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# Clinical Update: Literature Abstracts

## MEASURES

### Brief Cognitive Assessment of Cancer Patients: Evaluation of the Mini-Mental State Examination (MMSE) Psychometric Properties

Mystakidou, K., Tsilika, E., Parpa, E., Galanos, A., and Vlahos, L.

*Psychooncology*, *16* (2007), 352–357.

The aim of the present study was to validate the Greek version of the MMSE in advanced-cancer patients attending a palliative care unit. The sample consisted of 103 advanced-cancer patients. The questionnaire was completed at baseline and three days later. Together with the MMSE, the patients also completed the EORTC QLQ-C30 Cognitive functioning scale, and researchers recorded data on demographic characteristics, disease status, and treatment regimen. MMSE had overall Cronbach alpha of .890. Validity as performed using known-group analysis showed good results. MMSE discriminated well between subgroups of patients differing in disease severity as defined by ECOG performance status. Comparison between the MMSE and the EORTC Cognitive functioning scale was statistically significant ($p < .05$). These psychometric properties of the Greek version of the MMSE confirm it as a valid and reliable measure when administered to patients with advanced cancer.

### The Concept And Measurement of Meaning in Life in Dutch Cancer Patients

Jaarsma, T.A., Pool, G., Ranchor, A.V., and Sanderman, R.

*Psychooncology*, *16* (2007), 241–248.

We investigated the psychometric properties of a Dutch translation of the Personal Meaning Profile in a heterogeneous group of cancer patients. Our study resulted in a relatively short scale consisting of 39 of the 57 original items, divided into five factors, labeled "relation with God," "dedication to life," "fairness of life," "goal-orientedness," and "relations with other people," which can be summed to a total score of the experience of meaning in life. The internal consistency of the total scale as well as of its subdimensions was high. The experience of meaning in life was positively related to feelings of psychological well-being and negatively to feelings of distress. Furthermore, the experience of meaning in life was also related to traitlike characteristics as personality. Future research can investigate its appropriateness for populations other than cancer patients, and if and how the experience of meaning in life eventually changes as a result of existential threats.

### Validation of the French Version of the Brief Pain Inventory in Canadian Veterans Suffering from Traumatic Stress

Poundja, J., Fikretoglu, D., Guay, S., and Brunet, A.

*Journal of Pain and Symptom Management*, *33* (2007), 720–726.

Although pain is a significant clinical problem in individuals suffering from post-traumatic stress disorder (PTSD), reliable and valid measures of pain for this population are lacking. The goal of this study was to validate the Brief Pain Inventory (BPI) in French-speaking veterans suffering from PTSD ($n = 130$). We administered the BPI, as well as measures of PTSD, health status, quality of life, and social desirability, to veterans being assessed or treated for PTSD at a Veterans Affairs Canada clinic. The BPI showed strong internal consistency, as evidenced by Cronbach's alphas of .90 and .92 for the severity and interference subscales, respectively. Similar to previous findings, a two-factor structure (pain severity and pain interference) was found using an exploratory factor analysis. The two factors explained nearly 73% of the variance of the instrument. The BPI was also strongly correlated with health status and quality of life in the physical domain. In this veteran sample, nearly 87% of the veterans suffered from significant current pain. Veterans in our sample reported rates of pain severity that were similar to or higher than most of those reported by cancer patients and others with significant physical disability/illness. Overall,

the French version of the BPI is a reliable, valid measure of pain in PTSD-suffering populations. Pain is a major issue in veterans with PTSD and should be screened for with instruments such as the BPI.

### A Questionnaire to Evaluate the Knowledge and Attitudes of Health Care Providers on Pain

Zanolin, M.E., Visentin, M., Trentin, L., Saiani, L., Brugnolli, A., and Grassi, M.

*Journal of Pain and Symptom Management*, *33* (2007), 727–736.

The aims of this study were to survey the knowledge and attitudes of Italian health care professionals toward pain and develop a valid instrument to assess pain knowledge of physicians and nurses. A 21-item questionnaire on a Likert scale was given to 4961 health professionals in 20 hospitals in Italy who volunteered to participate in the study. The results were analyzed psychometrically in three phases: the Principal Component Analysis phase identified two components, of which only the one that had 10 items about pain knowledge and attitudes (PAK) was studied; the Homogeneity Analysis revealed its acceptable internal reliability (Cronbach's alpha = .72) and confirmed the Likert equidistance of the item options response; the Confirmatory Factor Analysis proved that it had a very good construct validity. A standardized score was calculated on the PAK questionnaire using the final 10 selected items, considering 100% as the best level of knowledge of pain management and 0% as the worst. The standardized mean score on the whole sample was equal to 52.6% (95% confidence interval: 52.3%–53.0%). There was a statistically significant difference ($p < .001$) in percentage score between physicians (56.5%) and nurses (51.3%). Knowledge was best among physicians in anesthesiology and emergency; this was followed by doctors in medicine and then surgeons. The knowledge of nurses was almost constant. This scale fills a void by providing a validated instrument for testing the general knowledge about pain treatment of hospital staff. It is brief and can easily be administered to a considerable number of people.

