

Original Article

End-of-Life Care in Lung Cancer Patients in Ontario: Aggressiveness of Care in the Population and a Description of Hospital Admissions

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Abstract

The purpose of this study was to describe (1) the aggressiveness of care in a population of patients who die of lung cancer and (2) differences in care between a sample of lung cancer patients who died in an acute care hospital (DH) and a sample of lung cancer patients who were admitted to hospital during the last six months of life but were discharged and died elsewhere (DO). All lung cancer deaths in 2002 were identified in the provincial registry. Cases were linked to administrative sources of health care data to describe the population as a whole and the aggressiveness of the care that they received. Primary data were collected from a province-wide sample of patients' hospital charts focusing on reasons for admission, care in hospital, advanced planning, pain, and disposition. In total, 5,855 patients who died of lung cancer in 2002 were eligible for inclusion in the cohort. Rates of in-hospital death, emergency room visits, intensive care unit admissions, and chemotherapy use near the end of life were 59.5%, 32.2%, 5.5%, and 4.6%, respectively. The records of 491 patients were abstracted for this study. The DH and DO groups were similar with respect to age, gender, neighborhood income level, and extent of metastatic disease. The most common chief complaints were shortness of breath, pain, inability to cope at home, and altered level of consciousness. Compared to patients in the DO group, those in the DH group presented with pain more often (19% vs. 10%, $P < 0.005$) and were more likely to be admitted with progressive chest malignancy (30% vs. 21%, $P < 0.05$). Regardless of reason for admission, pain was commonly documented as a problem during admission: 73.5% in the DH group and 62.4% in the DO group ($P < 0.05$). Lung cancer patients are heavy users of acute care beds and the emergency room at the end of life. Those who do or do not die in

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hospital are similar in many respects but our results suggest those dying in hospital have more problems with pain and burden from local chest malignancy. *J Pain Symptom Manage* 2008;35:267–274. © 2008 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

Key Words

Lung cancer, end-of-life care, in-hospital death

Introduction

Lung cancer is the most common cause of cancer death in the United States and Canada.^{1,2} The majority of patients present with unresectable or advanced disease and prognosis is often grave from the outset. This population is an important group to consider in the study of end-of-life cancer care.

Population-based studies of aggressiveness of care^{3,4} have been performed on the cancer population as a whole. Measures of aggressiveness have been based on indicators developed for use with administrative data.⁵ A population-based approach using administrative data allows for evaluation of the entire population of patients and avoids many of the pitfalls associated with recruiting and following a patient population.⁶

There are many studies indicating that patients prefer to die outside of the acute care setting, most often at home, or possibly in a hospice setting.^{7,8} Certainly, acute care beds are not the ideal place to address the needs of dying cancer patients. Acute care resources used by a cancer population with advanced illness diminish the ability of this sector to manage acute illnesses. A system that provides adequate management of palliative care patients in an alternative setting, such as home or hospice, is preferable.

In this study, we evaluate indicators of the aggressiveness of care at the end of life in lung cancer patients, using administrative data. In addition, we performed a retrospective chart review on a sample of lung cancer patients who did and did not die in hospital to compare patient characteristics and care during admission. To our knowledge, there have been no studies describing reasons for admission at the end of life in lung cancer patients and comparing the admissions in these two patient groups. Differences observed in those

who die in and out of acute care may indicate priority areas for improving community care, avoiding admissions and in-hospital deaths.

Methods

Study Design

This is a population-based descriptive study of a decedent cohort of lung cancer patients using administrative sources of data, in addition to a province-wide retrospective chart review. The study was approved by the Sunnybrook and Women's College Research Ethics Board (REB), the Ontario Cancer REB, and the local REBs of community hospitals that required separate approval.

Study Population

All patients who died of lung cancer (International Classification of Diseases 9 code-162) in 2002 were identified in the Ontario Cancer Registry (OCR). Cases were excluded if (1) the diagnosis of cancer was only made on the death certificate with no prior cancer diagnosis; (2) the insurance number was invalid during the last six months of life (this precludes linkage); (3) the patient died outside of Ontario; or (4) the patient's age was less than 20 years.

To maximize efficiency of hospital chart abstraction, a random sample of patients was not drawn from the population as a whole. Instead, a sample of hospitals in the province was taken and patients from these hospitals were eligible for abstraction. The hospitals were selected from three categories: (1) teaching hospitals or hospitals affiliated with a regional cancer center, (2) large hospitals not affiliated with a cancer center or teaching hospital, and (3) small or rural hospitals with <100 beds. Four hospitals from each of the first two categories were randomly chosen,

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