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Clinical Update: Literature Abstracts

MEASURES

Validation of a New Measure of Concept of a Good Death

Schwartz, C., Mazor, K., Rogers, J., Ma, Y., and Reed, G.

Journal of Palliative Medicine, *6* (2003), 575–583

The concept of a good death is central to end-of-life care research. Despite its importance and the high interest in the topic, there are few measures currently available for use in clinical research. This work describes the development and testing of a set of items intended to measure the importance of several components proposed to be critical to the concept of a good death. It is intended for use by healthcare providers and lay people in the context of end-of-life-care research and education. Four cohorts (n = 596) were recruited to participate, representing two helping profession disciplines, nonhelping professionals, and a range of ages, specifically: (1) undergraduate medical students, (2) master's degree students in nursing, (3) graduate students from the life sciences, and (4) practicing hospice nurses. Participants completed self-report questionnaires at baseline and retest. Psychometric analyses included item frequency distributions, factor analysis, a reliability, intraclass correlation, and measure of association. The new Concept of A Good Death measure demonstrated good item frequency distributions, acceptable internal consistency reliability, and test-retest stability. Its factor structure revealed that three distinct domains were measured, reflecting the psychosocial/spiritual, physical, and clinical aspects of a good death. An examination of patterns of correlations showed differential associations with death anxiety, spiritual beliefs and practices, anxious mood, and sociodemographic characteristics. The new Concept of A Good Death instrument appears to measure three distinct factors that people consider important to a good death. Ratings of the importance of these factors are reliable and valid. The instrument has the advantage of being a brief, self-report index in end-of-life-care research.

Measuring the Symptom Experience of Seriously Ill Cancer and Noncancer Hospitalized Patients Near the End of Life with the Memorial Symptom Assessment Scale

Tranmer, J., Heyland, D., Dudgeon, D., Groll, D., Squires-Graham, M., and Coulson, K.

Journal of Pain and Symptom Management, *25* (2003), 420–429

The objectives of this study were twofold: (1) to explore and compare the symptom experience of seriously ill hospitalized cancer and noncancer patients near the end of life using the Memorial Symptom Assessment Scale (MSAS) and (2) to determine if the MSAS is a valid and useful measure of symptom distress for patients with noncancer conditions. This was a prospective cohort study of hospitalized patients with end-stage congestive heart disease, chronic pulmonary disease, cirrhosis, or metastatic cancer. Eligible patients were interviewed to ascertain symptom prevalence, severity, and distress using the MSAS and levels of fatigue using the Piper Fatigue Scale (PFS). Sixty-six patients with metastatic cancer and 69 patients with end-stage disease were enrolled in the study. There was a significant difference in the prevalence of selected physical symptoms, but not psychological symptoms, between cancer and noncancer patients. There were no significant differences in symptom distress scores, a computed score of frequency, severity, and distress, if the symptom was present. In both groups, the principal components factor analysis with varimax rotation yielded one factor comprising psychological symptoms and a second factor comprising three subgroups of physical symptoms. Internal consistency was high for the psychological subscale (Cronbach alpha coefficients of 0.85 for the cancer group and 0.77 for the noncancer group) and for the physical subscale groupings with coefficients ranging between 0.78 to 0.87. The symptom scores were significantly correlated with perceptions of fatigue. These finding show that both seriously ill cancer and noncancer patients experience symptom distress, and that the MSAS seems to be a reliable measure of symptom distress in noncancer patients, as well as in those with cancer.

Use of the Cognitive Test for Delirium in Patients with Traumatic Brain Injury

Kennedy, R.E., Nakase-Thompson, R., Nick, T.G., and Sherer, M.

Psychosomatics, *44* (2003), 283–289

The sensitivity and specificity of the Cognitive Test for Delirium, which was originally developed for use in intensive care units, were tested in a group of patients with traumatic brain injury who were admitted to a neurorehabilitation center. Sixty-five consecutive patients were evaluated weekly by using the DSM-IV criteria for delirium and the Cognitive Test for Delirium. Complete ratings were available for 249 of 304 weekly observations. Analysis of the receiver operating characteristic curve suggested an optimum cutoff score of less than 22 for identification of delirium by using the Cognitive Test for Delirium, with a sensitivity of 72% and a specificity of 71% compared with the DSM-IV diagnosis. The results suggest that the Cognitive Test for Delirium provides an acceptable level of differentiation between delirious and nondelirious patients with traumatic brain injury.

The Memorial Symptom Assessment Scale: Modified for Use in Understanding Family Caregivers' Perceptions of Cancer Patients' Symptom Experiences

Lobchuk, M.M.

