

Palliative Care Journal Watch

A partnership between Pallium Canada and several Divisions of Palliative Care and Medicine across Canada and Internationally:

University of Calgary, University of Alberta, Queens University, Hadassah-Hebrew University Medical Center, University of Navarra (Spain)

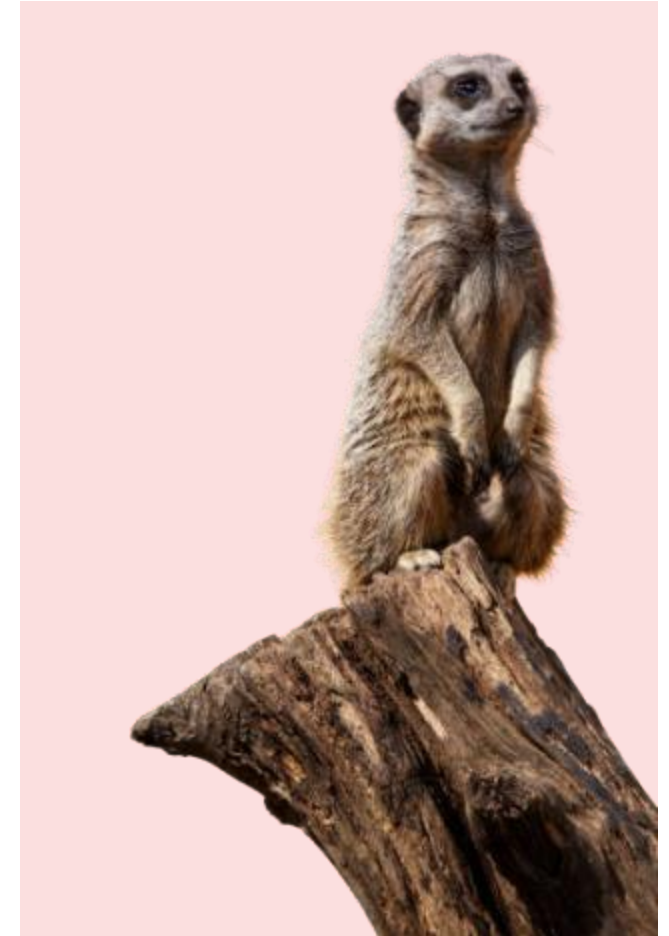


Hosts & Panelists: Dr. Jose Pereira, Dr. Leonie Herx, Dr. Sharon Watanabe, Dr. Aynharan Sinnarajah, Dr. Adir Shaulov

Date: November 19th, 2025

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 several divisions of palliative care/medicine across Canada and internationally.
 - University of Calgary
 - University of Alberta
 - Queen's University
 - Hadassah-Hebrew University Medical Center, Israel
 - University of Navarra, Spain
- With the assistance of the Pallium Canada team
- We regularly monitor over 30 journals and highlight articles that challenge us to think differently about a topic or confirm our current practices.



What to expect from today's session

- We will present and discuss our featured 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.

Introductions

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

Professor, Faculty of Medicine, and Institute for Culture and Society, University of Navarra, Spain.

Scientific Advisor and Co-Founder, Pallium Canada

Dr. Leonie Herx, MD, PhD, CCFP(PC), FCFP

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Director, Rotary Flames House, Children's Hospice & Palliative Care Services, Calgary, Alberta

Clinical Professor, Cumming School of Medicine, University of Calgary, Alberta

Senior Scientific Director, Palliative Institute, Alberta

Dr. Aynharan Sinnarajah, MD CCFP(PC) MPH

Chair, Dr. Gillian Gilchrist Palliative Care Research

Division of Palliative Care, Queen's University and Lakeridge Health, ON, Canada

Dr. Sharon Watanabe, MD, FRCPC

Director, Department of Symptom Control and Palliative Care, Cross Cancer Institute, Edmonton Zone, Alberta Health Services

Professor, Division of Palliative Care Medicine

Department of Oncology, Faculty of Medicine and Dentistry, University of Alberta

Guest panelist

Dr. Adir Shaulov

Director, Palliative Hematology Service, Department of Hematology, Hadassah Medical Center, Jerusalem, Israel

Director, Center for Dignified End-of-Life, Faculty of Medicine, Hebrew University of Jerusalem, Israel

Disclosures

Pallium Canada

- Pallium is a registered charity.
- Pallium generates funds to support operations and R&D from course registration and registration fees, sales of the Pallium Pocketbook sales, and philanthropy.

