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POLICY FORUM

High-Value Palliative Care for Cancer Patients

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I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

Hippocratic Oath, Modern Version

Although the Hippocratic Oath was written in antiquity, American medical students for generations have sworn to “apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism” [1]. As physicians we are bound by this oath to provide all measures to increase both the length and quality of our patients’ lives. For patients with advanced cancer, we advocate for a balance between therapeutic nihilism—a philosophy that would exclude these patients from clinical trials and the advancement of science—and overtreatment, which could result in physical, psychological, and financial harm. In this paper, we call on our fellow physicians to reaffirm their commitment to the Hippocratic Oath. We argue that integration and early adoption of palliative care for patients with advanced cancer is the optimal approach to maximizing their quantity and quality of life while reducing the physical and financial toxicities that neither extend life nor improve living.

What Is Palliative Care?

Palliative care, also known as palliative medicine or supportive care, “is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness—whatever the diagnosis” [2]. Palliative care can be offered to anyone with serious illness, regardless of age or stage of disease, and it can be provided to patients who are undergoing active treatment with curative intent. For the purpose of this paper, we will focus on palliative care for cancer patients who have advanced or incurable disease.

Palliative care is provided by an interdisciplinary team of palliative care doctors, nurses, social workers, and other specialists who work together with a patient’s other doctors to provide extra support and improve quality of life for the patient and his or her family [3]. All physicians who have attained basic core competencies in symptom management, psychosocial interventions, communication, and care transitions can practice primary palliative care [4]. Specialty palliative care is a consultative service dedicated to assisting

other clinicians using an interdisciplinary team for patients requiring more complex supportive care.

High-Value Palliative Care Interventions for Patients with Cancer

Although we are not accustomed to considering value in health care, there is a method of calculating it by dividing the quality of care by its cost [5]. The assumption underlying the effort to improve value in health care is that the cost should be proportional to the benefit. When we talk about value, we must ask whether the medical intervention that we are proposing improves the quality and quantity of life enough to justify its cost (financial, temporal, and symptomatologic). The financial cost can be grave: health care expenditures are cited as a major cause of personal bankruptcy [6].

The physical, psychological, and social costs of treatment are onerous for patients with advanced cancer, and the financial costs are particularly high; chemotherapeutic regimens frequently enter the market that are several times more expensive than similarly efficacious medicines [7]. Unfortunately, few comparative effectiveness studies exist in oncology [8], and expensive medications that provide little value over cheaper ones are depleting the financial resources of many Americans [9].

Low-value interventions are common in treating advanced cancer. A medical oncologic intervention known as palliative chemotherapy (which, despite its name, does not originate in palliative care as we describe it below) is offered to patients with advanced cancer to improve cancer-related symptoms and, potentially, survival, even if the cancer itself is incurable. More than half of all patients with incurable cancer receive palliative chemotherapy in their last months of life [10]. However, a recent prospective cohort study by Prigerson et al. of patients with end-stage metastatic cancer and life expectancy of less than six months found that palliative chemotherapy did not lengthen survival, irrespective of functional status, nor did it improve or worsen quality of life for patients with poorer functional status [11]. It actually worsened quality of life for patients with good functional status, even when controlling for clinical setting.

Skilled, sensitive, and honest communication about the limitations and burdens of palliative chemotherapy may improve quality of care and reduce the costs of potentially deleterious toxic therapies. This topic is especially relevant because patients occasionally opt for chemotherapy because they prefer to feel as if they are “doing something.” This may mean they believe the chemotherapy will have curative intent: up to 69 percent of patients with lung cancer and 81 percent of patients with colorectal malignancy receiving palliative chemotherapy were not aware that they could not expect to be cured of their diseases [12], suggesting that oncologists are not trained to speak to patients about the potential benefits and tradeoffs of palliative chemotherapy. Offering palliative chemotherapy is only appropriate if the patient understands that the benefits of

treatment might be minimal and that they may feel worse from it, particularly near the end of life. Equating treatment with hope in these cases is unethical.

Oncologists are uncertain about whether and how the cost of care should [affect their recommendations](#) [13]. Some oncologists feel that consideration of cost conflicts with their duty to individual patients and that cost should not enter into the discussion of whether or not to offer a therapy. Those oncologists may be more comfortable discussing whether the therapies offer any value in terms of quality or duration of life rather than discussing cost burden. For doctors who feel uncomfortable [discussing costs of care](#), the Prigerson study [11] provides a rationale for focusing instead on reduced quality of life when discussing value with their patients and colleagues.

