



Opioid Use Poses ‘Extremely Small Risk’ of Hastened Death in Hospice Patients

Survival among patients with advanced illness is affected by a complex interplay of variables, among which final opioid dose — but not percent of dose increase — was found to be a very weakly associated factor. That is according to the authors of a study published in the *Journal of Pain and Symptom Management*.

“Most clinicians understand the value of using opioids to relieve suffering at the end of life, but the fear of hastening the death of seriously ill persons contributes to unnecessary suffering,” says coauthor Stephen Connor, PhD, president of research and international development for the National Hospice and Palliative Care Organization. “This study reassures clinicians that their effective use of opioids in the seriously ill will not hasten death and will lead to better quality care.”

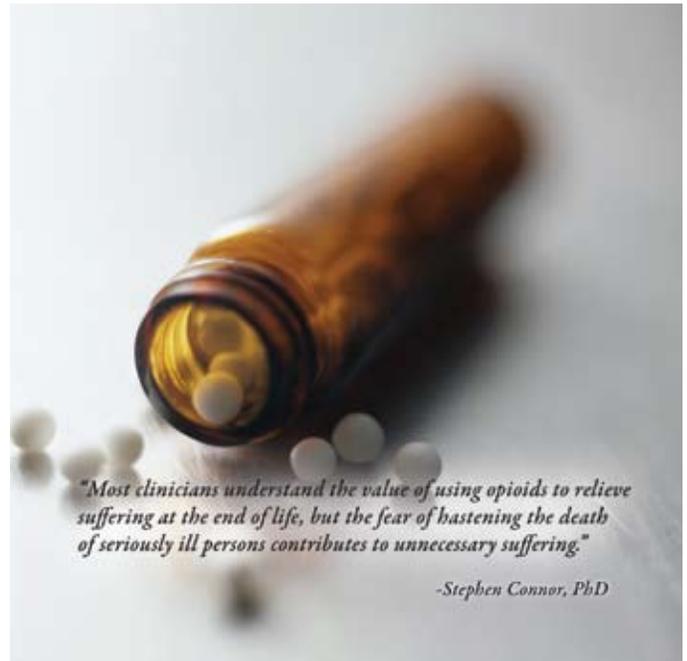
The investigators examined the association between survival and opioid dosing characteristics and other variables among 725 hospice patients (mean age, 76.6 years; cancer diagnosis, 42%) who received opioid therapy with at least one dose change prior to death. The study group was divided into subsamples based on maximum daily opioid dose administered. Findings include:

- No significant relationship was found between high-dose opioid treatment and the interval between final dose change and death (mean number of days, 12.5; median, 5 days; range: 0 to 231 days).
- Shorter survival was associated with cancer diagnosis, higher opioid dose, and lack of consciousness, but none of these variables accounted for more than 10% of the variation in survival time.

“The implication that opioid dose poses an extremely small risk of hastened death in this population was supported further by the relatively long intervals between final dose change and death, and the lack of higher opioid risk in subsamples receiving high doses,” write lead author Russell K. Portenoy, MD, of Beth Israel Medical Center, New York City, and colleagues.

Much of the moral justification for aggressive opioid therapy in the literature on end-of-life care is based on the ethical principle of double effect, which assumes a substantial risk of hastened death due to the opioid, note the authors. Similarly, literature on physician-hastened death assumes that opioid toxicity is substantial and can be used to shorten life at the end of life.

“These assumptions contrast with the common clinical experience of specialists in pain management or palliative medicine, who typically use opioid drugs in whatever doses are needed to achieve analgesia, and rarely encounter a scenario consistent with a primary opioid-related death,” they state.



“In a hospice population, survival is influenced by complex factors, many of which may not be measurable. Based on these findings, concern about hastening death does not justify withholding opioid therapy,” the authors conclude.

