

Palliative Care Journal Watch

A partnership between Pallium Canada and the Divisions of Palliative Care at Queen's University in Kingston, Canada, and McMaster University in Hamilton, Canada



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Medicine



Family Medicine

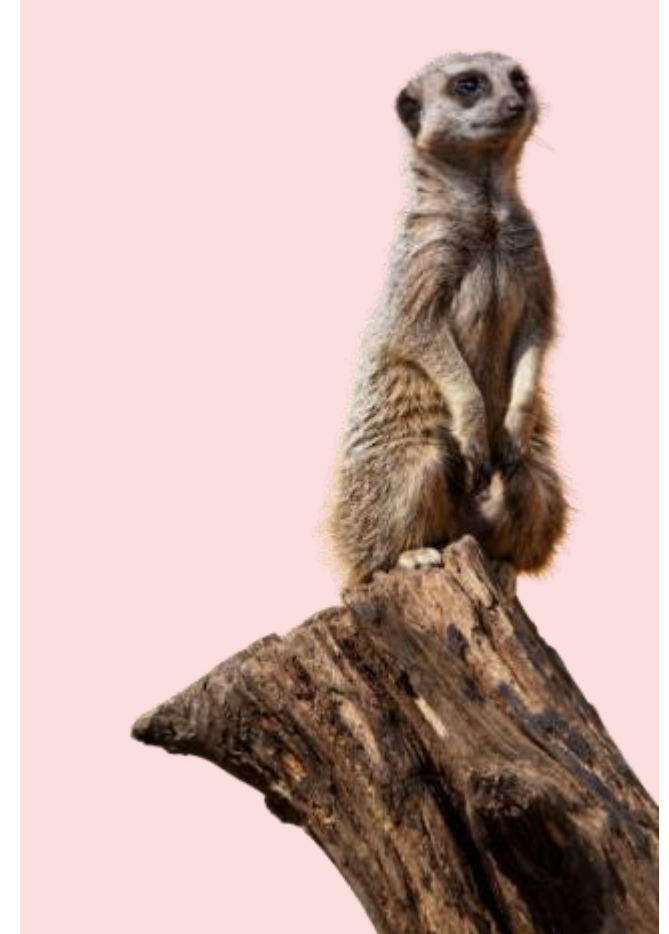
Host: Dr. José Pereira

Guest Panelists: Dr. Adrienne Selbie & Dr. Aynharan Sinnarajah

Date: June 19th, 2023

Welcome to the Palliative Care Journal Watch!

- Keeps you up to date on the latest peer-reviewed palliative care literature.
- Led by palliative care experts from the divisions of palliative care at 2 Canadian Universities:
 - McMaster University (Hamilton, Ontario)
 - Queen's University (Kingston Ontario)
- We regularly monitor over 20 journals and highlight papers that challenge us to think differently about a topic or confirm our current practices.



The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.



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What to Expect from Today's Session

- We will present and discuss the top 4 article selections and provide a list of honourable mentions.
- Please submit questions through the Q&A function.
- This session is being recorded and will be shared with registrants within the next week.
- Recordings, slides and links to articles from all our sessions are available at www.echopalliative.com/palliative-care-journal-watch/.
- Check out the Palliative Care Journal Watch Podcast.
- This 1 credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **8 Mainpro+ credits** (each 1-hour session is worth 1 Mainpro+ credit).

Introductions

Host

Dr. José Pereira, MBChB, CCFP(PC), MSc, FCFP, PhD

Professor and Director, Division of Palliative Care, Department of Family Medicine, McMaster University, Hamilton, ON, Canada

Scientific Officer and Co-Founder, Pallium Canada

Professor, Faculty of Medicine, University of Navarra, Spain

Guest Panelist

Dr. Aynharan Sinnarajah, MD CCFP(PC) MPH

Chair, Dr. Gillian Gilchrist Palliative Care Research, Division of Palliative Care, Queen's University / Lakeridge Health, ON, Canada

Dr. Adrienne Selbie, MD CCFP(PC)

Palliative Care Specialist and Assistant Professor at Queen's University, Kingston, ON, Canada.

Disclosures

Pallium Canada

- Not-for-profit.
- Funded by:
 - Health Canada (through contribution agreements 2001-2007, 2013-2018), Patrick Gillin Family Trust (2013-2016), Li Ka Shing Foundation (2019 to current), CMA (2019 to 2022), Boehringer Ingelheim (dissemination of LEAP Lung courses 2019 to current).
 - Partnerships with some provincial bodies.
 - Revenues from LEAP course registration fees and licenses, sales of Pallium Palliative Pocketbook.

