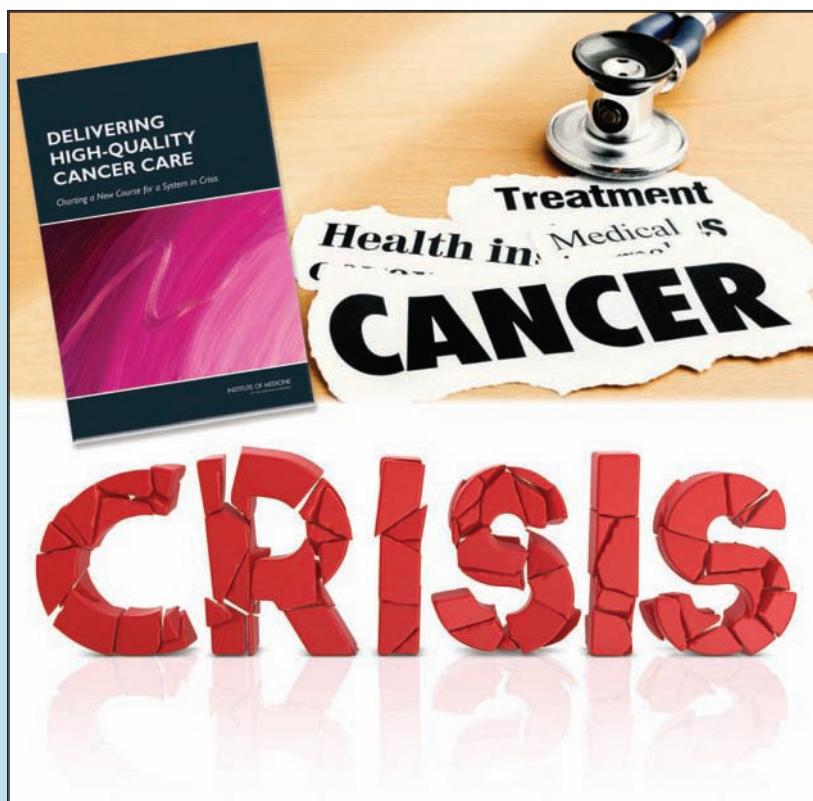


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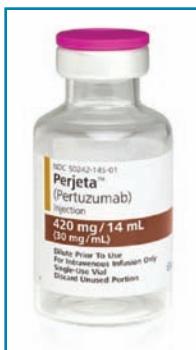


Cancer Care in Crisis

BY PEGGY EASTMAN

An aging population and rising cancer incidence, along with increasing scientific complexity and rapidly escalating costs, are placing the U.S. cancer care system in crisis mode. That is the conclusion of a new report from the Institute of Medicine, which aims to chart a new course through the current system described as too often fragmented, unresponsive to patient preferences, and not making sufficient use of palliative and hospice services.

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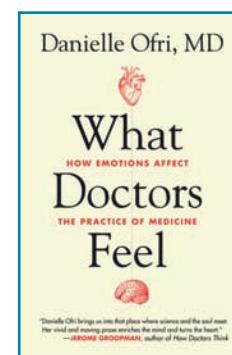
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New Dartmouth Atlas Report on Medicare Patients with Advanced Cancer: More Use of Hospice, but Aggressive Therapy at End of Life Continues

BY PEGGY EASTMAN

More Medicare patients with advanced cancer are entering hospice care, but referrals continue to be very late and often just days before death, according to a new study from the Dartmouth Atlas Project of the Dartmouth Institute for Health Policy & Clinical Practice. Further, using data from 2010, the project found that despite the increase in hospice use, more patients were treated in intensive care units (ICUs) in their last month of life than in the period from 2003 to 2007. Additionally, the percentage of patients seeing 10 or more physicians in the last six months of life escalated from 46.2 percent in 2003-2007 to 58.5 percent in 2010, a situation that the report speculated may reflect fragmented care.

This is the first Dartmouth Atlas report

containing a longitudinal analysis of the care provided to Medicare patients with advanced cancer. The report, "Trends in Cancer Care Near the End of Life: A Dartmouth Atlas of Health Care Brief," examined the last six months of claims records for 212,322 Medicare patients with advanced cancer who died in 2010 and compared them with a similar data set from 2003 to 2007.