Palliative care can offer high-value alternatives in care of advanced cancer. Palliative care not only decreases costs but, more importantly, improves quality of care. It has been shown to improve quality of life, patient satisfaction, caregiver burden, and survival in patients with serious illness [14]. In cancer care specifically, palliative care improves several key metrics of quality by alleviating pain, depression and psychosocial distress, fatigue, and dyspnea and by providing information and care planning [15]. Expertise in communication, complex decision making, and care transition makes palliative care clinicians ideal partners for oncologists who are weighing the benefits and risks of a given intervention in the context of a patient's goals [15]. By focusing on what is important to the patient, palliative care may temper unrealistic patient and family expectations that sometimes lead clinicians to offer services without evidence of utility or benefit.

Evidence supports the value of integrating palliative care into oncologic care at the time of diagnosis of advanced cancer. Introducing palliative care earlier in advanced cancer patients' illness results in higher utilization of hospice, reduction in futile aggressive care in intensive care settings, and extension of life for some patients [14, 16]. For example, Temel et al. [14] showed that patients with metastatic non-small-cell lung cancer who were randomly assigned to early palliative care concurrently with standard oncology care had significantly higher quality-of-life scores, fewer depressive symptoms, less aggressive end-of-life care, and a modest survival benefit compared to those who received standard oncology care. Furthermore, average hospice stay in the palliative care intervention group was eleven days, while the standard care group stayed only four [14]. One explanation for these differences is that patients who had simultaneous palliative care were better able to understand and process their prognoses and chose less chemotherapy near the end of life, which may account for their relatively longer survival period.

Early intervention is valuable not only for improvements in quality of life, but also for cost savings. The evidence demonstrating that early palliative care interventions reduce

cost is convincing. A multicenter prospective cohort study of patients admitted to the hospital with a diagnosis of advanced cancer found that earlier consultation was associated with estimated cost savings of 14 percent (if palliative care consultation occurred within six days) and 20 percent (if palliative care consultation occurred within two days), attributable to the reduced length of hospital stay and reduced intensity of hospital care [17]. Another study found that total average health care costs were \$6,766 lower for patients randomly assigned to usual care plus interdisciplinary care service (IPCS) than for those assigned to usual care alone [18]. Patients in the IPCS group also reported greater satisfaction with their care experiences and clinicians' communication [18]. These studies support early palliative care intervention for patients with advanced cancer as a means to raise quality and decrease the cost of care, thereby improving the value of care.

Barriers to High-Value Palliative Care for Cancer Patients

Despite the evidence for improved quality and reduced cost, many barriers to the implementation of high-value practices remain. Palliative care is often stigmatized as being synonymous with end-of-life or hospice care, when these are only components of what palliative care can offer to patients and their families [19]. In a culture in which Americans employ military metaphors [20] in referring to cancer patients who "battle," "fight," and sometimes "lose" their "wars" with cancer, patients, families, and clinicians may feel obliged to aggressively treat the disease even when the harms of treatment clearly outweigh the potential benefits. American values can conflict with pursuing a natural death, and dying is sometimes seen as the failure of the medical system rather than as the natural ending to every life.

The national anxiety surrounding death and dying [21] could explain why some oncologists believe that palliative care referrals destroy hope [22] and that providing potentially futile therapies is a means of tempering patient anxieties about death. These beliefs may be caused by a dearth of adequate primary palliative care education in medical school and residency programs, lack of proper reimbursement for the often lengthy and sensitive conversations about advance care planning (which we hope will soon change), and even differences in attitudes and opinions about palliative care within the oncologic community. For example, in a survey of hematologic and solid tumor specialists at MD Anderson Cancer Center, researchers found that hematologic specialists were more likely than solid tumor specialists to favor prescribing systemic therapy with moderate toxicity and no survival benefit for patients with poor functional status and an expected survival of one month. They also felt less comfortable discussing death and dying [23]. These practices are consistent with data showing that hematologic malignancy patients have high rates of ICU admission and prolonged hospitalizations in the last 30 days of life [23].