### Length of Survival of Patients with Cancer in Hospice: A Retrospective Analysis of Patients Treated at a Major Cancer Center versus Other Practice Settings

Younis, T., Milch, R., Abul-Khoudoud, N., Lawrence, D., Mirand, A., and Levine, E.G.

*Journal of Palliative Medicine*, *10* (2007), 381–389.

This is a retrospective study of the length of survival (LOS) in hospice of patients with cancer treated at a major cancer center compared to other treatment sites. Of 670 patients, the 185 (28%) treated at a major cancer center had unique characteristics, including higher median Palliative Performance Score (PPS) at the time of hospice enrollment (45 vs. 40, $p = .009$) and longer median LOS in hospice (35 vs. 21 days, $p = .02$: log rank test). Additional variables that predicted longer LOS were higher PPS, Medicare or Medicaid, self-referral, unmarried status, and nonexecuted advance directives. After adjusting survival for PPS with a Cox proportional hazard model, the hazard ratio for PPS remained statistically significant (95% confidence interval [CI]: 0.95–0.97) whereas that for the treatment site was not (95% CI: 0.73–1.04). The performance status, and not the treatment site, was the dominant predictor of the LOS of patients with cancer in hospice.

## SYMPTOM CONTROL

### Pilot Evaluation of Hypnosis for the Treatment of Hot Flashes in Breast Cancer Survivors

Elkins, G., Marcus, J., Stearns, V., and Hasan Rajab, M.

*Psychooncology*, *16* (2007), 487–492.

This single-arm, pilot study investigated the use of hypnosis to reduce hot flashes in 16 breast cancer survivors. Each patient provided baseline data and received four weekly sessions of hypnosis that followed a standardized transcript. Patients were also instructed in self-hypnosis. Throughout the clinical care, patients completed daily diaries of the frequency and severity of their hot flashes. Patients also completed baseline and posttreatment ratings of the degree to which hot flashes interfered with daily activities and quality of life. Results indicated a 59% decrease in total daily hot flashes and a 70% decrease in weekly hot flash scores from their baselines. There was also a significant decrease in the degree to which hot flashes interfered with daily activities for all measures including work, social activities, leisure activities, sleep, mood, concentration, relations with others, sexuality, enjoyment of life, and overall quality of life. This pilot study suggests that clinical hypnosis may be an effective nonhormonal and nonpharmacological treatment for hot flashes. A randomized, controlled clinical trial is planned to more definitively elucidate the efficacy and applicability of hypnosis for reducing hot flashes.

### Evaluation of Cognitive Function Associated with Chemotherapy: A Review of Published Studies and Recommendations for Future Research

Vardy, J., Rourke, S., and Tannock, I.F.

*Journal of Clinical Oncology*, *10* (2007), 2455–2463.

There is evidence that some cancer survivors suffer cognitive impairment after chemotherapy. Determining if a patient has cognitive impairment is challenging, especially because impairment is usually subtle. We assessed the design of studies evaluating cognitive function during or after chemotherapy in adult patients with solid tumors. We also reviewed methods used to evaluate cognitive function in subjects with other diseases and make recommendations for future studies. We identified 22 studies that met our criteria: 82% included women with breast cancer. Eight studies were longitudinal, 12 were cross-sectional, and 2 were follow-ups of cross-sectional studies. Sixteen studies used a battery of neuropsychological (NP) tests to assess subjects, and 13 included a control group. Ten studies (45%) had no explicit definition of cognitive impairment; most others used $z$ scores or $T$ scores and defined impairment based on standard deviations below the mean, but there was no consistency for the cutoff point used or the number of tests required. There is no consistency in defining cognitive impairment, in the NP batteries used, or in statistical methods in studies of cognitive function of cancer patients. We suggest guidelines to define criteria for cognitive impairment. Use of summary scores and control groups is recommended. Practice effect should be adjusted for in longitudinal studies. A balance is needed between comprehensive batteries and briefer tests, which still need to be sensitive to mild impairment.

### Donepezil for Cancer Fatigue: A Double-Blind, Randomized, Placebo-Controlled Trial

Bruera, E., El Osta, B., Valero, V., Driver, L.C., Pei, B.L., Shen, L., Poulter, V.A., and Palmer, J.L.

*Journal of Clinical Oncology*, *25* (2007), 3475–3481.