Mitigating Potential Biases:

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

Disclosures of Hosts/Guest Panelists:

- No conflicts of interest to disclose
 - Dr. José Pereira
 - Dr. Leonie Herx
 - Dr. Sharon Watanabe
 - Dr. Aynharan Sinnarajah
 - Dr. Adir Shaulov

Featured articles

1. Wang S, Fong R, Hui F, Seevaratnam B, Nguyen D, Teuteberg W. **Is Training Alone Enough? A Comparison of Serious Illness Communication Training With and Without Implementation Strategies**. Journal of Palliative Medicine. Published online September 9, 2025. doi:10.1177/10966218251376726
2. Schenker Y, Belin SC, Wang T, et al. **Facilitated Versus Patient-Directed Advance Care Planning Among Patients With Advanced Cancer: A Randomized Clinical Trial**. JCO Oncol Pract. 2025;21(10):1447-1457. doi:10.1200/OP-25-00046
3. Iqbal J, Moineddin R, Quinn KL, et al. **Novel Systemic Anticancer Treatments and Health Services Use at the End of Life Among Adults With Cancer**. J Clin Oncol. 2025;43(30):3279-3291. doi:10.1200/JCO-24-02816
4. Shah MP, Wenger NS, Glaspy J, et al. **Patient-reported discordance between care goals and treatment intent in advanced cancer**. Cancer. 2025;131(17):e35976. doi:10.1002/cncr.35976

Featured Articles

Is Training Alone Enough? A Comparison of Serious Illness Communication Training With and Without Implementation Strategies.

Article Reference:

Wang S, Fong R, Hui F, Seevaratnam B, Nguyen D, Teuteberg W. Is Training Alone Enough? A Comparison of Serious Illness Communication Training With and Without Implementation Strategies. Journal of Palliative Medicine. Published online September 9, 2025.
doi:10.1177/10966218251376726

Selected and Presented by:

Dr. Aynharan Sinnarajah

Background

- Serious illness communication is recognized as key for high-quality, patient-centered care, but adoption remains inconsistent in practice
- The Serious Illness Care Program (SICP) provides standardized tools and training for clinicians to support timely advance care planning discussions
- Prior studies show that training alone raises clinician confidence but doesn't reliably change behavior or documentation practices long term

Methods

- Retrospective review of SICP impact (Oct 2020 - May 2023);
 - Stanford Health Care (San Francisco): 2 hospital campuses, 60 outpatient clinics
- Intervention groups: (1) Training Only (didactic (1hr), role play (1-2hr), EHR demo), and (2) Training + Implementation (structured patient ID, data feedback, coaching, department specific QI incentives)
- Participants: Physicians, Physicians-in-training, Advanced practice providers, SW, OT, Nurses, Dietitian, Case managers across departments
- Outcomes: Frequency of documented SICs (never/seldom (1-4) /occasional (5-11) /frequent (≥ 12) users) within 1 year after training; Sustained usage over 6 consecutive months (at least 1/mth)
 - Documented SICs must include shared prognosis statement, patient values

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Key Results

- N=940 clinicians (Training + Implementation: 631; Training only: 309)
- Training with Implementation group had a lower percentage of “never users” (57.6%) than Training Only (78.9%) [$p < 0.01$]
- Documented SICs increased across all usage categories (seldom: 23.5% vs 14.6%, occasional: 10.2% vs 4.2%, frequent: 8.5% vs 2.2%; all $p < 0.01$).
- Sustained users (at least one SIC each month for six months): much higher in Implementation group (9.4% vs 1.6%, $p < 0.01$).
- Implementation support positively affected both short-term and long-term adoption rates.
- Data dashboards and standardized templates enabled performance tracking and accountability.

Key discussion points

- Behavioral change is facilitated by infrastructure: coaching, accountability, workflow integration, and incentives.
- Team-based approaches and leadership support are critical for practice change and sustainability.
- Higher rates of documentation may reflect genuine engagement but could also be influenced by incentives or department priorities.
- Training programs initiated requests for ongoing education, reinforcing their intrinsic value even if practice change is incomplete.
- Structured documentation is an imperfect but practical proxy for improved patient-centered conversations

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Strengths

- Engaged clinicians from diverse disciplines and departments, inpatient and outpatient
- Used standard EHR templates and real-time feedback for robust data collection
- Multi-component implementation support (coaching, incentives, workflow redesign)
- Large sample size (940 clinicians) and extended observation period (up to 12 months)

Limitations

- Non-randomized, retrospective design limits ability to infer causality; baseline differences may exist
- Organizational context, incentive programs, and variable department engagement may confound results (not randomized)
- Documentation rates do not necessarily capture conversation quality, patient experience, or goal concordance
- Single-site study may limit generalizability to other systems or regions

Practice Impact

- System-level support and infrastructure are crucial for advancing serious illness communication beyond traditional training models
- Implementation strategies improve not just adoption, but also the sustainability and routine integration of SICs into workflow
- Study reinforces that **BOTH** educational and organizational investments are needed to foster high-value, patient-centered care.