Journal of Pain and Symptom Management, *26* (2003), 644–654

The purpose of this study was to determine whether the Memorial Symptom Assessment Scale (MSAS) could serve as a feasible, reliable, and valid tool for use in assessing the reports of 98 family caregivers (FC) on the symptom experiences of advanced stage cancer patients. The MSAS consists of subscales that describe psychological symptom distress (PSYCH), physical symptom distress (PHYS), and global symptom distress (Global Distress Index [MSAS-GDI]). The majority of FCs was able to respond to 32 MSAS symptom items; however, the greatest difficulty in FC responding occurred on the "sexual interest" item. The mean PSYCH score was 1.42 ($SD = 0.83$), the mean PHYS score was 0.96 ($SD = 0.67$), and the mean MSAS-GDI was 1.46 ($SD = 0.24$). Internal consistency was high in the PHYS ($\alpha = 0.84$), PSYCH ($\alpha = 0.82$), and MSAS-GDI ($\alpha = 0.84$) subscales. The average item-scale correlation ranged between $r = 0.50$ and 0.60, indicating that the items were moderately to strongly correlated with the respective total subscales. The average interitem correlation ranged between $r = 0.30$ and 0.45, indicating that the items were moderately correlated with each other on the respective subscales. Good to excellent intraclass correlations (ICC) with patients' ordinal ratings support the concurrent validity and utility of the PHYS and MSAS-GDI subscales in FC populations who care for cancer patients in the home setting. Depending on the symptom, a range of slight to substantial Kappa values on dichotomous PHYS and PSYCH items, and fair ICC values on the ordinal PSYCH subscale provide questionable validity in FC populations caring for cancer patients.

SYMPTOM CONTROL

The Symptoms of Dying Children

Drake, R., Frost, J., and Collins, J.J.

Journal of Pain and Symptom Management, *26* (2003), 594–603

The purpose of this study was to examine the symptom prevalence, characteristics, and distress of children dying in hospital. Symptoms during the last week of life were obtained from the medical records. Symptoms and their characteristics during the last day of life were determined by nurse interview. Thirty children with an average age of 8.9 years were evaluated. The dominant disease process was cancer ($n = 18$), most likely location of death was intensive care ($n = 20$), and major physiological disturbances at the time of death was respiratory failure ($n = 9$) and encephalopathy ($n = 9$). The majority of children (90%) did not have a preexisting do not resuscitate (DNR) order and 58% of these children had this addressed for the first time in the last day of life. The mean (±*SD*) number of symptoms per patient in the last week of life was 11.1 ± 5.6 and six symptoms occurred with a prevalence of 50% or more. The location of death had a significant ($p < 0.02$) impact on the mean number of symptoms: ward (14.3 ± 6.1) versus intensive care (9.5 ± 4.7). In general, symptoms in the last day of life were not associated with a high level of distress. In summary, the symptom burden of dying children is high. Symptoms were, at times, distressing but children were generally comfortable. The findings suggest the application of the palliative care paradigm and a more aggressive approach to symptom control to all areas of the hospital may prove beneficial to dying children.

Agitated Terminal Delirium and Association with Partial Opioid Substitution and Hydration

Morita, T., Tei, Y., and Inoue, S.

Journal of Palliative Medicine, *6* (2003), 557–563

Delirium is often a distressing symptom for both patients and their families, and its prevention is important. The primary aim of this study was to clarify the effects of partial opioid substitution and hydration on the occurrence of agitated delirium in the final stage of cancer.

A historical control study was undertaken on consecutive terminally ill cancer patients admitted to a palliative care unit (164 in 1996–1997 and 120 in 2000–2001). In 2000–2001, we actively performed hydration and partial opioid substitution from morphine with fentanyl on individual grounds. Two independent raters evaluated the degree of agitation and cognitive impairment during the final week, using the Memorial Delirium Assessment Scale, the Agitation Distress Scale, the Communication Capacity Scale, and a consciousness scale.

Compared to 1996–1997, in 2000–2001, the use of artificial hydration (33% to 44%, $p = 0.053$) and opioid rotation (3.0% to 41%, $p < 0.01$) increased, whereas there were no statistically significant differences in hydration volume, the mean dose, and the high-dose requirements of morphine. The prevalence of agitated delirium, the agitation score, the percentage of patients achieving clear-complex communication, and the percentage of patients who maintained clear consciousness did not significantly change.

Partial opioid substitution with fentanyl and moderate levels of hydration had no significant preventive effects on the occurrence of agitated delirium in the last week on a mass level. We should explore new strategies to prevent agitated delirium that are practically available in Japan.

Multidimensional Independent Predictors of Cancer-Related Fatigue

Hwang, S.S., Chang, V.T., Rue, M., and Kasimis, B.

