Keeping Cancer Patients Out of the Hospital at the End of Life

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Caring for patients at the end of life is perhaps the most noble of the medical arts, and for oncologists, it is a daily reality. All too often, cancer takes a deadly toll, and oncologists are actively engaged in the management of the dying patient. Such care includes treatment with appropriate therapies and referral to specialists for appropriate palliative interventions. But these treatment decisions are the “easy” part of medical care for the clinical team. The more challenging tasks lie in communicating to patients and their families what can—and cannot—be achieved and what the future is likely to hold. Those conversations depend on familiarity with the disease but also on familiarity with the person who has the disease: understanding their preferences, social supports, financial circumstances, cognitive function, and personality.

Patients know a lot about one aspect of end-of-life care, which is their own preference for the place of death. Multiple surveys from many different countries have asked people where they would prefer to spend their final days. Across all cultures and nationalities, the vast majority of cancer patients want to die at home. Dying at home is not only the preferred option “in theory,” or according to preference surveys. It is also, for most, the option that affords the optimal patient experience. Patients with cancer who die at home experience a better quality of life in their terminal days than those who die in a hospital or intensive care unit, and the bereaved family is less likely to experience major stress or grief disorder.

Of course, the time and place of death are not choices readily given to us, and it is easy to understand how acute medical events and complex social circumstances make orchestrating the end of life a clinical challenge. Nonetheless, these basic observations underscore the importance of more actively managing the end of life as part of humane and comprehensive cancer care.

Economic factors matter, too. Most of the costs of cancer care arise in the last year of life, and most of the costs in the last year relate to hospitalization, with hospital-based care accounting for 70% to 80% of costs during that time, regardless of tumor type. Thus, clinicians, patients, and payers have an aligned set of goals—maximizing good care at the end of life by keeping cancer patients out of the hospital.

Recent data, however, suggest that the hospital remains a critical weigh-station for cancer patients in the last months of life. A study of Medicare beneficiaries found that 80% of end-stage cancer patients had been hospitalized within the last 90 days before death, with 27% admitted to an ICU in the last month of life. Fourteen percent of patients had 3 or more hospitalizations in the last 90 days before death, such that patients with cancer spent an average of 10 of their final 90 days and 5 of their last 30 days in the hospital. Compared with data from 2000, data from 2009 suggested greater rates of hospitalization and ICU care.

At the same time, use of hospice services among patients with cancer is increasing; 60% of patients with cancer were in a hospice program at time of death. What is apparent, however, is that hospice services are often introduced late; in the final month of life. In the last 30 days, the percentage of patients with cancer in hospice or palliative care programs surges from about 20% to about 60%. This includes the 12% of patients who transition to hospice in the final 3 days before their death.

My own recent inpatient attending service bears out the general experience documented in these reports: patients with cancer who have been doing “well” with late stage disease begin an abrupt decline, heralded by hospitalization for symptom...
control or new complications of advanced disease. For some, there is a rallying phase after initial hospitalization, as adjustments to treatments or well-timed palliative interventions alleviate the problem. For many, the hospitalization marks a transition to an abrupt decline in function, with diminished performance status, increasing symptoms, and redirections in the goals of care. Frequently, this means urgent initiation of hospice services and a rapid transition to end of life care that lasts only a matter of days or a few weeks before death.

In my hospital network, hospitalization functions as a complicated catalyst for these transitions. Urgent testing, including diagnostic laboratory studies or CT and MRI scans, is more readily available at any hour at the hospital, as are consultations with specialists in pain, palliative care, and radiation therapy and access to procedures such as paracentesis or thoracentesis. The hospital experience at the time of progressive symptoms allows the family to understand profoundly the clinical situation, and make plans, including home-care plans, for the pending death. It provides care for the patient while the primary oncologist can formulate a plan and share it with the patient and family. Care coordinators at the hospital enable transitions to home or institutional hospice as appropriate. For all these reasons, a hospitalization at the end of life is both understandable, valuable, and in some ways, clinically efficient.

That efficiency comes at a price, however, which is the functional and financial cost of hospitalization. To avoid hospitalization, clinicians and patients need readier access to the pain and palliative care services, care coordinators, and medical subspecialists who are integral to end-of-life care. Emergency services must be accessible outside of the hospital on a near-continuous basis, which may mean hiring more such specialists and insisting on their accessibility on a more round-the-clock, outpatient basis.

Ultimately, too, it means that the oncologist must be better prepared to help the patient and family move to end-of-life care, ideally before the terminal hospital admission in the last weeks of life. Screening for end-of-life needs is an important part of being an oncologist. The NCCN Clinical Practice Guidelines in Oncology for Palliative Care focus on important clinical factors for predicting end-of-life care needs, including progressive symptoms, deteriorating performance status, increasing patient or family distress, and laboratory or radiologic evidence of key organ function worsening. With a greater appreciation for these hallmarks of clinical deterioration in cancer patients, clinical teams and families can be better prepared for the inevitable. Advanced planning will not avoid every hospitalization or ICU stay, nor should it. Things happen that cannot be anticipated. But if we want to serve the personal needs of our patients and their families and the financial needs of our society and institutions, being ready to act before a terminal hospitalization might make a big difference. Oncologists and cancer centers need to work as hard to keep patients out of the hospital at the end of life as they do to prolong survival in the years beforehand.

References