This program has received financial support from:

- Health Canada in the form of a contribution program.

Disclosures of Host/Guest Panelists:

- Dr. José Pereira: Scientific Advisor, Pallium Canada.
- Dr. Adrienne Selbie: No conflicts of interest to declare
- Dr. Aynharan Sinnarajah: No conflicts of interest to declare

Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content.

Featured articles

1. Chi N-C, Nakad L, Han S, et al. **Family Caregivers' Challenges in Cancer Pain Management for Patients Receiving Palliative Care.** American Journal of Hospice and Palliative Medicine®. 2023;40(1):43-51. <https://pubmed.ncbi.nlm.nih.gov/35503240/>
2. Groninger H, Nemati D, Cates C, Jordan K, Kelemen A, Shipp G, Munk N. **Massage Therapy for Hospitalized Patients Receiving Palliative Care: A Randomized Clinical Trial.** J Pain Symptom Manage. 2023 May;65(5):428-441. doi: 10.1016/j.jpainsymman.2023.01.011. Epub 2023 Jan 31. PMID: 36731805. <https://pubmed.ncbi.nlm.nih.gov/36731805/>
3. Reblin M, Jacob E, Tay DL, Li H, Thomas Hebdon MC, Beck A, Donaldson G, Cloyes KG, Ellington L. **Family Caregiver Reports of Their Own and Patient Symptoms in Cancer Home Hospice Approaching End-of-Life.** Am J Hosp Palliat Care. 2023 May;40(5):508-516. doi: 10.1177/10499091221108119. Epub 2022 Jun 10. PMID: 35689339; PMCID: PMC9734284. <https://pubmed.ncbi.nlm.nih.gov/35689339/>
4. Zhukovsky DS, Heung Y, Enriquez P, Itzep N, Lu Z, Nortje N, Stanton P, Wong A, Bruera E. **Just-in-Time Decision Making: Preliminary Findings of a Goals of Care Rapid Response Team.** J Pain Symptom Manage. 2023 Apr;65(4):e337-e343. doi: 10.1016/j.jpainsymman.2022.11.022. Epub 2022 Dec 8. PMID: 36496112; PMCID: PMC9729166. <https://pubmed.ncbi.nlm.nih.gov/36496112/>

Family Caregivers' Challenges in Cancer Pain Management for Patients Receiving Palliative Care

Article Reference:

Chi N-C, Nakad L, Han S, et al. American Journal of Hospice and Palliative Medicine®. 2023;40(1):43-51.

Selected by:

Aynharan Sinnarajah

Presented by:

Aynharan Sinnarajah

Key Points

- 60% of individuals with advanced cancer have pain; 38% experience moderate to severe pain
- Crucial role that family caregivers play in managing pain for their loved ones with cancer.
- Need knowledge and skills in pain assessment and management, overcome their own fear and concerns about pain management
- Limited research on the specific challenges faced by family caregivers in providing pain management to cancer patients receiving palliative care. They were afraid to manage pain and medications. They needed more info on pain management and medications. They needed strategies to communicate with their care team about this.
- The article aims to address this gap in knowledge and provide insights into potential solutions or interventions to alleviate these challenges.

Methods Used

- Secondary analysis of a study of caregivers who participated in a clinical trial looking at caregiving challenges. Patients had cancer and received outpatient palliative care
- In person or phone interview; 30-minute interviews
- Caregivers: Anyone defined as caregiver by patient
- Qualitative approach → Deductive thematic analysis
- In-person or telephone interviews with family caregivers of cancer patients receiving palliative care.

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Key Findings/Results:

- 40 caregivers
- Caregiver demographic characteristics: Average age 77 yo. Most female, Caucasian, college-educated or higher, and spouses or parents. Most spent >20 hours / week caregiving x > 1 year
- Patient demographic characteristics: Average age 59 yo. Most female, Caucasian, Married. 2 most common cancers: Lung, Colorectal.
- 3 categories of challenges faced by family caregivers
 1. **Communication and teamwork issues:**
 - Inadequate guidance re: pain management from care team (e.g. Lack of guidance when patient discharged from hospital)
 - Difficulties in communicating with healthcare teams: Stigma conveyed by healthcare team
 - Inappropriate communication amongst care teams: Oncology and palliative care teams had 2 different pain management plans
 - Ineffective pain management plan: Balance of adequate pain relief and side effects
 2. **Caregiver-related issues:** Emotional distress, Lack of knowledge or skills in pain management (sometimes did Google / WebMD searches to learn more), Physical strain (continuously tracking pain meds; ensuring safe use; interfere with other responsibilities like work)
 3. **Patient-related issues:** Difficulty assessing pain levels, Reluctance to report pain or take medication, Side effects from pain medication
- Family caregivers who were older, female, or had lower levels of education reported more challenges in managing pain for their loved ones with cancer