Journal of Pain and Symptom Management, *26* (2003), 604–614

The purpose of this study was to identify independent predictors of clinically significant fatigue based upon a multidimensional model. A total of 180 cancer patients completed the Brief Fatigue Inventory (BFI), Functional Assessment of Cancer Therapy-Fatigue (FACT-F), Memorial Symptom Assessment Scale Short Form (MSAS-SF), and the Zung Self-Rating Depression Scale (SDS). Additional data included Karnofsky Performance Status (KPS) score, laboratory tests, and demographic information. The BFI usual fatigue severity $\geq 3/10$ was defined as clinically significant fatigue. Possible independent variables were identified from a biopsychosocial model of fatigue. Fisher's exact test was used to univariately assess the association of each variable with clinically significant fatigue. Multiple logistic regression analyses were used to identify independent predictors of fatigue within each dimension, and then across dimensions. Fatigue was present in 113 (62%) patients, and 80 (44.4%) patients had usual fatigue $\geq 3/10$. The unidimensional independent predictors were use of analgesics (situation dimension); hemoglobin and serum sodium (biomedical dimension); feeling drowsy, dyspnea, pain, and lack of appetite (physical symptom dimension); and feeling sad and feeling irritable (psychological symptom dimension). In a multidimensional model, dyspnea, pain, lack of appetite, feeling drowsy, feeling sad, and feeling irritable predicted fatigue independently with good calibration (Hosmer Lemeshow Chi Square = 5.73, $p = 0.68$) and discrimination (area under the receiver operating characteristic curve = 0.88). Physical and psychological symptoms predict fatigue independently in the multidimensional model, and superseded laboratory data. These findings support a symptom-oriented approach to assessment of cancer-related fatigue.

The Relationship of APOE Genotype to Neuropsychological Performance in Long-Term Cancer Survivors Treated with Standard Dose Chemotherapy

Ahles, T.A., Saykin, A.J., Noll, W.W., Furstenberg, C.T., Guerin, S., Cole, B., and Mott, L.A.

Psycho-Oncology, *12* (2003), 612–619

The primary purpose of this study was to compare the neuropsychological performance of long-term survivors of breast cancer and lymphoma treated with standard dose chemotherapy who carried the $\varepsilon 4$ allele of the Apolipoprotein E (APOE) gene to those who carry other APOE alleles.

Patients in the sample of long-term survivors (mean = 8.8 ± 4.3 years posttreatment) of breast cancer ($N = 51$, age = 55.9 ± 8.8) or lymphoma ($N = 29$, age = 55.8 ± 11.6) who had been treated with standard-dose chemotherapy completed a standardized battery of neuropsychological and psychological tests. Survivors were also classified into two groups based on the presence ($N = 17$) or absence ($N = 63$) of at least one $\varepsilon 4$ allele of APOE.

Analysis of covariance, controlling for age, gender, education, diagnosis, and WRAT-3 reading subtest (a proxy measure of baseline IQ), indicated that survivors with at least one $\varepsilon 4$ allele scored significantly lower in the visual memory ($p < 0.03$) and the spatial ability ($p < 0.05$) domains and tended to score lower in the psychomotor functioning ($p < 0.08$) domain as compared to survivors who did not carry an $\varepsilon 4$ allele. No group differences were found on depression, anxiety, or fatigue.

The results of this study provide preliminary support for the hypothesis that the $\varepsilon 4$ allele of APOE may be a potential genetic marker for increased vulnerability to chemotherapy-induced cognitive decline.

The Role of Cognitive Impairment in Desire for Hastened Death: A Study of Patients with Advanced AIDS

Pessin, H., Rosenfeld, B., Burton, L., and Breitbart, W.

General Hospital Psychiatry, 25 (2003), 194–199

To examine the relationship between cognitive impairment and desire for death in patients with advanced AIDS, we evaluated 128 patients with advanced AIDS consecutively admitted to three long-term-care facilities. Participants completed a clinical assessment that included a self-report measure of desire for hastened death in the medically ill (Schedule of Attitudes toward Hastened Death), three measures of cognitive functioning designed to screen for cognitive impairment (Dementia Rating Scale, Mini-Mental State Exam, HIV Dementia Scale), and other measures of physical and psychological functioning. Participants who were classified as cognitively impaired obtained significantly higher scores on the measure of desire for death than did patients without cognitive impairment. This modest association between cognitive impairment and desire for death remained significant even after controlling for the impact of depression on desire for death. Specific aspects of cognitive functioning such as memory and psychomotor coordination appeared to be more salient than executive functioning or abstract reasoning. Cognitive impairment appears to have a modest, but significant impact on patients' desire for hastened death. Aggressive treatment of cognitive symptoms in the terminally ill is necessary to disentangle the various factors that may drive end-of-life treatment decisions.

COMMUNICATION

Doctors' Strategies When Breaking Bad News to Terminally Ill Patients

Friedrichsen, M.J., and Strang, P.M.