*Source: “Opioid Use and Survival at the End of Life: A Survey of a Hospice Population,” *Journal of Pain and Symptom Management*; December 2006; 32(6): 532-540. Portenoy RK, Sibirceva U, Smout R, Horn S, Connor S, Blum RH, Spence C, Fine PG; Department of Pain Medicine and Palliative Care, and Cancer Center, Beth Israel Medical Center, New York City; Institute for Clinical Outcomes Research and Department of Anesthesiology, University of Utah Medical Center, Salt Lake City; National Hospice and Palliative Care Organization, Alexandria, Virginia.*

*Reprinted with permission from *Quality of Life Matters* newsletter, copyright 2007. Published by *Quality of Life Publishing Co.*, Naples, FL*



“Undertreatment of pain is a far more pressing concern than is the risk of hastened death... and physicians should be encouraged to use opioids effectively to relieve suffering at the end of life.”

— Portenoy, et al

Journal of Pain and Symptom Management



New Research Shows Families Referred Too Late to Hospice Have More Unmet Needs

By Mark M Murray, President/CEO

The biggest complaint we hear from our patients and families is they wish they had known about or been offered hospice care sooner.

In our last issue of H&P we covered new research revealing that patients who received hospice care lived longer on average than patients who do not receive hospice care. This has implications upon the appropriate point of entry and timing of referrals to hospice care. The biggest complaint we hear from our patients and families is they wish they had known about or been offered hospice care sooner. Now, according to research published in the July issue of the *Journal of Pain and Symptom Management*, families who felt their dying loved ones were referred “too late” to hospice care reported more unmet needs and lower satisfaction with the quality of care provided at the end of life. One out of ten families (11.4 percent) indicated that hospice care was not provided soon enough. Inadequate symptom management, poor care coordination, and insufficient emotional support were some of the problems associated with late referrals, according to the study.

Researchers with the National Hospice and Palliative Care Organization (NHPKO) and The Warren Alpert Medical School of Brown University, Center for Gerontology and Health Care Research were somewhat surprised to find that it was not the length of hospice service a dying person received but perceived late referrals to hospice that had a greater effect on the quality of care reported by family caregivers. The study, “Timing of Referral to Hospice and Quality of Care,” was based on data collected through the Family Evaluation of Hospice Care (FEHC), an Internet based repository containing more than 250,000 surveys from families collected from nearly 1,000 American hospice programs over the past two years. Developed by Brown and NHPKO, the FEHC surveys let researchers look at the relationship of length of stay, perceived timing of hospice referral, and the quality of end-of-life care.

According to Stephen Connor, PhD, NHPKO vice president for research and one of the authors of the study, “While the majority of families felt their loved one was referred to hospice at the right time, those who thought they got hospice care too late reported greater concerns and more problems with care. The better we can understand referral patterns and factors that influence hospice admissions, the more successful we will be at getting hospice care to

patients and families at the optimal time. In many cases, families aren’t aware of what they are missing and don’t realize how hospice can make a world of difference for the comfort and quality of life for their loved ones.”

Timely referrals ensure that patients and families can experience the wide range of available services and benefits hospices can provide. Hospice provides symptom control, pain management, and emotional and spiritual support expressly tailored to the patient’s needs and wishes. Family members also receive support, caregiver training, and help coping with the loss of their loved one. Experts agree that hospice is most beneficial when provided for at least three months. NHPKO reports that the median length of service was 26 days in 2005 with 30 percent of people served by hospice in the U.S. dying in seven days or less. Furthermore, while eight out of 10 Americans have indicated they would prefer to spend their final days at home, those who received hospice for seven days or less were more likely to be cared for outside of their homes.

Along these same lines, the July 26, 2007, issue of the *New England Journal of Medicine* includes a commentary by Gail Gazelle, MD that encourages physicians to better understand the role of hospice in caring for the terminally ill. Gazelle is a member of the Division of General Medicine and Primary Care at Brigham and Women’s Hospital in Boston and also president of MD Can Help. NHPKO data was used in “Understanding Hospice – An Underutilized Option for Life’s Final Chapter” to address some of the basic misunderstandings among health professionals that lead to late referrals. She writes, “With the growing number of baby boomers seeking more control over all aspects of their health care, the use of hospice care will probably continue to increase. It is especially important, therefore, that physicians become more familiar with what hospice care offers and work to overcome barriers in talking frankly with patients about what lies ahead.” Gazelle also states, “Evaluation studies reveal consistently high family satisfaction, with 98% of family members willing to recommend hospice care to others in need. And the extensive expertise of physicians specializing in hospice and palliative medicine was recognized in 2006, when the field was accredited as a fully independent



medical subspecialty.”