The objective of this paper is to evaluate the effectiveness of donepezil compared with placebo in cancer patients with fatigue as measured by the Functional Assessment for Chronic Illness Therapy-Fatigue (FACIT-F). Patients with fatigue score $\geq 4$ on a scale of 0 to 10 (0 = no fatigue, 10 = worst possible fatigue) for more than 1 week were included. Patients were randomly assigned to receive donepezil 5 mg or placebo orally every morning for 7 days. A research nurse contacted the patients by telephone daily to assess toxicity and fatigue level. All patients were offered open-label donepezil during the second week. FACIT-F and/or the Edmonton Symptom Assessment System (ESAS) were assessed at baseline and days 8, 11, and 15. The FACIT-F fatigue subscale score on day 8 was considered the primary end point. Of 142 patients randomly assigned to treatment, 47 patients in the donepezil group and 56 in the placebo group were assessable for final analysis. Fatigue intensity improved significantly on day 8 in both donepezil and placebo groups. However, there was no significant difference in fatigue improvement by FACIT-F ($p = .57$) or ESAS ($p = .18$) between groups. In the open-label phase, fatigue intensity continued to be low as compared with baseline. No significant toxicities were observed. Donepezil was not significantly superior to placebo in the treatment of cancer-related fatigue.

### The Desire for Hastened Death in Patients with Metastatic Cancer

Rodin, G., Zimmermann, C., Rydall, A., Jones, J., Shepherd, F.A., Moore, M., Fruh, M., Donner, A., and Gagliese, L.

*Journal of Pain and Symptom Management*, *33* (2007), 661–675.

A substantial minority of patients in palliative care settings report a high desire for hastened death (DHD), in association with physical and emotional distress, low social support, and impaired spiritual well-being. To clarify to what extent DHD emerges in association with suffering prior to the end of life, we determined its prevalence and correlates in ambulatory patients with metastatic cancer, the majority of whom had an expected survival of $>6$ months. We hypothesized that DHD in this sample would be directly linked to physical and psychological distress and inversely related to perceived social support, self-esteem, and spiritual well-being. Three hundred twenty-six outpatients completed the Schedule of Attitudes Toward Hastened Death (SAHD), Brief Pain Inventory, Memorial Symptom Assessment Scale, Beck Depression Inventory-II (BDI-II), Beck Hopelessness Scale (BHS), Medical Outcomes Study Social Support Survey, FACIT-Spiritual Well-Being Scale, Rosenberg Self-Esteem Scale, and Karnofsky Performance Status. Over 50% of participants reported pain, $>20\%$ reported elevated levels of depression (BDI-II $\geq 15$) and hopelessness (BHS $\geq 8$), but $<2\%$ had a high DHD (SAHD $\geq 10$). DHD was correlated positively with hopelessness, depression,

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and physical distress and negatively with physical functioning, spiritual well-being, social support, and self-esteem; it was not associated with treatment status or proximity to death. Over 34% of the variance in predicting SAHD scores was accounted for by hopelessness, depression, and functional status. The relative absence of a strong DHD in this sample suggests that the will to live tends to be preserved in cancer patients prior to the end of life, in spite of significant emotional and physical suffering.

### Objective Physical Activity and Self-Reported Quality of Life in Patients Receiving Palliative Chemotherapy

Dahele, M., Skipworth, R.J., Wall, L., Voss, A., Preston, T., and Fearon, K.C.

*Journal of Pain and Symptom Management*, *33* (2007), 676–685.

There is little objective data on how cancer and its therapy affect physical activity. The main aims of this pilot study were (1) to compare physical activity in patients receiving palliative chemotherapy and healthy controls, and (2) to explore the relationship between patients' activity, quality of life (QOL), and clinical performance status. A miniaturized electronic meter objectively recorded activity for 1 week in 20 patients with upper gastrointestinal cancer receiving palliative chemotherapy and in 13 age-matched healthy controls. Patients also completed the European Organization for Research and Treatment of Cancer (EORTC) QLQ-C30, Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F; fatigue), and Functional Assessment of Anorexia and Cachexia Therapy (FAACT; anorexia/cachexia) quality-of-life questionnaires. The patients' median estimated total energy expenditure was 8% lower ($p = .0003$), median time spent upright was approximately 2 h/day less ($p = .0002$), and median steps taken/day was 43% lower ($p = .002$) than that of the control group. Neither estimated energy expenditure nor average steps taken/day correlated significantly with EORTC QLQ-C30 physical functioning, fatigue, or global health status/QOL. There was no correlation with the FAACT "Trial Outcome Index" (TOI), but the FACIT-F TOI and both estimated energy expenditure and the average steps taken/day correlated significantly ($r = .59$, $p = .009$ and $r = .59$, $p = .008$). It is concluded that patients receiving palliative chemotherapy were less active than healthy controls; however, the relationship between physical activity and QOL requires further characterization.