Journal of Palliative Medicine, *6* (2003), 565–574

Breaking bad news to patients with a terminal disease is a difficult task for physicians. The aim of this study was to study how doctors perceive their strategies when giving information to cancer patients about discontinuing active tumor treatment. Thirty doctors with different demographic characteristics working with patients with cancer in Sweden participated. Semistructured interviews were conducted and analyzed using a qualitative phenomenographic method. The goal when giving this information was described as making the patient understands while being as considerate as possible. However, the strategies for reaching this goal were different: (1) explaining and convincing information (i.e., giving a long explanation about why treatment has to be discontinued); (2) softening the impact of the information, with the doctor recommending discontinuation of treatment; (3) and preparing either the patient or the physician himself/herself for the information; (4) adapting or tailoring the information to the patient, with the doctor actively seeking knowledge about the patient in order to be able to adapt the information to the patient's level, or with the doctor briefly describing the situation and then remaining silent, allowing room for the patient's reactions and questions (i.e., letting the patient take an active part). When giving information, the doctors' goal was to make patients understand, but the strategies differed depending on the context.

Factors Affecting Patient and Clinician Satisfaction with the Clinical Consultation: Can Communication Skills Training for Clinicians Improve Satisfaction?

Shilling, V., Jenkins, V., and Fallowfield, L.

Psycho-Oncology, *12* (2003), 599–611

The provision of adequate information in a clear and sensitive manner can improve cancer patients' experience of care. Satisfaction with the cancer consultation may impact on satisfaction with care in general and adjustment to the disease. This study aims to identify factors that influence patient and clinician satisfaction with the cancer consultation and whether satisfaction can be improved with communication skills training. One hundred sixty doctors from 34 UK cancer centers participated. Half were randomized to attend a communication skills training course. Patient satisfaction data are presented at baseline and following a communication skills course or in the case of the control doctors, three months after baseline. Clinicians also rated their satisfaction with the consultations. Overall patient satisfaction was not related to the speciality, seniority, or sex of the clinician or patient, site of primary cancer, or type of treatment. Satisfaction was related to patients' age, psychological morbidity, and, most significantly, satisfaction with the length of wait in clinic. Clinician satisfaction was not related to age, sex, or cancer site, but clinicians were less satisfied following consultations with patients being treated palliatively. Communication skills training had a nonsignificant positive effect on patient satisfaction. The subtle benefits of improved communication may be overshadowed by practical problems such as waiting too long to see the doctor, which have an adverse effect on satisfaction.

How to Optimize Physicians' Communication Skills in Cancer Care: Results of a Randomized Study Assessing the Usefulness of Posttraining Consolidation Workshops

Razavi, D., Merckaert, I., Marchal, S., Libert, Y., Conradt, S., Boniver, J., Etienne, A.-M., Fontaine, O., Janne, P., Klastersky, J., Reynaert, C., Scalliet, P., Slachmuylder, J.-L., and Delvaux, N.

Journal of Clinical Oncology, *21* (2003), 3141–3149

Although there is wide recognition of the usefulness of improving physicians' communication skills, no studies have yet assessed the efficacy of posttraining consolidation workshops. This study aims to assess the efficacy of six 3-hour consolidation workshops conducted after a 2.5-day basic training program.

Physicians, after attending the basic training program, were randomly assigned to consolidation workshops or to a waiting list. Training efficacy was assessed through simulated and actual patient interviews that were audiotaped at baseline and after consolidation workshops for the consolidation-workshop group, and approximately 5 months after the end of basic training for the waiting-list group. Communication skills were assessed according to the Cancer Research Campaign Workshop Evaluation Manual. Patients' perceptions of communication skills improvement were assessed using a 14-item questionnaire. Sixty-three physicians completed the training program. Communication skills improved significantly more in the consolidation-workshop group compared with the waiting-list group. In simulated interviews, group-by-time repeated measures analysis of variance showed a significant increase in open and open directive questions ($p = 0.014$) and utterances alerting patients to reality ($p = 0.049$), as well as a significant decrease in premature reassurance ($p = 0.042$). In actual patient interviews, results revealed a significant increase in acknowledgments ($p = 0.022$) and empathic statements ($p = 0.009$), in educated guesses ($p = 0.041$), and in negotiations ($p = 0.008$). Patients interacting with physicians who benefited from consolidation workshops reported higher scores concerning their physicians' understanding of their disease ($p = 0.004$). Consolidation workshops further improve a communication skills training program's efficacy and facilitate the transfer of acquired skills to clinical practice.

Effect of Communications Training on Medical Student Performance

Yedidia, M.J., Gillespie, C.C., Kachur, E., Schwartz, M.D., Ockene, J., Chepaitis, A.E., Snyder, C.W., Lazare, A., and Lipkin, M., Jr.