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Summary of Key Points:

- Provides insights into potential solutions or interventions to alleviate these challenges, including improving communication between healthcare teams and family caregivers, providing education and training on pain management for family caregivers, and addressing emotional distress through counseling or support groups
- Emphasizes the need for healthcare providers to recognize and support the important role of family caregivers in managing pain for their loved ones with cancer receiving palliative care
- Need further research to better understand the experiences of family caregivers in managing pain for their loved ones with cancer receiving palliative care and to develop effective interventions to address these challenges

Importance of Article

- Challenges of caregiving for patients with pain (emotional burden of tracking medication use, additional burden if caregiver also working)
- Offer counseling or support groups for family caregivers to address emotional distress related to caregiving responsibilities.
- Seems important to enhance home care supports.
- Regular touch base with caregivers re: handling medication use, whether they know how to give opioids and how to assess pain
 - Improve communication (regular meetings or check-ins with family caregivers), providing clear and concise information about pain management, and involving family caregivers in decision-making processes
 - Education and training programs for family caregivers on pain management, including how to assess pain levels, how to administer medication, and how to manage side effects
- Potential gap in cancer pain management research (unmeasured variable of caregiver involvement, knowledge, comfort)

Discussion

Massage Therapy for Hospitalized Patients Receiving Palliative Care: A Randomized Clinical Trial

Article Reference:

Groninger H, Nemati D, Cates C, Jordan K, Kelemen A, Shipp G, Munk N. J Pain Symptom Manage. 2023 May;65(5):428-441.

Selected by:

Adrienne Selbie

Presented by:

Adrienne Selbie

Summary of Key Points:

- Non-pharmacologic care is a key element of symptom management in Palliative Care.
- Implementing such services in hospital settings can be challenging.
- Therapeutic massage is an effective strategy for improving QOL and pain control
- Question:
 - **What is the optimal dosage and delivery of massage therapy in inpatient setting?**

Methods:

Prospective Randomized 3-arm comparative effectiveness trial

Arms

1. Single Massage of 20 minutes.
 2. 3 consecutive days of 20-minute massage.
 3. 3 consecutive days of 10-minutes massage.
- Participants: Hospitalized patients receiving Palliative Care Consultation, who were expected to stay for at least 4 days.
 - Intervention:
 - Licensed Palliative Care Trained Massage Therapists
 - Individualized to each patients' symptoms and preference
 - Evaluation
 - McGill QOL questionnaire pre and post intervention (Primary)
 - ESAS, Distress Thermometer, Peace Question (secondary)

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Key Results/Findings:

- Participation:
 - 387 patients
 - 73-91% received full allotted intervention.
- Primary Analysis
 - Patients with baseline and follow up assessment completed
 - Symptoms: Pain (47%), wellbeing (46.0%), tiredness (42.0%), and distress (40.4%)
 - Interested in receiving massage again (95.7%, 89.2%, and 91.3% in Arms I-III, respectively)
 - **Many participants experienced clinically meaningful change in their symptoms but no dosing approach was superior to any other**
- Secondly (Repeated Measure) Analysis:
 - Distress
 - **“Frequency mattered more than the massage session duration.”**
 - Pain
 - **consistent across all study arms: only short-term improvements were found regardless of frequency and massage duration”.**

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Selected by:

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Summary of Key Discussion Points:

- First study to look at dosing differences in Massage therapy in Palliative Patients.
- Largest Massage Dosing Study for any patient population.
- Important Finding:
 - Massage had an acute positive impact on QOL, symptoms, well being (physical and psychological).
 - Frequency mattered more than duration.
 - Neither frequency or duration mattered significantly for pain improvement
 - Overall, More long-lasting benefit for frequency over duration

FINAL COMMENT

- Beyond effectiveness to specifics of Implementation; closer to effecting system integration and change

Discussion

Family Caregiver Reports of Their Own and Patient Symptoms in Cancer Home Hospice Approaching End-of-Life

Article Reference:

Reblin M, Iacob E, Tay DL, Li H, Thomas Hebdon MC, Beck A, Donaldson G, Cloyes KG, Ellington L. Am J Hosp Palliat Care. 2023 May;40(5):508-516.