### Quality of Life in Patients with Brain Metastases Treated with a palliative course of Whole-Brain Radiotherapy

Doyle, M., Bradley, N.M., Li, K., Sinclair, E., Lam, K., Chan, G., Chow, E., Barnes, E.A., Danjoux, C., and Tsao, M.N.

*Journal of Palliative Medicine*, *10* (2007), 367–374.

The primary objective of this study was to assess whether there was an improvement in quality of life for patients with brain metastases as measured 1 and 2 months after a course of whole-brain radiotherapy. The secondary objective was to assess the level of agreement between patient and proxy quality of life scores. Sixty patients with brain metastases and their proxy completed the Functional Assessment of Cancer Therapy-Brain (FACT-BR) questionnaire independently. Proxies were given instructions to answer from the patient's perspective. Quality-of-life assessments were conducted at baseline, 1 month, and 2 months after completion of whole-brain radiotherapy. Paired $t$ tests with Bonferroni adjustment for multiple comparisons were calculated to detect significant differences in global quality-of-life scores. Lin's concordance correlation coefficient measured agreement between patient and proxy quality-of-life ratings. No significant difference was detected in overall quality of life after whole-brain radiotherapy. At 2 months after whole-brain radiotherapy, there was a trend toward worsening general and brain-specific quality-of-life scores. There was poor concordance between patients and their proxies for all quality-of-life domains at baseline. At 2 months after whole-brain radiotherapy, there was a trend toward worsening general and brain-specific quality-of-life scores. Proxy rating of patients' quality of life showed poor concordance at baseline.

### Palliative Sedation Therapy in the Last Weeks of Life: A Literature Review and Recommendations for Standards

de Graeff, A. and Dean, M.

*Journal of Palliative Medicine*, *10* (2007), 67–85.

Palliative sedation therapy (PST) is a controversial issue. There is a need for internationally accepted definitions and standards. A systematic review of the literature was performed by an international panel of 29 palliative care experts. Draft papers were written on various topics concerning PST. This paper is a summary of the individual papers, written after two meetings and extensive e-mail discussions. PST is defined as the use of specific sedative medications to relieve intolerable suffering from

refractory symptoms by a reduction in patient consciousness, using appropriate drugs carefully titrated to the cessation of symptoms. The initial dose of sedatives should usually be small enough to maintain the patients' ability to communicate periodically. The team looking after the patient should have enough expertise and experience to judge the symptom as refractory. Advice from palliative care specialists is strongly recommended before initiating PST. In the case of continuous and deep PST, the disease should be irreversible and advanced, with death expected within hours to days. Midazolam should be considered first-line choice. The decision whether or not to withhold or withdraw hydration should be discussed separately. Hydration should be offered only if it is considered likely that the benefit will outweigh the harm. PST is distinct from euthanasia because (1) it has the intent to provide symptom relief, (2) it is a proportionate intervention, and (3) the death of the patient is not a criterion for success. PST and its outcome should be carefully monitored and documented. When other treatments fail to relieve suffering in the imminently dying patient, PST is a valid palliative care option.

### The Relationship between Cancer-Related Fatigue and Patient Satisfaction with Quality of Life in Cancer

Gupta, D., Lis, C.G., and Grutsch, J.F.

*Journal of Pain and Symptom Management*, *34* (2007), 40–47.

Fatigue affects a majority of patients undergoing cancer-related therapies. We conducted a study of 954 adult cancer patients presenting for treatment at our hospital between April 2001 and November 2004 to quantify the relationship between fatigue and patient satisfaction with quality of life (QOL). Fatigue was measured using the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire fatigue subscale. Patient satisfaction with QOL was measured using the Ferrans and Powers Quality of Life Index (QLI). The relationship between fatigue and QLI was evaluated using univariate and multivariate linear regression after controlling for the effects of clinical and demographic factors. Of the 954 patients, 579 were females and 375 were males, with a median age at presentation of 56 years (range 20–90 years). Sixty-six percent had failed prior treatment. The most common cancers were breast (26%), colorectal (19%), and lung (16%) cancers. After controlling for the effects of age and prior treatment history, every 10-unit increase in fatigue was statistically significantly associated with 1.5-, 0.22-, 0.77-, 0.27-, and 0.85-unit declines in QLI health and physical, social and economic, psychological and spiritual, family, and global function scores, respectively. Consequently, a 30-point increase in fatigue score correlates with a 4.5-point decline in QLI health functioning—a clinically significant decline. In our study, we found that fatigue is strongly associated with patient satisfaction with QOL independent of the effects of age and prior treatment history.

### First Do No Harm . . . Terminal Restlessness or Drug-Induced Delirium

White, C., McCann, M.A., and Jackson, N.

*Journal of Palliative Medicine*, *10* (2007), 345–351.