JAMA, *290* (2003), 1157–1165

Although physicians' communication skills have been found to be related to clinical outcomes and patient satisfaction, teaching of communication skills has not been fully integrated into many medical school curricula or adequately evaluated with large-scale controlled trials.

The objective of this study was to determine whether communications training for medical students improves specific competencies known to affect outcomes of care. A communications curriculum instituted in 2000–2001 at three U.S. medical schools was evaluated with objective structured clinical examinations (OSCEs). The same OSCEs were administered to a comparison cohort of students in the year before the intervention.

Participants included 138 randomly selected medical students (38% of eligible students) in the comparison cohort, tested at the beginning and end of their third year (1999–2000), and 155 students in the intervention cohort (42% of eligible students), tested at the beginning and end of their third year (2000–2001). Intervention comprehensive communications curricula were developed at each school using an established educational model for teaching and practicing core communication skills and engaging students in self-reflection on their performance. Communications teaching was integrated with clinical material during the third year, required clerkships, and was supported by formal faculty development.

Standardized patients assessed student performance in OSCEs on 21 skills related to five key patient care tasks: relationship development and maintenance, patient assessment, education and counseling, negotiation and shared decision making, and organization and time management. Scores were calculated as percentage of maximum possible performance.

Adjusting for baseline differences, students exposed to the intervention significantly outperformed those in the comparison cohort on the overall OSCE (65.4% *vs*. 60.4%; 5.1% difference; 95% confidence interval [CI], 3.9%–6.3%; $p < 0.001$), relationship development and maintenance (5.3% difference; 95% CI, 3.8%–6.7%; $p < 0.001$), organization and time management (1.8% difference; 95% CI, 1.0%–2.7%; $p < 0.001$), and subsets of cases addressing patient assessment {6.7% difference; 95% CI, 5.9%–7.8%; $p < 0.001$) and negotiation and shared decision making (5.7% difference; 95% CI, 4.5%–6.9%; $p < 0.001$). Similar effects were found at each of the three schools, although they differed in magnitude.

Communications curricula using an established educational model significantly improved third-year students' overall communications competence as well as their skills in relationship building, organization and time management, patient assessment, and negotiation and shared decision making—tasks that are important to positive patient outcomes. Improvements were observed at each of the three schools despite adaptation of the intervention to the local curriculum and culture.

Patient Preference for Radiotherapy Fractionation Schedule in the Palliation of Painful Bone Metastases

Shakespeare, T.P., Lu, J.J., Back, M.F., Liang, S., Mukherjee, R.K., and Wynne, C.J.

Journal of Clinical Oncology, *21* (2003), 2156–2162

The radiotherapeutic management of painful bone metastases is controversial, with several institutional and national guidelines advocating use of single-fraction radiotherapy. We aimed to determine patient choice of fractionation schedule after involvement in the decision-making process by use of a decision board.

Advantages and disadvantages of two fractionation schedules (24 Gy in six fractions *vs*. 8 Gy in one fraction) used in the randomized Dutch Bone Metastasis Study were discussed with patients using a decision board. Patients were asked to choose a fractionation schedule, to give reasons for their choice, and to indicate level of satisfaction with being involved in decision making.

Sixty-two patients were entered. Eighty-five percent (95% confidence interval, 74% to 93%) chose 24 Gy in six fractions over 8 Gy in one fraction ($p < 0.0005$). Variables including age, sex, performance status, tumor type, pain score, and paying class were not significantly related to patient choice. Multiple fractionation was chosen for lower retreatment rates (92%) and fewer fractures (32%). Single-fraction treatment was chosen for cost (11%) and convenience (89%). Eighty-four percent of patients expressed positive opinions about being involved in the decision-making process.

Decision board instruments are feasible and acceptable in an Asian population. The vast majority of patients preferred 24 Gy fractionated radiotherapy compared with a single fraction of 8 Gy. These results indicate the need for further research in this important area and serve to remind both clinicians and national or institutional policy makers of the importance of individual patient preference in treatment decision making.

Effect of Ethics Consultations on Nonbeneficial Life-Sustaining Treatments in the Intensive Care Setting: A Randomized Controlled Trial

Schneiderman, L.J., Gilmer, T., Teetzel, H.D., Dugan, D.O., Blustein, J., Cranford, R., Briggs, K.B., Komatsu, G.I., Goodman-Crews, P., Cohn, F., and Young, E.W.D.

JAMA, *290* (2003), 1166–1172

Ethics consultations increasingly are being used to resolve conflicts about life-sustaining interventions, but few studies have reported their outcomes. Our objective was to investigate whether ethics consultations in the intensive care setting reduce the use of life-sustaining treatments delivered to patients who ultimately did not survive to hospital discharge, as well as the reactions to the consultations of physicians, nurses, and patients/surrogates. The design was a prospective, multicenter, randomized controlled trial from November 2000 to December 2002.