ADDITIONAL NOTES: CHAPC is proud to be the only hospice program within our eight county service area employing a staff physician accredited in hospice and palliative medicine: David Tribble, MD, ABHPM, FAAFP.

With 69 questions covering 13 dimensions, CHAPC is also pleased to participate in the FEHC survey process which not only allows for reporting of collected data from our families, but also the ability to benchmark our

response data with collected Indiana specific data and the aggregate national data results on a ongoing quarterly basis.

Dr. Gazelle’s article has been posted to the NEJM web site and may be viewed in its entirety at: <http://content.nejm.org/cgi/reprint/357/4/321.pdf> for free.



Online Resources Help Physicians Assess Appropriateness of Palliative Care

<http://www.getpalliativecare.org>

The Center to Advance Palliative Care (CAPC) has launched a website resource (www.getpalliativecare.org) offering information to assist physicians and their patients with serious illness in making decisions about the appropriateness of palliative care.

“Palliative care relieves suffering and ensures the best possible quality of life,” says Diane Meier, MD, CAPC director. “We are especially interested in making it clear that *palliative care is appropriate at any stage of a serious illness.*”

Patient information includes a brief questionnaire to help determine the appropriateness of palliative care, a three-step process for obtaining such care (Step 1 is “Talk to your doctor”), and a national directory of palliative care providers.

Physicians are offered a set of criteria for assessing whether a palliative care consultation would be of benefit to them and their patients, along with a downloadable one-page patient/family handout entitled “What Should You Know about Palliative Care?”

General palliative care referral criteria include:

PRESENCE OF A SERIOUS, CHRONIC ILLNESS

- Difficulty managing physical or emotional symptoms related to serious medical illness
- Patient, family, or physician uncertainty regarding prognosis and/or goals of care
- Patient, family, or physician query about the appropriateness of hospice

INTENSIVE CARE UNIT CRITERIA

- Multi-organ failure
- Prolonged or difficult ventilator withdrawal
- Family distress impairing surrogate decision making

ONCOLOGY CRITERIA

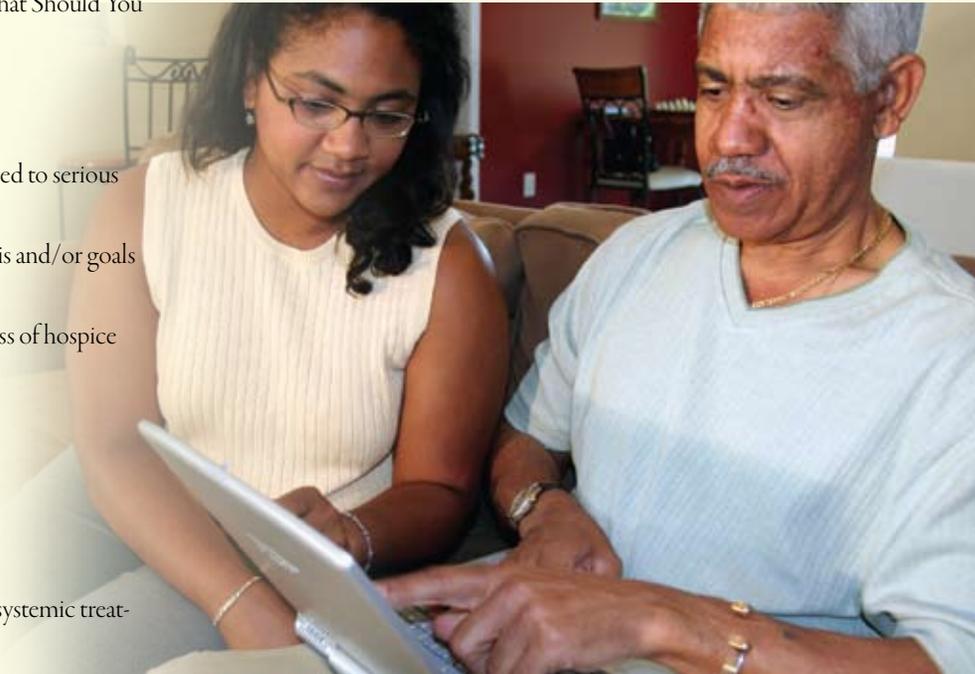
- Metastatic or locally advanced cancer progressing despite systemic treatments with or without weight loss and functional decline