Selected by:

Aynharan Sinnarajah

Presented by:

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Summary of Key Points:

- “Caregivers are involved in actively monitoring symptoms for home hospice patients and often act as a primary decision-maker regarding a course of intervention and administering care.”
- “Caregiving role is often associated with high levels of burden and psychological distress”.
- Patient and caregiver physical and psychological health can be interdependent.
- “Few studies have assessed the relationship between caregivers’ report of the patient’s health and their own symptoms over time, and particularly at end of life”
- Might help with targeted interventions.

Methods:

- “Multi-site longitudinal, observational study of cancer home hospice patients and their informal family caregivers (kin or non-kin).”
- 2017 – 2020 via hospice agencies (home hospice in US)
- Last 60 days of life
- Patients: >18 yo of age, cancer diagnosis, had a prognosis of 1 week or more to live, and had an eligible caregiver.
- Caregivers: >18 yo, could speak and understand English were eligible.
- Caregivers completed demographic data survey AND daily reports of symptoms (in last 24h) for patient and themselves.
- Summary of demographic variables
- Exploratory Factor Analysis: Combine outcomes into fewer domains (Patient symptoms, Caregiver symptoms, Caregiver outlook),
- Mixed effects analysis to explore associations between outcomes over time and as death approaches

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Key Results and Findings:

- 61 patient-caregiver dyads.
- Median 38 days before death, for 1st enrollment.
- At least 1 day of moderate-to-severe symptoms were reported in the majority of dyads.
 - Top 3 moderate to severe patient symptoms: Fatigue (68.5%), pain (49.6%), poor appetite (43.1%).
 - Top 3 moderate to severe caregiver symptoms: Lack of sense of peace (74.2%), not feeling positive (69.7%), fatigue (57%).
- High correlation between patient symptom severity and caregiver distress at patient symptom severity
- Previous scores for an individual positively predicted the next scores for that individual
- Previous patient symptoms positively associated with the next caregiver symptoms
- Previous caregiver symptoms negatively associated with next report of patient symptoms
- Previous patient symptoms positively associated with next report of caregiver outlook
- Patient and caregiver symptoms and caregiver outlook worsened over time
- Relationship between patient and caregiver symptoms strengthened closer to death

Family Caregiver Reports of Their Own and Patient Symptoms in Cancer Home Hospice Approaching End-of-Life

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Aynharan Sinnarajah

Summary of Key Discussion Points:

- One of first studies to assess caregiver reports of patient and their own symptoms.
- With the high symptoms in last 2 months of life, important to keep focusing on improved symptom management at EOL.
- As symptoms of patients worsened over time and usually positively associated, important to address symptoms early and often.
- Counterintuitive relationship of increased caregiver symptoms leading to less patient symptoms next → Caregivers working hard to improve patient symptoms to their own health's detriment; Maybe they view the improvement that their own caregiving is going to be further extended.
- Caregivers play an important role in symptom management.
- Caregiver distress is real and some related to symptom management.

Additional thoughts:

- Don't often think of caregiver suffering/symptoms and speaks to importance of also inquiring into caregiver health.
 - Challenge though is that we can't fully look after caregiver health and would likely advise them to go talk to their family physician etc.
- Focused primarily on caregiver psychological health
- The counterintuitive relationship is interesting. And it means that when a patient's symptoms are improving, caregiver's symptom might worsen still and should still be inquired about.
- Wonder about Intensity of home care supports and whether it helps with caregiver symptoms.

Discussion

Just-in-Time Decision Making: Preliminary Findings of a Goals of Care Rapid Response Team

Article Reference:

Zhukovsky DS, Heung Y, Enriquez P, Itzep N, Lu Z, Nortje N, Stanton P, Wong A, Bruera E. J Pain Symptom Manage. 2023 Apr;65(4):e337-e343.

Selected by:

Adrienne Selbie

Presented by:

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Summary of Key Points:

- Goals of Care Conversations should be part of a continuum of Advanced Care Planning Discussions.
- Absence can lead to care that is not aligned with patients' preferences, goals and values.
- Intervention
 - Goals of Care Rapid Response Team
 - All cancer patients
 - Deployed to clarify GOC for patients at high risk of requiring higher/ICU level care.
- Intervention Aim:
 - Feasibility assessment
 - Goal
 - "Promote patient and family understanding
 - medical situation
 - prognosis and treatment options
 - Ensure the medical team's understanding of the patient's GOC.