The setting was adult intensive care units (ICUs) of seven U.S. hospitals representing a spectrum of institutional characteristics. Five hundred fifty-one patients in whom value-related treatment conflicts arose during the course of treatment took part in the study. Patients were randomly assigned either to an intervention (ethics consultation offered; $n = 278$) or to usual care ($n = 273$). The primary outcomes were ICU days and life-sustaining treatments in those patients who did not survive to hospital discharge. We examined the same measures in those who did survive to discharge and also compared the overall mortality rates of the intervention and usual care groups. We also interviewed physicians and nurses and patients/surrogates about their views of the ethics consultation.

The intervention and usual-care groups showed no difference in mortality. However, ethics consultations were associated with reductions in hospital (-2.95 days, $p = 0.01$) and ICU (-1.44 days, $p = 0.03$) days and life-sustaining treatments (-1.7 days with ventilation, $p = 0.03$) in those patients who ultimately did not survive to discharge. The majority (87%) of physicians, nurses, and patients/surrogates agreed that ethics consultations in the ICU were helpful in addressing treatment conflicts.

Ethics consultations were useful in resolving conflicts that may have inappropriately prolonged nonbeneficial or unwanted treatments in the ICU.

QUALITY OF PALLIATIVE CARE

End-of-Life Practices in European Intensive Care Units: The Ethicus Study

Sprung, C.L., Cohen, S.L., Sjokvist, P., Baras, M., Bulow, H.-H., Hovilehto, S., Ledoux, D., Lippert, A., Maia, P., Phelan, D., Schobersberger, W., Wennberg, E., and Woodcock, T. and for the Ethicus Study Group

JAMA, *290* (2003), 790–797

Although the adoption of practice guidelines is standardizing many aspects of patient care, ethical dilemmas are occurring because of forgoing life-sustaining therapies in intensive care and are dealt with in diverse ways between different countries and cultures.

The objectives of the study were to determine the frequency and types of actual end-of-life practices in European intensive care units (ICUs) and to analyze the similarities and differences. The design and setting were a prospective, observational study of European ICUs. Participants included consecutive patients who died or had any limitation of therapy. Prospectively defined end-of-life practices in 37 ICUs in 17 European countries were studied from January 1, 1999, to June 30, 2000. Measures included comparison and analysis of the frequencies and patterns of end-of-life care by geographic regions and different patients and professionals.

Of 31,417 patients admitted to ICUs, 4248 patients (13.5%) died or had a limitation of life-sustaining therapy. Of these, 3086 patients (72.6%) had limitations of treatments (10% of admissions). Substantial intercountry variability was found in the limitations and the manner of dying: unsuccessful cardiopulmonary resuscitation in 20% (range, 5%–48%), brain death in 8% (range, 0%–15%), withholding therapy in 38% (range, 16%–70%), withdrawing therapy in 33% (range, 5%–69%), and active shortening of the dying process in 2% (range, 0%–19%). Shortening of the dying process was reported in seven countries. Doses of opioids and benzodiazepines reported for shortening of the dying process were in the same range as those used for symptom relief in previous studies. Limitation of therapy *versus* continuation of life-sustaining therapy was associated with patient age, acute and chronic diagnoses, number of days in ICU, region, and religion ($p < 0.001$).

The limiting of life-sustaining treatment in European ICUs is common and variable. Limitations were associated with patient age, diagnoses, ICU stay, and geographic and religious factors. Although shortening of the dying process is rare, clarity between withdrawing therapies and shortening of the dying process and between therapies intended to relieve pain and suffering and those intended to shorten the dying process may be lacking.

Assessment of Quality of Life in Outpatients with Advanced Cancer: The Accuracy of Clinician Estimations and the Relevance of Spiritual Weil-Being: A Hoosier Oncology Group Study

Fisch, M.J., Titzer, M.L., Kristeller, J.L., Shen, J., Loehrer, P.J., Jung, S.-H., Passik, S.D., and Einhorn, L.H.

Journal of Clinical Oncology, *21* (2003), 2754–2759

The purpose of the study was to evaluate the association between quality-of-life (QOL) impairment as reported by patients and QOL impairment as judged by nurses or physicians, with and without consideration of spiritual well-being (SWB). A total of 163 patients with advanced cancer were enrolled into a therapeutic trial, and cross-sectional data were derived from clinical and demographic questionnaires obtained at baseline, including assessment of patient QOL and SWB. Clinicians rated the QOL impairment of their patients as mild, moderate, or severe. Clinician-estimated QOL impairment and patient-derived QOL categories were compared. Correlation coefficients were estimated to associate QOL scores using different instruments. The analysis of variance method was used to compare Functional Assessment of Cancer Therapy-General scores on categorical variables.