EMERGENCY DEPARTMENT CRITERIA

- More than one recent prior hospitalization with same symptoms/problems
- Patient, caregiver, or physician desire for hospice
- Consideration of ventilator and/or intensive care unit admission in a patient with: moderate to severe dementia; metastatic cancer and functional decline; or chronic disease(s) and poor baseline functional status

CAPC (www.capc.org), located at Mount Sinai School of Medicine, is a national organization supporting health care professionals who wish to start and sustain palliative care programs for patients facing serious, complex illness.

Reprinted with permission from Quality of Life Matters newsletter, copyright 2007. Published by Quality of Life Publishing Co., Naples, FL



CHAPC Medical Director Available for Consults

In addition to the online resources from the Center to Advance Palliative Care, CHAPC’s medical director, David Tribble, MD, ABHPM, FAAFP, having received his certification in hospice and palliative medicine from the American Board of Hospice and Palliative Medicine is available for consultation regarding issues of symptom relief (restlessness, nausea, dyspnea, as well as pain), hospice eligibility, as well as suffering of a more existential type.

Dr. Tribble can be reached by calling The Center for Hospice and Palliative Care at (574) 243-3100 or (800) 413-9083.

The Center for Hospice and Palliative Care

111 Sunnybrook Court
South Bend, IN 46637
(574) 243-3100 • (800) 413-9083

112 South Center Street, Suite C
Plymouth, IN 46563
(574) 935 4511 • (800) 774-2784

2901 East Bristol Street, Suite C
Elkhart, IN 46514
(574) 264-3321 • (866) 264-3321

Life Transition Center
215 Red Coach Drive
Mishawaka, IN 46545
(574) 255-1064

www.centerforhospice.org

©2007

The Center for Hospice and Palliative Care

Center for Hospice Announces Staff Achievements

The Center for Hospice and Palliative Care, Inc. is pleased to announce the following staff achievements:

David B. Tribble, MD, medical director and chief medical officer, has been designated as a Fellow of the American Academy of Family Physicians. The Degree of Fellow recognizes members who have distinguished themselves among their colleagues and in their communities by service to family medicine, advancement of health care to the American people, and professional development through medical education and research. Tribble, who earlier this year achieved board certification in hospice and palliative medicine, has served as medical director of The Center for Hospice and Palliative Care for 14 years.

Ryan J. Trzaskowski, MPA, director of community and provider relations, and **Ellen D. Brown, BA**, volunteer resources coordinator, have been recognized by The National Hospice and Palliative Care Organization for completion of Level I of the Hospice Manager Development Program (MDP). The MDP is a comprehensive management training program designed to help managers develop skills to meet the challenges and changes they face in managing programs, systems and people. Trzaskowski and Brown are two of only 133 hospice leaders nationally to have attained Level I designation.



David B. Tribble, M.D.
Medical Director and
Chief Medical Officer



Ryan J. Trzaskowski, M.P.A.
Director of Community
and Provider Relations



Ellen D. Brown, B.A.
Volunteer Resources
Coordinator

Non-Profit Org
U.S. POSTAGE
PAID
Permit No. 376
South Bend, IN



Center for Hospice
and Palliative Care
111 Sunnybrook Court
South Bend, IN 46637