Offer GOC decision support in real time, prioritized by Patient Need

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Selected by:

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Methods:

- Recruitment
 - Patient identified as high risk of needing higher/ICU level care.
 - Daily review of the patient lists for the Medical emergency rapid interventions team, ICU.
 - Patients receiving high flow O2/Bipap.
 - Patients without ACP note in EMR
 - Participation approved by primary oncologist.
- Intervention:
 - Rapid response Team consultation within 24 h (often 3-4 hours).
- Invited Participants:
 - Patient, POA/SDM, other as desired by patient/POA/SDM
 - Primary medical oncologist, inpatient MRP, Critical Care Provider, Palliative Care GOC provider, SW, Ethicist, Chaplain.
- Process
 - Ethicist Led Meetings (focus on identification of difficult questions and value clarification).
 - Pall Care Specialist participated in all aspects of meetings + opportunity for ongoing clinical care.
- Assessment
 - Retrospective Chart review for Care limitation after GOC RRT intervention.
 1. Change in location to lower intensity unit
 2. Change from full code to DNR
 3. Withdrawal of life sustaining therapy

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Key Results/ Findings:

- 89 Patient referred, 85% received a total of 95 consultations from GOC RRT.
- Care Limitation occurred in 75% of patients.

Benefits:

- Extra support to Health Care Providers not as comfortable with acute GOC conversations
- Palliative Care Team to avoid negative associations of “mandatory referrals” while still increasing exposure to Palliative Approach to Care.

Findings:

- Feasible—85% referrals led to consultation.
 - Primary oncologists had a hard time getting to last minute meetings.
 - Requires a centre with +++ resources
- Limited Care Escalation
 - Change in resuscitation status (66%).
 - Change in location and withdrawal of life sustaining treatments (21%).

Summary of Key Discussion Points:

- Raises many further questions
 - Confirm de-escalation is more goal concordant care
 - Reproducibility? With fewer resources?
 - How important is the expert level communication in this process?
 - Is the Just-in-Time nature of this required?

Discussion

Honourable Mentions

1. Buchman DZ, Lo S, Ding P, Dosani N, Fazelzad R, Furlan AD, Isenberg SR, Spithoff S, Tedesco A, Zimmermann C, Lau J. **Palliative care for people who use drugs during communicable disease epidemics and pandemics: A scoping review on access, policies, and programs and guidelines.** Palliat Med. 2023 Apr;37(4):426-443. doi: [10.1177/02692163221143153](https://doi.org/10.1177/02692163221143153). Epub 2022 Dec 15. PMID: 36522840; PMCID: PMC9760505.
2. Kratina, S., Lo, C., Strike, C., Schwartz, R., & Rush, B. (2023). **Psychedelics to Relieve Psychological Suffering Associated with a Life-Threatening Diagnosis: Time for a Canadian Policy Discussion.** Healthcare Policy 18(4), 2-10. doi:[10.12927/hcpol.2023.27048](https://doi.org/10.12927/hcpol.2023.27048).
3. Bacon M, Kematich B, Suliman I, Scullion B, Chua I, Given S, Lally K. **Development of PharmPAL: A Collaborative Practice Pharmacy Clinic in Ambulatory Palliative Care.** Am J Hosp Palliat Care. 2023 May;40(5):475-479. doi: [10.1177/10499091221120593](https://doi.org/10.1177/10499091221120593). Epub 2022 Sep 2. PMID: 36052826.
4. Helgeson SA, Burnside RC, Robinson MT, Mack RC, Ball CT, Guru PK, Moss JE. **Early Versus Usual Palliative Care Consultation in the Intensive Care Unit.** Am J Hosp Palliat Care. 2023 May;40(5):544-551. doi: [10.1177/10499091221115732](https://doi.org/10.1177/10499091221115732). Epub 2022 Jul 14. PMID: 35833450.
5. Wentlandt K, Wolofsky KT, Weiss A, Hurlburt L, Fan E, Zimmermann C, Isenberg SR. **Differences in Palliative Care Provision by Primary and Specialist Providers Supporting Patients with COVID-19: A Qualitative Study.** J Palliat Med. 2023 Apr 27. doi: [10.1089/jpm.2022.0560](https://doi.org/10.1089/jpm.2022.0560). Epub ahead of print. PMID: 37103488.

Wrap-up

- Please fill out our feedback survey- a link will come up in your browser after this webinar ends.
- A recording of this webinar and a copy of the slides will be e-mailed to registrants within the next week.
- Recordings, slides and links to articles from all our sessions are available at www.echopalliative.com/palliative-care-journal-watch/.
- To listen to this session and previous sessions, check out the **Palliative Care Journal Watch** podcast.
- We hope to see you at our next session!



Thank You to our Journal Watch Contributors!

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Thank You



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