Terminal restlessness is a term frequently used to refer to a clinical spectrum of unsettled behaviors in the last few days of life. Because there are many similarities between the clinical pictures observed in terminal restlessness and delirium, we postulate that at times what is referred to as terminal restlessness may actually be an acute delirium sometimes caused by medication used for symptom control. It is important therefore to consider the causes for this distressing clinical entity, treat it appropriately, and ensure the treatment provided does not increase its severity. This brief review aims to consider the medications that are commonly used toward the end of life that may result in a picture of delirium (or terminal restlessness). These include opioids, antisecretory agents, anxiolytics, antidepressants, antipsychotics, antiepileptics, steroids, and nonsteroidal anti-inflammatory drugs (NSAIDs). This review also aims to raise awareness regarding the recognition and diagnosis of delirium and to highlight the fact that delirium may be reversible in up to half of all cases. Good management of delirium has the potential to significantly improve patient care at the end of life.

### Phase II Study: Integrated Palliative Care in Newly Diagnosed Advanced Non-Small-Cell Lung Cancer Patients

Temel, J.S., Jackson, V.A., Billings, J.A., Dahlin, C., Block, S.D., Buss, M.K., Ostler, P., Fidias, P., Muzikansky, A., Greer, J.A., Pirl, W.F., and Lynch, T.J.

*Clinical Oncology*, *25* (2007), 2377–2382.

The purpose of this study is to assess the feasibility of early palliative care in the ambulatory setting in patients with newly diagnosed advanced non-small-cell lung cancer (NSCLC). Patients were eligible if

they had a performance status of 0 to 1 and were within 8 weeks of diagnosis of advanced NSCLC. Participants received integrated care from oncology and palliative care throughout the course of their disease. Participants were scheduled to meet with the palliative care team (PCT) and complete quality-of-life (QOL) and mood questionnaires monthly for 6 months. The study was deemed feasible if 64% of patients completed at least 50% of their scheduled visits and QOL assessments. Fifty-one patients were enrolled into the trial. One died within 72 hours and was not assessable. Ninety percent (95% CI, 0.78–0.96) of study participants complied with at least 50% of the palliative care visits. Eight-six percent (95% CI, 0.73–0.94) of the participants met the full feasibility requirements by both meeting with the PCT and completing QOL assessments at least 50% of the time. QOL and mood analyses confirmed the high symptom burden in patients with newly diagnosed advanced NSCLC. At least 50% of participants experienced some degree of shortness of breath, cough, difficulty breathing, appetite loss, weight loss, or unclear thinking at their baseline assessment. More than one third of patients had a probable mood disorder at baseline. Integrated palliative and oncology care is feasible in ambulatory patients with advanced NSCLC.

## PSYCHOSOCIAL INTERVENTION

### Effects of Prayer and Religious Expression within Computer Support Groups on Women with Breast Cancer

Shaw, B., Han, J.Y., Kim, E., Gustafson, D., Hawkins, R., Cleary, J., McTavish, F., Pingree, S., Eliason, P., and Lumpkins, C.

*Psychooncology*, *16* (2007), 676–687.

Research indicates that two common ways breast cancer patients or women with breast cancer cope with their diagnosis and subsequent treatments are participating in computer support groups and turning to religion. This study is the first we are aware of to examine how prayer and religious expression within computer support groups can contribute to improved psychosocial outcomes for this population. Surveys were administered before group access and then 4 months later. Message transcripts were analyzed using a word counting program that noted the percentage of words related to religious expression. Finally, messages were qualitatively reviewed to better understand results generated from the word counting program. As hypothesized, writing a higher percentage of religion words was associated with lower levels of negative emotions and higher levels of health self-efficacy and functional well-being, after controlling for patients' levels of religious beliefs. Given the proposed mechanisms for how these benefits occurred and a review of the support group transcripts, it appeared that several different religious coping methods were used, such as putting trust in God about the course of their illness, believing in an afterlife and therefore being less afraid of death, finding blessings in their lives, and appraising their cancer experience in a more constructive religious light.

### Supportive-Expressive Group Therapy for Women with Metastatic Breast Cancer: Survival and Psychosocial Outcome from a Randomized Controlled Trial

Kissane, D.W., Grabsch, B., Clarke, D.M., Smith, G.C., Love, A.W., Bloch, S., Snyder, R.D., and Li, Y.

*Psychooncology*, *16* (2007), 277–286.