The most troubling finding from the new report is that it shows that patients with advanced care are often receiving care that does not reflect their wishes.

The most troubling finding from the new report is that it shows that patients with advanced care are often receiving care that does not reflect their wishes: "Our research continues to find that patients with advanced cancer are often receiving

aggressive care until their final days, when we know that most patients would prefer care directed toward a better quality of life through hospice and palliative services," said the study's lead author, David C. Goodman, MD, MS, co-principal investigator for the Dartmouth Atlas Project, in a statement accompanying the report.

The study found that in 2010 just as many patients with advanced cancer were likely to receive aggressive treatments such as endotracheal intubation, a feeding tube, or cardiopulmonary resuscitation in the last month of life or to receive chemotherapy during the last two weeks of life as in 2003-2007. "Fuller discussions with patients who have advanced cancer on their

control, and satisfaction with their care and choices."

Next year, ASCO—which is on record as encouraging integration of palliative care into oncology at every stage of the cancer continuum—will host its first evidence-based Palliative Care in Oncology Symposium (asco.org/meetings/ascos-palliative-care-oncology-symposium).

Also agreeing, end-of-life care pioneer Ira Byock, MD, Professor of Medicine at the Geisel School of Medicine at Dartmouth, urged cancer patients and their physicians to make better use of the benefits of palliative care. "The longstanding assumption is that the more diagnostic tests and treatments patients receive, the



prognosis and options for care can lead to a better quality of life than many receive today," he added.

Hudis and Byock

Commenting on the Dartmouth Atlas report in a statement, American Society of Clinical Oncology President Clifford A. Hudis, MD, said that while the increase in referrals to hospice (even if they are often late), is good news, "it's also clear there is much more we can do to improve the timely use of hospice care and avoid unnecessarily and ineffective, aggressive treatment."

Hudis, Chief of the Breast Cancer Medicine Service at Memorial Sloan-Kettering Cancer Center, added, "This report should be a reminder to the oncology community: we can and must keep striving to deliver the right care at the right time."

He noted that when patients with advanced cancer communicate with their physicians early in the course of treatment about the kind of care they want, "these important discussions lead to greater use of palliative and hospice care, and can improve a patient's quality of life, sense of

better off they will be. However, two decades of studies by Dartmouth Atlas researchers have proven that this supposition is often wrong," he said in a commentary accompanying the report.

"In advanced illnesses, including cancer, higher levels of medical treatments are commonly associated with more suffering, but little or no extension of life."

Study Specifics

Specifically, the Dartmouth Atlas study on advanced cancer patients found that:

- 61.3 percent of patients entered hospice care in the last month of life in 2010, compared with 54.6 percent in 2003-2007;
- 24.7 percent of patients died in the hospital in 2010, compared with 28.8 percent in 2003-2007; and
- 28.8 percent of patients were admitted to the ICU in the last month of life in 2010, compared with 23.7 percent in 2003-2007.
- The percentage of patients receiving life-sustaining in the last month of life was slightly up in 2010: 9.4 percent, compared with 9.2 percent in 2003-2007.

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SIMONE

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far for us oncologists to learn from. But reading these two articles back to back has led me to believe we have a lot to learn from people at places like The Beatitude Campus.

We cannot say that we have found the best approach to managing terminal cancer

that physicians adopt, and what strikes me is that a more humane, less torturing (for patient, family, and doctors) approach is out there that may be adaptable to the care of terminal cancer patients.

I would like to see senior representatives from Beatitudes invited to the ASCO Annual Meeting to describe the techniques and approaches they are using so effectively. ☐

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New 'Choosing Wisely' Lists from American College of Surgeons and Commission on Cancer

The American College of Surgeons (ACoS) and Commission on Cancer (CoC) have released separate lists of specific tests or procedures in surgery and surgical oncology that are commonly ordered, but potentially unnecessary, as part of the American Board of Internal Medicine Foundation's "Choosing Wisely" campaign. Each organization has identified five targeted, evidence-based recommendations to support discussions between physicians and patients about care options that may not be necessary.

"This initiative will help provide cancer patients with a highly credible resource to obtain reliable information when discussing certain aspects of their care with their physicians," said David P. Winchester, MD, FACS, Medical Director of the ACoS's Cancer Programs.