There was no significant association between self-assessment scores and marital status, education level, performance status, or predicted life expectancy. However, a strong relationship between SWB and QOL was noted ($p < 0.0001$). Clinician-estimated QOL impairment matched the level of patient-derived QOL correctly in approximately 60% of cases, with only slight variation depending on the method of categorizing patient-derived QOL scores. The accuracy of clinician estimates was not associated with the level of SWB. Interestingly, a subset analysis of the inaccurate estimates revealed an association between lower SWB and clinician underestimation of QOL impairment ($p = 0.0025$).

Clinician estimates of QOL impairment were accurate in more than 60% of patients. SWB is strongly associated with QOL, but it is not associated with the overall accuracy of clinicians' judgments about QOL impairment.

Identifying Psychosocial Risk Indicative of Subsequent Resource Use in Families of Newly Diagnosed Pediatric Oncology Patients

Kazak, A.E., Cant, M.C., Jensen, M.M., McSherry, M., Rourke, M.T., Hwang, W.-T., Alderfer, M.A., Beele, D., Simms, S., and Lange, B.J.

Journal of Clinical Oncology, *21* (2003), 3220–3225

The primary purpose of this prospective study was to identify the level of risk for psychosocial distress in families of children newly diagnosed with cancer. Additional study aims were to examine concordance among family and staff reports of psychosocial risk, to determine changes in risk status over time, and to predict the use of psychosocial resources during the first months of treatment. Caregivers of 125 children newly diagnosed with cancer completed the Psychosocial Assessment Tool (PAT) at diagnosis (t1) and 3 to 6 months later (t2). Primary oncologists and nurses completed an analogous measure of perceived family psychosocial risk at t1 and t2. At t2, oncology social workers reported types and intensity of psychosocial interventions provided. The PAT identified three subsets of families who presented with increasing levels of psychosocial risk at diagnosis. In general, there was moderate concordance among family, oncologist, and nurse reports of psychosocial risk. PAT scores at t1 predicted t2 PAT scores and psychosocial resource use at t2 beyond demographic or disease factors. A brief screening tool (PAT) is valuable in identifying psychosocial risk factors at diagnosis and is predictive of later use of psychosocial resources. As a next step in this research, the development of psychosocial interventions to match family risk level may be an effective and cost-efficient approach to working with families to address their concerns and promote short- and long-term adjustment.

Predictors of Depression and Life Satisfaction among Spousal Caregivers in Hospice: Application of a Stress Process Model

Haley, W.E., LaMonde, L.A., Han, B. Burton, A.M., and Schonwetter, R.

Journal of Palliative Medicine, *6* (2003), 215–224

Using a stress process model, risk factors (caregiving stressors, caregiver health, and negative social interactions) and protective factors (caregiving appraisals and social resources) were examined as predictors of family caregiver well-being (depression and life satisfaction). Eighty spousal caregivers of hospice patients with dementia or lung cancer completed structured interviews and self-report measures assessing components of the stress process model. Results suggest that objective measures of patient impairment or amount of care provided are not strong predictors of caregiver depression or life satisfaction. Female gender, caregiver health problems, and negative social interactions were risk factors for poorer caregiver well-being. Caregivers who subjectively appraised caregiving tasks as less stressful, who found meaning and subjective benefits from caregiving, and with more social resources had lower depression and higher life satisfaction, even after controlling for patient impairment and caregiver appraisal variables. Regression models accounted for 42% of variance in caregiver depression and 52% of variance in caregiver life satisfaction. Counseling for hospice family caregivers could utilize the stress process framework and pay particular attention to finding meaning or subjective benefits from caregiving and remaining active in social roles. Further research providing evidence on caregiver risk and protective factors could improve the conceptual and empirical basis for psychosocial interventions for hospice family caregivers.

Patterns of Functional Decline at the End of Life

Lunney, J.R., Lynn, J. Foley, D.J., Lipson, S., and Guralnik, J.M.

JAMA, *289* (2003), 2387–2392

Clinicians have observed various patterns of functional decline at the end of life, but few empirical data have tested these patterns in large populations. Our objective was to determine if functional decline differs among four types of illness trajectories: sudden death, cancer death, death from organ failure, and frailty. Design, Setting, and Participants We used cohort analysis of data from four U.S. regions in the prospective, longitudinal Established Populations for Epidemiologic Studies of the Elderly (EPESE) study. Of the 14,456 participants aged 65 years or older who provided interviews at baseline (1981–1987), 4871 died during the first 6 years of follow-up; 4190 (86%) of these provided interviews within 1 year before dying. These decedents were evenly distributed in 12 cohorts based on the number of months between the final interview and death. Self- or proxy-reported physical function (performance of seven activities of daily living [ADLs]) within 1 year prior to death predicted ADL dependency prior to death.

