



Palliative care for patients with chronic obstructive pulmonary disease ☆

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Summary Chronic obstructive pulmonary disease (COPD) is a leading cause of mortality and disability worldwide. For many patients, maximal therapy for COPD produces only modest relief of disabling symptoms and these symptoms result in a significantly reduced quality of life. Despite the high morbidity and mortality, patients with COPD do not receive adequate palliative care. One reason these patients may receive poor quality palliative care is that patient–physician communication about palliative and end-of-life care is unlikely to occur. The purpose of this review is to summarize recent research regarding patient–physician communication about palliative care for patients with COPD. Understanding the barriers to this communication may be an important step to improving communication about end-of-life care and improving patient-centered outcomes. Further research is needed to develop and test interventions that can enhance patient–physician communication about palliative and end-of-life care for patients with COPD.

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Introduction

Chronic obstructive pulmonary disease (COPD) is the fourth leading cause of mortality and the 12th

leading cause of disability worldwide.^{1,2} Age-adjusted mortality from COPD continues to increase while mortality from other leading causes of death, including cardiovascular disease and cancer, is decreasing. Some estimates suggest that by the year 2020, COPD will be the third leading cause of mortality and the fifth leading cause of disability worldwide.³⁻⁵ For many patients, maximal therapy for COPD or other chronic lung diseases produces only modest relief of dyspnea and other disabling symptoms, and these symptoms result in a significantly reduced quality of life. Despite the high morbidity and mortality associated with COPD, patients with COPD do not receive adequate palliative care. Some studies suggest that the proportion of patients with COPD that receive palliative care and the quality of this palliative care compare poorly to palliative care received by patients with cancer.⁶⁻⁸ Recently, there has been growing recognition of the importance of high quality palliative care for patients with COPD, as evidenced by the inclusion of palliative care considerations in the recent American Thoracic Society/European Respiratory Society (www.thoracic.org/copd) and Canadian Thoracic Society COPD Guidelines released in 2004.⁹ Despite this recent interest, studies suggest that most patients with COPD do not discuss end-of-life issues with their physicians, even though most patients wish to have such conversations.¹⁰⁻¹² In this paper I provide a brief narrative review of recent research regarding patient-physician communication about palliative care for patients with COPD.

Poor palliative care in COPD and the potential link to poor communication

The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of disease or the need for other therapies.¹³ As such, palliative care expands traditional disease-model medical treatments to include the goals of enhancing quality of life, optimizing function, helping with decision-making, and providing opportunities for personal growth.¹³ The Study to Understand Prognosis and Preferences for Outcomes and Treatments (SUPPORT) found that, compared to patients with lung cancer, patients with COPD were much more likely to die in the intensive care unit, on mechanical ventilation, and with dyspnea.⁷ These differences in care occurred despite the fact that most patients with COPD preferred treatment focused on comfort rather

than on prolonging life. In fact, SUPPORT found that patients with lung cancer and patients with COPD were equally likely to prefer not to be intubated and not to receive CPR.⁷ A study in Britain also found that patients with COPD were much less likely to die at home and much less likely to receive palliative care services than patients with lung cancer.⁶ Additional studies document the poor quality of palliative care for patients with COPD.¹⁴ Health care for these patients was often initiated in response to acute exacerbations rather than being initiated proactively based on a previously developed plan for managing their disease.¹⁵ Finally, a recent study of patients with COPD or lung cancer in the US Veterans Affairs health system found that patients with COPD were much more likely to be admitted to an ICU and have greater lengths of stay in the ICU during their terminal hospitalization than patients with lung cancer.⁸

The differences in health care for patients with COPD compared to those with cancer may be due, in part, to the difficulty physicians have prognosticating for patients with COPD and especially in identifying with confidence those patients who are likely to die within 6 months. The prognostic models used in SUPPORT documented this difficulty. These models showed that, at 5 days prior to death, lung cancer patients were predicted to have less than 10% chance of surviving 6 months while COPD patients were predicted to have more than 50% chance.⁷ Uncertainty concerning prognosis plays a much more prominent role in discussions of prognosis and end-of-life care for patients with COPD than for patients with lung cancer. It is therefore not surprising that physicians have a more difficult time knowing when to raise issues about end-of-life care for patients with COPD. Despite these difficulties in prognostication, it remains the responsibility of physicians caring for patients with severe COPD to educate patients about end-of-life care to ensure that these patients receive the best possible care that is in line with their informed preferences for care at the end of life (Table 1).

Although the precise reasons that patients with COPD receive less palliative care than those with lung cancer are not entirely clear, several studies have shown that only a minority of patients with moderate to severe COPD have discussed treatment preferences and end-of-life care issues with their physicians.¹⁰⁻¹² Further, the majority of these patients believe their physicians do not know their preferences for end-of-life care.^{10,11} We recently found that only a third of patients with oxygen-dependent COPD had discussed end-of-life care with their physicians and less than 25% of physicians

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