Discussion

Facilitated Versus Patient-Directed Advance Care Planning Among Patients With Advanced Cancer: A Randomized Clinical Trial.

Article Reference:

Schenker Y, Belin SC, Wang T, et al. Facilitated Versus Patient-Directed Advance Care Planning Among Patients With Advanced Cancer: A Randomized Clinical Trial. JCO Oncol Pract. 2025;21(10):1447-1457. doi:10.1200/OP-25-00046

Presented by:

Dr. Jose Pereira

Background

- Advance care planning (ACP) is important component of care: Person-centred.
- ACP defined as:
 - “a process that supports... understanding and sharing personal values, life goals, and preferences regarding future medical care,”
- Various approaches (vary in complexity and costs): e.g.
 - In-person facilitated ACP (structured conversations led a trained facilitator).
 - Written and web-based ACP tools (self-paced completion by pts).

Study aim:

- Compare impact of facilitated ACP (trained facilitator) versus model with a patient-directed website and written materials (PREPARE for Your Care)
- PEACe-compare Study (Patient Centered and Efficacious Advance Care Planning in Cancer)

Methods

- Participants randomly assigned to one of the two groups.
- Primary outcome:
 - Patient-reported ACP engagement (Baseline and 12 weeks).
 - 15-item validated survey
- Secondary outcomes: Advance directive completion and EOL communication
- Adult patients with advanced solid tumors and their caregivers; academic and community oncology clinics.

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Presented by:

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Key Results

- n= 400 patients enrolled (mean age, 67.9 yrs, women 48%, mainly ECOG 1 and 2).
- At 12 weeks, Pts in facilitated vs patient-directed group reported:
 - Higher ACP engagement (4.34 v 4.08)
 - Higher odds of completing an advance directive (74.8% v 60.6%; OR, 2.52).
 - No differences between the facilitated and patient-directed groups in the odds of having a conversation about EOL wishes with family or friends or physicians
 - All ACP behaviors increased significantly from baseline in both groups.

Key discussion points

- Both approaches impactful.
- Suggest Stepped approach in practice: 1st patient-direct, then facilitated if needed.

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Presented by:

Dr. Jose Pereira

Strengths

- Randomized study, relatively large

Limitations

- 36% of eligible patients declined participation (risk of nonresponse bias).
- Not possible to blind patients to the intervention.
- 33% of patients died or were lost to follow-up before 12-week outcome assessments.

Practice Impact

- Individualize approach to initiating ACP.

Discussion

Novel Systemic Anticancer Treatments and Health Services Use at the End of Life Among Adults With Cancer.

Article Reference:

Iqbal J, Moineddin R, Quinn KL, et al. Novel Systemic Anticancer Treatments and Health Services Use at the End of Life Among Adults With Cancer. J Clin Oncol. 2025;43(30):3279-3291. doi:10.1200/JCO-24-02816

Presented by:

Dr. Sharon Watanabe

Background

- Known: Receipt of chemotherapy in the last 30 days of life is associated with poor quality of end-of-life (EOL) care
- Unknown: Trends in the use of novel systemic anticancer treatments (SACT) e.g. immunotherapy, targeted therapy in Canada, and their impact on quality of EOL care
- Purpose: Examine trends in SACT use and association with quality of EOL care in Ontario

Methods

- Design: Population-based, retrospective observational cohort study using linked health administrative data
- Cohort:
 - Adults in Ontario
 - Died 2015-2021
 - Diagnosed with cancer within 5 years of death
 - Received SACT (chemotherapy, hormonal therapy, immunotherapy, targeted therapy, combination)
- Outcomes and variables:
 - Receipt of last dose of SACT in last 30 days of life
 - ≥ 2 ED visits, ≥ 2 hospitalizations, ≥ 1 ICU admission in the last 30 days of life
 - Death in hospital/ED
 - Primary outcome: high health services use at EOL (composite indicator of above three outcomes)
- Statistical analyses
 - Interrupted time series (ITS) analysis using segmented linear regression for trends in SACT and health services use
 - Univariable and multivariable logistic regression analyses adjusted for sociodemographic and clinical variables
 - Examine association of SACT at EOL with health services use at EOL and hospital/ED death
 - Exploratory subgroup analyses by cancer type (hematologic malignancies vs solid tumors) and cancer stage (stage I-III vs stage IV)