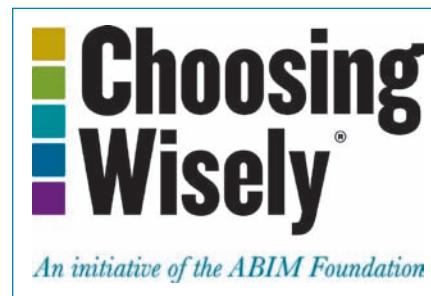
To develop its list, ACoS solicited recommendations from the organization's Committee on Trauma and Advisory Councils for Colon and Rectal Surgery, General Surgery, and Pediatric Surgery, as well as from the Commission on Cancer. All of the recommendations collected were reviewed, and five items were selected for the final list. They are:

- Do not perform axillary lymph node dissection for clinical stages I and II breast cancer with clinically negative lymph nodes without attempting sentinel node biopsy;

- Avoid the routine use of "whole-body" diagnostic computed tomography (CT) scanning in patients with minor or single system trauma;

- Avoid colorectal cancer screening tests on asymptomatic patients with a life expectancy of less than 10 years and no family or personal history of colorectal neoplasia;

- Avoid admission or preoperative chest x-rays for ambulatory patients with unremarkable history and physical exam; and



- Do not use CT for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.

The CoC appointed a multidisciplinary task force to develop its list. The recommendations for candidate interventions were solicited from panel members and other CoC leaders. The panel

voted on each intervention to select the final list of recommended interventions, which are:

- Do not perform surgery to remove a breast lump for suspicious findings unless needle biopsy cannot be done;

- Do not initiate surveillance testing after cancer treatment without providing the patient a survivorship care plan;

- Do not use surgery as the initial treatment without considering neoadjuvant systemic and/or radiation for cancer types and stage where it is effective at improving local cancer control, quality of life, or survival;

- Do not perform major abdominal surgery or thoracic surgery without a pathway or standard protocol for post-operative pain control and pneumonia prevention; and

- Do not initiate cancer treatment without defining the extent of the cancer (through clinical staging) and discussing intent of treatment with the patient.

Both lists are posted online at: www.facs.org/choosingwisely. With the release of these new lists, the Choosing Wisely campaign will have covered some 250 tests and procedures in various subspecialties that the individual society partners say are overused and inappropriate, and that physicians and patients should discuss. □

DARTMOUTH ATLAS REPORT

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- The percentage of patients receiving chemotherapy in the last two weeks of life remained the same in both data sets: six percent.

The report found that the pace of improvement in use of palliative care services was "uneven and varied markedly across regions and hospitals, including academic

medical centers and NCI-designated Cancer Centers." This variation occurred even within the same state.

For example, in the Rochester, N.Y. hospital referral region, the percentage of Medicare patients with advanced cancer dying in the hospital increased from 25.4 percent in 2003-2007 to 30.5 percent in 2010. But in East Long

Island, N.Y. the percentage of patients dying in the hospital decreased in 2010 to 35.6 percent from 42.5 percent in 2003-2007—even as this region continued to have one of the nation's highest in-hospital death rates for Medicare patients with advanced cancer.

Although there is an increased awareness of the importance of discussing cancer treatment choices with patients, the report found that communication gaps often undermine those discussions. For example, a recent article cited in the Dartmouth Atlas study found that the majority of patients with advanced lung and colorectal cancer did not understand that chemotherapy was unlikely to cure their cancer (*Weeks et al: Patients' expectations about effects of chemotherapy for advanced cancer: NEJM 2012;367:1616-1625*).

"This report should be a reminder to the oncology community: we can and must keep striving to deliver the right care at the right time."

In that issue, a study of palliative care services in 71 NCI-designated U.S. cancer centers and a random sample of 71 non-NCI designated cancer centers (the centers were identified by using the Commission of Cancer database) found much heterogeneity in the infrastructure and delivery of palliative care in the United States. That study found that NCI-designated cancer centers were significantly more likely to have: a palliative care physician; an inpatient palliative care consultation team; and an outpatient palliative care clinic. However, few cancer centers had an institution-operated hospice or dedicated palliative care beds. □

However, few cancer centers had an institution-operated hospice or dedicated palliative care beds. □

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