Mixed reports exist about the impact of supportive-expressive group therapy (SEGT) on survival. From 485 women with advanced breast cancer recruited between 1996 and 2002, 227 (47%) consented and were randomized within an average 10 months of cancer recurrence in a 2:1 ratio to intervention with 1 year or more of weekly SEGT plus three classes of relaxation therapy (147 women) or to control receiving three classes of relaxation therapy (80 women). The primary outcome was survival; psychosocial well-being was appraised secondarily. Analysis was by intention-to-treat. SEGT did not prolong survival (median survival 24.0 months in SEGT and 18.3 in controls; univariate hazard ratio for death 0.92 [95% CI, 0.69–1.26]; multivariate hazard ratio, 1.06 [95% CI, 0.74–1.51]). Significant predictors of survival were treatment with chemotherapy and hormone therapy ($p < .001$), visceral metastases ($p < .001$) and advanced disease at first diagnosis ($p < .05$). SEGT ameliorated and prevented new DSM-IV depressive disorders ($p = .002$), reduced hopelessness-helplessness ($p = .004$), trauma symptoms ($p = .04$), and improved social functioning ($p = .03$). SEGT did not prolong survival. It improved quality of life, including treatment of and protection against depression.

### A Randomized Controlled Clinical Trial of Psychoanalytic Psychotherapy for Panic Disorder

Milrod, B., Leon, A.C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., Aronson, A., Singer, M., Turchin, W., Klass, E.T., Graf, E., Teres, J.J., and Shear, M.K.

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*American Journal of Psychiatry*, *164* (2007), 265–272.

The purpose of this study was to determine the efficacy of panic-focused psychodynamic psychotherapy relative to applied relaxation training, a credible psychotherapy comparison condition. Despite the widespread clinical use of psychodynamic psychotherapies, randomized controlled clinical trials evaluating such psychotherapies for axis I disorders have lagged. To the authors' knowledge, this is the first efficacy randomized controlled clinical trial of panic-focused psychodynamic psychotherapy, a manualized psychoanalytical psychotherapy for patients with DSM-IV panic disorder. This was a randomized controlled clinical trial of subjects with primary DSM-IV panic disorder. Participants were recruited over 5 years in the New York City metropolitan area. Subjects were 49 adults ages 18–55 with primary DSM-IV panic disorder. All subjects received assigned treatment, panic-focused psychodynamic psychotherapy or applied relaxation training in twice-weekly sessions for 12 weeks. The Panic Disorder Severity Scale, rated by blinded independent evaluators, was the primary outcome measure. Subjects in panic-focused psychodynamic psychotherapy had significantly greater reduction in severity of panic symptoms. Furthermore, those receiving panic-focused psychodynamic psychotherapy were significantly more likely to respond at treatment termination (73% vs. 39%), using the Multicenter Panic Disorder Study response criteria. The secondary outcome, change in psychosocial functioning, mirrored these results. Despite the small cohort size of this trial, it has demonstrated preliminary efficacy of panic-focused psychodynamic psychotherapy for panic disorder.

## QUALITY OF PALLIATIVE CARE

### Hospice and Palliative Care Development in Africa: A Multi-Method Review of Services and Experiences

Clark, D., Wright, M., Hunt, J., and Lynch, T.

*Journal of Pain and Symptom Management*, *33* (2007), 698–710.

There is a paucity of information on hospice and palliative care provision in Africa and only a weak evidence base upon which to build policy and practice development. We set out to assess the current state of provision across the continent, mapping the existence of services country by country and exploring the perspectives and experiences of those involved. A multimethod review was conducted involving a synthesis of evidence from published and gray literature, ethnographic field visits to seven countries, qualitative interviews with 94 individuals from 14 countries, and the collation of existing public health data. Forty-seven African countries were reviewed, involving the assistance of numerous hospice and palliative care activists, including clinicians, managers, volunteers, policy makers, and staff of donor organizations. The 47 countries of Africa could be grouped into four categories: no identified hospice or palliative care activity (21 countries), capacity building activity is underway to promote hospice and palliative care delivery (11 countries), localized provision of hospice and palliative care is in place, often heavily supported by external donors (11 countries), and hospice and palliative care services are approaching some measure of integration with mainstream service providers and gaining wider policy recognition (4 countries). Overall, services remain scattered and piecemeal in most African countries, and coverage is poor. Nongovernmental organizations are the predominant source of provision. Major difficulties relate to opioid availability, workforce development, and achieving sustainable critical mass. Models exist in Uganda, Kenya, South Africa, and Zimbabwe for the development of affordable, sustainable community-based hospice and palliative care services, but sensitivity is required in adopting Western models of hospice and palliative care for implementation in the African cultural context. Overall, interest in the development of hospice and palliative care in Africa has never been greater.

### End-of-Life Care in Hospital: Current Practice and Potentials for Improvement

Becker, G., Sarhatlic, R., Olschewski, M., Xander, C., Momm, F., and Blum, H.E.

*Journal of Pain and Symptom Management*, *33* (2007), 711–719.