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Presented by:

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Key Results

- Cohort: 68,963 patients
- Receipt of SACT at EOL: 18,337 (26.6%) → 11,342 (61.9%) chemotherapy alone; 1,811 (9.9%) chemotherapy and immunotherapy; 2,506 (13.7%) immunotherapy alone; 1,407 (7.7%) targeted therapy alone; 954 (5.2%) hormonal therapy alone; 317 (1.7%) other combinations
- Trend in receipt of SACT at EOL: Increased by 0.072% per month, mainly driven by an increase of 0.064% per month ($P < .001$) of immunotherapy alone
- Univariable analysis - SACT (vs no SACT) at EOL: Significantly more likely to have high health services use (42.4% vs 24.2%), including ≥ 2 ED visits (23.5% vs 13.0%), ≥ 2 hospitalizations (16.3% vs 9.3%), ≥ 1 ICU admission (19.1% vs 9.7%), and more likely to die in hospital (62.0% vs 37.1%)
- Multivariable analysis - SACT (vs no SACT) at EOL:
 - Associated with increased odds of high health services use (adjusted odds ratio [aOR] 2.12) and hospital death (aOR, 2.61)
 - 2.36 chemotherapy and immunotherapy, 2.20 chemotherapy alone, 1.92 immunotherapy alone, 1.75 targeted therapy alone.
 - Patients who received chemotherapy and immunotherapy had highest odds of ≥ 1 ICU admission at the EOL (aOR 2.63) and hospital death (aOR 3.10).
- Subgroup analyses:
 - aORs of high health services use according to SACT at EOL were similar or greater among patients with solid tumours vs hematologic malignancies and stage IV vs stage I-III cancers
- Trend in health services use at EOL:
 - Patients who received both chemotherapy and immunotherapy at EOL → marginal monthly increase of 0.111% ($P = .042$) in rate of high health services use and statistically significant monthly increase of 0.088% ($P = .001$) in rate of hospital death

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Key discussion points

- In this population-based study of over 68,000 adults with cancer, the rate of SACT at EOL increased significantly between March 2015 and March 2021, driven mainly by increased receipt of immunotherapy
- Receiving SACT at EOL was associated with high health services use at EOL and increased hospital deaths, even after accounting for medical and demographic characteristics
- Several possible reasons (provider, patient, organization) for increasing rates of SACT and immunotherapy at EOL
- Recent study: practices with higher rates of SACT at EOL did not have improved survival vs those with lower rate

Strengths

- Conducted in a country with single-payer national health system
- Data coverage of entire population of Ontario

Limitations

- Associations rather than direct causation
- Unable to account for some potentially confounding factors, e.g. ethnicity/race, religious/cultural affiliation
- Unable to assess patient preferences regarding care at EOL, characteristics of individual prescribing clinicians, or the prevalence and content of EOL discussions

Practice Impact

- Clinicians should carefully consider patient prognosis, toxicities, and likelihood of benefit from SACT, including immunotherapy and targeted therapy (not necessarily less toxic)
- Timely goals of care discussions should be prioritized over commencing/continuing SACT in patients with far advanced cancer
- Guidelines regarding SACT at EOL need to be updated to include novel therapies

Discussion

Patient-reported discordance between care goals and treatment intent in advanced cancer.

Article Reference:

Shah MP, Wenger NS, Glaspy J, et al. Patient-reported discordance between care goals and treatment intent in advanced cancer. Cancer. 2025;131(17):e35976. doi:10.1002/cncr.35976

Selected and presented by:
Dr. Adir Shaulov

Background

- Advance care planning and communication helps achieve medical care consistent with patient values goals and preferences
- There is little data on concordance between patients' preferred goals and the care they actually receive

Methods

- Post-hoc cross-sectional analysis of baseline survey data from a prospective study (published in 2019) of different tools to promote advance care planning in serious illness, performed at three large centers (UCLA, UCSF, UC Irvine)
- Participants: Patients with cancer, heart failure, COPD, renal disease, liver disease or ALS, in addition to either age>75 or advanced features (poor prognosis, developing incapacity, worsening functional status, or high burden of disease) as identified by an automated validated algorithm. Must be over 18, have had at least 2 primary care visits over 12 months and have no advance directive or physician order for EoL care over the past 3 years
- Outcomes: Concordance between baseline patient responses as to the care they would prefer in their current condition and the care they perceive that they are receiving:
 - Medical care that focuses on **extending** your life as much as possible, even if it means having more pain and discomfort (**life-extending care**)
 - Medical care that focuses on **relieving** your pain and discomfort as much as possible, even if that means not living as long (**comfort-focused care**)
 - I am not sure
- Other baseline data: demographic characteristics (age, gender, race, ethnicity, language, and partnered status), quality of physician communication (Consumer Assessment of Healthcare Providers and Systems communication scale), general mental and physical health (Patient-Reported Outcomes Measurement and Information System global physical and mental health items), depression and anxiety (Patient-Reported Outcomes Measurement and Information System-29)
- Mortality data was captured at 24 months