Politically, palliative care has been stigmatized as health care rationing. Fear mongering led to palliative care being likened to “death panels,” a strategy which was successful in quelling much of the national debate about health care reform [24]. Six years after reimbursement for advance care planning was removed from the Affordable Care Act [25] following Sarah Palin’s infamous Facebook post likening goals-of-care conversations to governmental execution of seniors [26], the Centers for Medicare and Medicaid Services announced that they will reimburse doctors for these conversations beginning in 2016 [27]. This development provides hope that, while some politicians may delay popularization of palliative care, ultimately, policymakers embrace it as valuable to the health of our nation.

Lack of a robust workforce of palliative care physicians is yet another barrier to providing Americans with access to good supportive care. Despite sound evidence of palliative care’s efficacy, only 66 percent of large hospitals had a palliative care program and just 59 percent of National Cancer Institute (NCI)-designated cancer centers and 22 percent of non-NCI-designated cancer centers had an outpatient palliative care clinic or team in 2013 [28]. To increase the ranks of palliative care specialists, it is imperative that we train more physicians in the specialty and that basic palliative care training become a standard component of medical school, residency, and continuing medical education. Below we summarize the barriers to high-value palliative care for cancer patients:

Table 1. Barriers to high-value palliative care for cancer patients	
●	Stigma of palliative care as synonymous with end-of-life or hospice care
●	Politicization of palliative care (“pulling plug on grandma”)
●	Lack of adequate primary palliative care education
●	Paucity of palliative care specialists
●	Some oncologists’ preference to give systemic therapies at the end of life

Promoting High-Value Practices in Palliative Care for Cancer Patients

To encourage high-value palliative care, we urge the adoption of high-value standards in diverse health care settings [29]. For example, one recent retrospective cohort study of patients with advanced solid tumors diagnosed and followed at Veterans Affairs (VA) hospitals found that study patients only received appropriate nonhospice palliative care 49.5 percent of the time, even within a health delivery system into which palliative care is deeply penetrated and well integrated [30]. Further research clarifying the barriers to

appropriate implementation of high-value palliative care in health systems is imperative so that sustainable programs can develop and flourish nationally.

Palliative care quality standards should result in increased revenue for payers, and we argue that penalties should be considered for failure to do so. If giving chemotherapy at the end-of-life has been shown not only to have no effect on increasing the quantity of life but also to worsen its quality, then why are physicians reimbursed for these harmful practices? When a given intervention's potential for no benefit or even harm is greater than its potential for benefit, then why should it be the default treatment [31]?

More [research](#) examining the value of specific interventions for specific malignancies might strengthen the existing evidence base showing that more harm than benefit results from physicians offering toxic therapies near the end of life. This research ultimately might help guide decision making for clinicians and payers.

Cultural change is, of course, more difficult to achieve. Over time we hope that emerging evidence in favor of palliative care, along with development of sustainable and efficient care delivery models, will encourage oncology to embrace palliative care as the fourth pillar [32] of comprehensive cancer care alongside medical oncology, surgical oncology, and radiation oncology. Integrating palliative care into the medical curriculum would be the most effective way to produce a generation of physicians who embrace the principle and practices of palliative care. We also believe that training "palliative oncologists" [33], physicians with specialty training in both hematology/oncology and palliative care, would supply our health care system with physicians who can serve as experts and ambassadors for both fields, generating novel research questions and designing models of care integration. Training successive generations of health care professionals to practice palliative care will require coordinated effort from educators, institutions, policymakers, and payers to create an environment in which palliative care is part of the standard of care for patients with advanced malignancy. Below we summarize these and other recommendations for improving high-value palliative care for cancer patients.

Table 2. Recommendations for expanding high-value palliative care for cancer patients
● Early consultation
● More research on implementation of palliative care for patients with malignancies
● Improved primary palliative care education
● Increased workforce of palliative care specialists
● Payment systems in which meeting of palliative care quality metrics is rewarded

Conclusion

We advocate for a reaffirmation of the Hippocratic Oath, to ensure that patients do not suffer needlessly and to make sure that we do not cause iatrogenic suffering with toxic medicines that do not improve or extend life. We believe that innovation can occur at the intersection of palliative care and medical oncology. We can create a space for new approaches to treating serious illness that maximize the quantity and quality of life while reducing physical, psychological, and financial harm.

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