Two factors may be at play here: a well-documented reluctance on the part of many primary care doctors to treat pain and depression, and some level of distrust since medications were prescribed based on an assessment by a palliative care team member (who may have been a social worker or other non-physician).

The *New England Journal* study found palliative care teams were far more successful, in part, because physicians at Massachusetts General were well integrated into the group. It did not, however, attempt to describe which elements of the program were most beneficial to patients. Other, non-randomized trials, however, found that the ability to manage pain is a key factor in both better mood and longer life expectancy. In fact, quality of life measures such as levels of pain and ability to function normally may be a better predictor of life expectancy than standard diagnostic measures.⁴

Although the *New England Journal* paper did not look specifically at costs, a separate 2008 study found important financial benefits to this care.⁵

That study tracked

nearly 3,000 palliative care patients at eight hospitals. It found significant reductions in costs, compared to patients who received standard treatment only, among both discharged patients and those who died in the hospital. Among patients discharged alive, total costs fell by an average of \$279 per day compared to similar patients receiving usual care, and by an average of \$2,642 per admission, from \$19,379 for a patient receiving standard care to \$16,737 for one receiving palliative care.

These cost reductions are obviously good for Medicare, but they improved the bottom line for hospitals as well. According to the authors, "Whether a hospital is paid on a diagnosis-related group or a per diem basis, they benefit from the lower costs." This may be especially true for facilities that operate at or near capacity and could earn greater returns by filling their beds with higher margin patients.

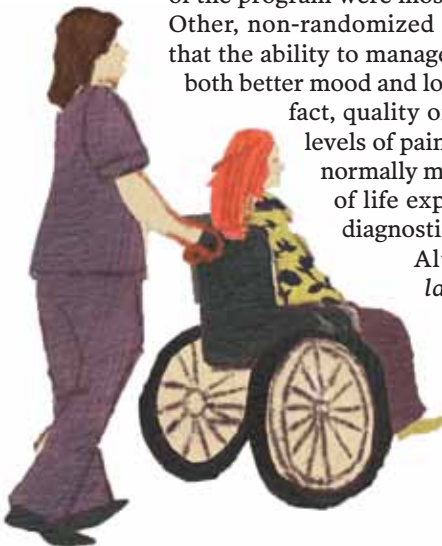
Keep in mind that these studies looked at palliative care programs associated with hospitals only. To date, relatively few nursing facilities operate formal palliative care programs, though many partner with hospices.

Still, this research is powerful evidence that palliative care works, especially if made available early. More hospitals and skilled nursing facilities would do their patients a great service by adopting this model. And patients with serious illnesses should begin seeking out providers who do.

HOWARD GLECKMAN is author of *Caring for Our Parents* (St. Martin's Press) and a resident fellow at the Urban Institute, Washington, D.C.

NOTES

1. Jennifer S. Temel et al., "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer," *The New England Journal of Medicine* 363 (Aug. 19, 2010): 733-742.
2. R. Sean Morrison et al., "Cost Savings Associated with U.S. Hospital Palliative Care Consultation Programs," *Archives of Internal Medicine* 168, no. 16 (2008): 1783-90.
3. Michael W. Rabow et al., "The Comprehensive Care Team: A Controlled Trial of Outpatient Palliative Medicine Consultation," *Archives of Internal Medicine* 164, (January 12, 2004): 83-91.
4. Benjamin Movsas et al., "Quality of Life Supersedes the Classic Prognosticators for Long-Term Survival in Locally-Advanced Non-Small Cell Lung Cancer," *Journal of Clinical Oncology* 27 (2009): 5816-22.
5. Morrison et al., "Cost Savings."



JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, January-February 2011
Copyright © 2011 by The Catholic Health Association of the United States