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Key Results

- 1100 patients completed baseline survey: 231 advanced cancer, 163 advanced heart failure, 109 advanced COPD, 213 advanced renal disease, 72 advanced liver disease, 0 advanced ALS, 311 advanced age + one of the above
- Cancer patients were younger than those with other serious illness (62 vs 71y), more likely to be in a committed relationship (71% vs 57%), report better mental and physical health [$p<0.01$]
- Physician communication scores and 24-month mortality were similar among cancer and non-cancer patients, as well as those wishing for life-extending or comfort-focused care
- Cancer patients had similar goals of care to non-cancer patients (25% vs 23% life-extending, 49% vs 48% comfort-focused)
- However, cancer patients were more likely to report receiving life-extending care (51% vs 35%) and less likely to report receiving comfort-focused care (19% vs 28%) [$p<0.01$].
- Among patients preferring comfort-focused care ($n=526$), cancer patients ($n=113$) were more likely than non-cancer patients ($n=413$) to report receiving life-extending care (37% vs 19%) [$p<0.01$]
- Mortality of cancer patients wishing for comfort-focused care was not statistically significant whether receiving goal concordant or discordant care

Key discussion points

- Cancer patients with comfort-focused care goals are more likely to receive goal-discordant care than non-cancer patients. Possible causes may include:
 - Communication gaps in cancer patients (although communication scores were similar)
 - Cancer patients were younger and more fit, which may affect communication
 - Toxicity of cancer treatment may cause misunderstanding of the goal of treatment received

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Strengths

- Insight as to patients' wishes and perception of their treatment
- Similarity between the groups

Limitations

- The study refers to patient perception of clinician goals, rather than data from clinicians – Is this true or perceived goal discordance? Which is important?
- The survey presented a dichotomy of comfort vs life-prolongation that does not accurately represent reality
- Potential heterogeneity of diseases was not captured
- Multiple sites in a single state may not be relevant to other settings
- Patients with advance care directives were excluded
- Data prior to 2019
- Post-hoc analysis

Practice Impact

- Communication skills are of importance in achieving goal concordant care, and emphasis should be put on this competency
- Good communication should be bidirectional; patients' goals of care should be ascertained, and the intention of the physician in instituting treatment should be made explicit

Honourable Mentions

1. Higginson IJ, Bajwah S, Krajnik M, Jolley CJ, Hui D. **Recent advances in understanding the role of antidepressants to manage breathlessness in supportive and palliative care.** Current Opinion in Supportive & Palliative Care. 2025;19(2):83-94. doi:10.1097/SPC.0000000000000761
2. Cherny NI, Nortjé N, Kelly R, et al. **A taxonomy of the factors contributing to the overtreatment of cancer patients at the end of life. What is the problem? Why does it happen? How can it be addressed?** ESMO Open. 2025;10(1):104099. doi:10.1016/j.esmoop.2024.104099
3. Bergerot CD, Bergerot PG, Razavi M, et al. **The impact of a geriatric assessment-guided management intervention (GAIN-S) on prognostic awareness: A randomized controlled trial.** Cancer. 2025;131(17):e70054. doi:10.1002/cncr.70054
4. Othman NO, Abdel-Aal HH, Elsherief WA, Farag DE, Hunter CN, Alsirafy SA. **Olanzapine for Anorexia in Patients With Incurable Cancer and Cachexia (OIAncCa): A Double-Blind, Placebo-Controlled, Randomized Clinical Trial.** Journal of the National Comprehensive Cancer Network. 2025;23(9):385-392. doi:10.6004/jnccn.2025.7033

Wrap-up

- Please fill out our feedback survey a link has been shared in the chat!
- A recording of this webinar and a copy of the slides will be e-mailed to registrants within the next week.
- To listen to this session and previous sessions, check out the **Palliative Care Journal Watch** podcast.



NOTE: recordings, slides and links to articles from all our sessions are available at www.echopalliative.com/palliative-care-journal-watch/.

Thank You to our Journal Watch Contributors!

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Thank You



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