From July until September 2004, all deaths were registered prospectively in all departments of Freiburg University Hospital, Germany, a large teaching hospital with approximately 55,000 inpatient admissions per year. A retrospective chart review was done for all patients who died during this time period using a tool validated in two American and Australian projects. Main outcome measures were patients' identification as dying by medical staff, do not resuscitate (DNR) orders, and the presence of comfort care plans. The cohort comprised 226 consecutive death events. Seven percent of patients had a written advance directive. DNR orders were available for 65% of patients and were entered into the charts, on average, 5.9 days prior to death. Thirty-eight percent of charts had evidence that staff

recognized that the patients were dying. This prognosis was noted on average 3.8 days prior to death. According to chart notes, clinicians documented cancer patients as dying more frequently than patients with cardiovascular disease ($p = .029$). In the chart entries, comfort care plans were completed fully for 14% and partially for 27% of patients. On average, comfort care plans were put in place 9 days prior to death. Cancer patients had significantly more frequent comfort care plans than patients with cardiovascular diseases ($p < .001$). In 59% of medical charts, there was no evidence of a comfort plan. Approximately one third of dying patients received active life-sustaining treatment at time of death. These data highlight the need for systematic strategies to monitor patients' needs and to improve quality of care, especially during the last 4 days before death.

### The End of Life: A Qualitative Study of the Perceptions of People over the Age of 80 on Issues Surrounding Death and Dying

Lloyd-Williams, M., Kennedy, V., Sixsmith, A., and Sixsmith, J.

*Journal of Pain and Symptom Management*, *34* (2007), 60–66.

This study explored how elderly people living in the community perceive issues around death, dying, and the end of life using a qualitative grounded theory approach. Forty individuals aged between 80 and 89 years who were living alone in the community were interviewed and were identified through purposive and random sampling. The results revealed that issues associated with end of life included fear of how they would die, fear of becoming a burden to others, wanting to prepare for and have a choice with regard to where and when they die, and issues relating to assisted dying. The study demonstrated that issues relating to the end of life are a major concern for older people, but are seldom addressed by professionals. Listening to and understanding the views and experiences of the older age group regarding end-of-life care is needed if adequate person-centered care is to be delivered to this ever-growing population group.

### Hospice Care for patients with Dementia

Mitchell, S.L., Kiely, D.K., Miller, S.C., Connor, S.R., Spence, C., and Teno, J.M.

*Journal of Pain and Symptom Management*, *34* (2007), 7–16.

Dementia is a leading cause of death in the United States. Although guidelines exist to determine hospice eligibility for dementia, only a small percentage of patients dying with this condition receive hospice care. Hospice recipients with dementia have not been well characterized, and little is known about the quality of care they receive. The Family Evaluation of Hospice Care (FEHC) survey was adopted by the National Hospice and Palliative Care Organization (NHPCO) in 2003 as a standard benchmarking tool. The FEHC collects data from bereaved families regarding the quality of hospice care. An online repository of 2005 FEHC data was used to describe hospice recipients over 65 years of age who died with dementia and to examine their families' evaluation of hospice care. Decedents with cancer and chronic terminal conditions were also analyzed for comparison purposes. A total of 77,123 surveys submitted by 796 hospices nationwide met the study's eligibility criteria. Decedent diagnoses were as follows: dementia, $n = 8686$ (11.3%); cancer, $n = 35{,}693$ (46.3%); and other chronic diseases, $n = 32{,}744$ (42.4%). Decedents with dementia were more likely to be >85 years, female, and have length of stays >180 days. Evaluation of care in all FEHC domains did not significantly differ between groups. Approximately three quarters of bereaved family members of decedents in all groups perceived the overall quality of care as excellent; however, opportunities to improve care were also identified. These data suggest that the evaluation of hospice care for older patients is generally high and does not vary with respect to terminal diagnoses.

### Outcomes from a National Multispecialty Palliative Care Curriculum Development Project

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In 1998 we completed a successful regional pilot project in palliative care curriculum development among 32 internal medicine residency programs recruited from the Midwestern United States. Between 1999 and 2004 this project was expanded to include 358 U.S. programs, from four specialties, based on new training requirements in internal medicine, family medicine, neurology, and general surgery. The aim of this paper is to assess the 1-year outcomes from residency programs participating in a national multispecialty palliative care curriculum development project using outcome data obtained from residency programs' responses to a structured progress report 12 months after enrolling in the project and from published residency project reports. Three hundred fifty-eight residency programs, representing 27% of all eligible training programs in the four specialties,

participated in the project. Outcome data were available from 224 residencies (63%). Most programs started new teaching in pain, nonpain symptom management, and communication skills. More than 50% of programs integrated palliative care topics within established institutional grand rounds, morbidity/mortality conferences, or morning report. More than 70% of internal medicine and family practice programs began new direct patient care training opportunities utilizing hospital-based palliative care or hospice programs. New faculty development initiatives and use of quality improvement projects to drive curriculum change were reported in less than 50% of programs. Focused short-term instruction in palliative care curriculum development, in a diverse group of residency programs, is feasible and associated with significant curriculum change.

