

Journal Watch

Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment.

Reference: *JAMA*. October 8, 2008. 300 (14): 1665-1673. Wright AA, Zhang B, Ray A, et al.

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Received during: Journal Rounds, TPCU on October 23, 2008.

Abstract:

Context: Talking about death can be difficult. Without evidence that end-of-life discussions improve patient outcomes, physicians must balance their desire to honor patient autonomy against a concern of inflicting psychological harm.

Objective: To determine whether end-of-life discussions with physicians are associated with fewer aggressive interventions.

Design, setting, and participants: A US multisite, prospective, longitudinal cohort study of patients with advanced cancer and their informal caregivers (n = 332 dyads), September 2002-February 2008. Patients were followed up from enrollment to death, a median of 4.4 months later. Bereaved caregivers' psychiatric illness and quality of life was assessed a median of 6.5 months later.

Main outcome measures: Aggressive medical care (eg, ventilation, resuscitation) and hospice in the final week of life. Secondary outcomes included patients' mental health and caregivers' bereavement adjustment.

Results: One hundred twenty-three of 332 (37.0%) patients reported having end-of-life discussions before baseline. Such discussions were not associated with higher rates of major depressive disorder (8.3% vs 5.8%; adjusted odds ratio [OR], 1.33; 95% confidence interval [CI], 0.54-3.32), or more worry (mean McGill score, 6.5 vs 7.0; P = .19). After propensity-score weighted adjustment, end-of-life discussions were associated with lower rates of ventilation (1.6% vs 11.0%; adjusted OR, 0.26; 95% CI, 0.08-0.83), resuscitation (0.8% vs 6.7%; adjusted OR, 0.16; 95% CI, 0.03-0.80), ICU admission (4.1% vs 12.4%; adjusted OR, 0.35; 95% CI, 0.14-0.90), and earlier hospice enrollment (65.6% vs 44.5%; adjusted OR, 1.65; 95% CI, 1.04-2.63). In adjusted analyses, more aggressive medical care was associated with worse patient quality of life (6.4 vs 4.6; F = 3.61, P = .01) and higher risk of major depressive disorder in bereaved caregivers (adjusted OR, 3.37; 95% CI, 1.12-10.13), whereas longer hospice stays were associated with better patient quality of life (mean score, 5.6 vs 6.9; F = 3.70, P = .01). Better patient quality of life was associated with better caregiver quality of life at follow-up (beta = .20; P = .001).

Conclusions: End-of-life discussions are associated with less aggressive medical care near death and earlier hospice referrals. Aggressive care is associated with worse patient quality of life and worse bereavement adjustment.

Comments:

Strengths/Uniqueness: This study is unique in that it looked at measurable psychological and medical outcomes of an end-of-life discussion, instead of evaluating patient preferences on this topic. It looked at how a "communication intervention" can have a positive impact on several distinct outcomes. They controlled for possible confounding factors.

Weaknesses: As this is a prospective study, there is the possibility of a selection bias. They were unable to show a direct causal relationship between end-of-life discussions and the outcome measures because of possible confounding factors. We do not know what was involved in the patient's self-reported "end-of-life" discussion with their physician. Also, the nature of end-of-life discussions is such that they must be individualized to each patient.

Relevance to Palliative Care: Providers of palliative care often see patients with terminal cancer who have not had an end-of-life discussion with a physician, or who may misunderstand previous discussions regarding prognosis. This study emphasizes the importance of having a clear and informed discussion with patients around their goals for end-of-life care. This study also shows important association between length of hospice stay and improved quality of life, as well as decreased quality of life and more aggressive interventions, which is also relevant to the management of palliative care patients.