## COMMUNICATION

### Transforming Doctor-Patient Relationships to Promote Patient-Centered Care: Lessons from Palliative Care

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Palliative care was studied for its potential to yield lessons for transforming doctor–patient relationships to promote patient-centered care. Examination of patient and provider experiences of the transition from curative to palliative care promises valuable insights about establishing and maintaining trust as the goals of care shift and about addressing a broad spectrum of patient needs. The study was guided by a conceptual framework grounded in existing models to address five dimensions of doctor–patient relationships: range of needs addressed, source of authority, maintenance of trust, emotional involvement, and expression of authenticity. Data collection included observation of the care of 40 patients in the inpatient hospice unit and at home, interviews with patients and family members, and in-depth interviews with 22 physicians and two nurses providing end-of-life care. Standard qualitative procedures were used to analyze the data, incorporating techniques for maximizing the validity of the results and broadening their relevance to other contexts. Findings provide evidence for challenging prominent assumptions about possibilities for doctor–patient relationships: questioning the merits of the prohibition on emotional involvement, dependence on protocols for handling difficult communication issues, unqualified reliance on consumer empowerment to assure that care is responsive to patients' needs, and adoption of narrowly defined boundaries between medical and social service systems in caring for patients. Medical education can play a role in preparing doctors to assume new roles by openly addressing management of emotions in routine clinical work, incorporating personal awareness training, facilitating reflection on interactions with patients through use of standardized patients and videotapes, and expanding capacity to effectively address a broad range of needs through teamwork training.

### Spirituality Training for Palliative Care Fellows

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Spirituality is a major domain of palliative medicine training. No data exist on how it is taught, nor is there a consensus about the content or methods of such education. We surveyed palliative medicine fellowship directors in the United States to learn how they teach spirituality, who does the teaching, and what they teach. A PubMed (www.pubmed.gov) search using the terms "spirituality" and "medical education" was completed. Thirty-two articles outlined spirituality education content and methods in medical schools and residency programs. From these articles, a survey on spirituality education in palliative medicine fellowship training was prepared, pilot-tested, revised, and then distributed by e-mail in June 2004 to the 48 U.S. palliative medicine fellowship directors listed on the American Board of Hospice and Palliative Medicine (AAHPM) website, but excluding the three fellowship programs represented by the authors. Follow-up requests were sent by e-mail twice during the 6-week collection period. The Institutional Review Board at the Medical College of Wisconsin approved the study. Fourteen fellowship directors completed the survey (29% of all programs; 42% of those currently teaching fellows as indicated on the AAHPM website). All programs indicated they taught "spirituality"; 12 of 14 had separate programs for teaching spirituality and 2 of 14 reported they taught spirituality to their fellows but not as a distinct, separate program. All respondents taught the definitions of spirituality and religion, common spiritual issues faced by patients at end of life (which was not defined further), and the role of chaplains and clergy. Chaplains provided spirituality education in all of the responding programs, but other team members were frequently involved. The most common formats for education in the domains of knowledge and attitudes were small group discussion, lecture, and self-study. Small group discussion, supervision, and shadowing

a chaplain or other professional were the most common methods used for skills. Faculty written or oral evaluations of fellows were the most common forms of evaluation, with little evidence of more robust assessment methods, such as structured role-play (none of the programs surveyed). Palliative medicine fellowship programs generally agree on the content of training on spirituality, but have not incorporated robust educational and evaluation methods to ensure that fellows have obtained the desired attitudes, knowledge, and skills to meet the Initial Voluntary Program Standards for Residency Education in Palliative Medicine of the American Board of Hospice and Palliative Medicine. Based on the survey data and results from the literature review, broad recommendations are made to enhance spirituality education.

**Go Wish: A Tool for End-of-Life Care Conversations**

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The Go Wish card game is an advance care planning tool developed by Coda Alliance to help people have conversations about end-of-life care. Initially, this tool was designed as an easy, entertaining exercise for low-functioning assisted-living facility residents, their family members, and their CNA/nursing assistants (many of whom have limited English language skills.) Use of the tool can be proctored by staff or even a caregiver after minimal instruction. It turns out to be a widely applicable and inexpensive tool to help people discuss end-of-life care. The cards focus the conversations, provide important vocabulary to give voice to patients' needs and concerns, and offer a means for sharing those ideas. The Go Wish tool has developed into professionally designed and printed cards that are boxed as a game set. This paper describes the development of the Go Wish cards and reports on some of the diverse cases in which they have been useful.