Mean function declined across the 12 cohorts, simulating individual decline in the final year of life. Sudden death decedents were highly functional even in the last month before death (mean [95% confidence interval {CI}] numbers of ADL dependencies: 0.69 [0.19–1.19] at 12 months before death *vs*. 1.22 [0.59–1.85] at the final month of life, $p = .20$); cancer decedents were highly functional early in their final year but markedly more disabled 3 months prior to death (0.77 [0.30–1.24] *vs*. 4.09 [3.37–4.81], $p < 0.001$); organ failure decedents experienced a fluctuating pattern of decline, with substantially poorer function during the last 3 months before death (2.10 [1.49–2.70] *vs*. 3.66 [2.94–4.38], $p < 0.001$); and frail decedents were relatively more disabled in the final year and especially dependent during the last month (2.92 [2.24–3.60] *vs*. 5.84 [5.33–6.35], $p < 0.001$). After controlling for age, sex, race, education, marital status, interval between final interview and death, and other demographic differences, frail decedents were more than 8 times more likely than sudden death decedents to be ADL dependent (OR, 8.32 [95% CI, 6.46–10.73); cancer decedents, 1.5 times more likely (OR, 1.57 [95% CI, 1.25–1.96]); and organ failure decedents, 3 times more likely (OR, 3.00 [95% CI, 2.39–3.77]). Trajectories of functional decline at the end of life are quite variable. Differentiating among expected trajectories and related needs would help shape tailored strategies and better programs of care prior to death.

PSYCHOSOCIAL INTERVENTIONS

Couples Therapy at End of Life

Mohr, D.C., Moran, P.J., Kohn, C., Hart, S., Armstrong, K., Dias, R., Bergsland, E., and Folkman, S.

Psycho-Oncology, *12* (2003), 620–627

This study reports on a preliminary uncontrolled study of a treatment for couples in which one partner is diagnosed with a terminal illness. In this study nine couples, in which one partner was diagnosed with a terminal illness and had less than 18 months to live, were offered eight sessions of couples therapy. Follow-up data were available for six couples. Two patients died during treatment and a third patient moved out of the area prior to completing the follow-up assessment. Significant decreases were seen in the patients' distress about dying and the frequency of partners' worry about their partner dying. Improvements were also seen in relationship quality. Although the size of the study precludes generalizing these findings to a larger population, this study supports further exploration of couples therapy as a potentially useful adjunct to end-of-life care.

Cognitive-Existential Group Psychotherapy for Women with Primary Breast Cancer: A Randomized Controlled Trial

Kissane, D.W., Bloch, S., Smith, G.C., Miach, P., Clarke, D.M., Ikin, J., Love, A., Ranieri, N., and McKenzie, D.

Psycho-Oncology, *12*, 6 (2003), 532–546

The investigators conducted a randomized, controlled trial of cognitive-existential group therapy (CEGT) for women with early stage breast cancer receiving adjuvant chemotherapy with the aim of improving mood and mental attitude to cancer.

Women were randomized to 20 sessions of weekly group therapy plus 3 relaxation classes or to a control arm receiving 3 relaxation classes. Assessments, independently done at baseline, 6, and 12 months, included a structured psychiatric interview and validated questionnaires covering mood, attitudes to cancer, family relationships, and satisfaction with therapy.

Three hundred and three of 491 (62%) eligible patients participated over 3 years. Distress was high preintervention: 10% were diagnosed as suffering from major depression, 27% from minor depression and 9% from anxiety disorders. On an intention-to-treat analysis, there was a trend for those receiving group therapy ($n = 154$) to have reduced anxiety ($p = 0.05$, 2-sided) compared to controls ($n = 149$). Women in group therapy also showed a trend towards improved family functioning compared to controls ($p = 0.07$, 2-sided). The women in the groups reported greater satisfaction with their therapy ($p < 0.001$, 2-sided), appreciating the support and citing better coping, self-growth, and increased knowledge about cancer and its treatment. They valued the CEGT therapy. Overall effect size for the group intervention was small

($d = 0.25$), with cancer recurrence having a deleterious effect in 3 of the 19 therapy groups. Psychologists as a discipline achieved a moderate mean effect size ($d = 0.52$). CEGT is a useful adjuvant psychological therapy for women with early stage breast cancer. Interaction effects between group members and therapists are relevant to outcome. Group-as-a-whole effects are powerful, but the training and experience of the therapist is especially critical to an efficacious outcome.

Writing Therapy for the Bereaved: Evaluation of an Intervention

O'Connor, M., Nikoletti, S., Kristjanson, L.J., Loh, R., and Willcock, B.

Journal of Palliative Medicine, *6* (2003), 195–204

Bereavement is a risk factor for a wide range of well-documented negative outcomes. As such, a range of sensitive and appropriate interventions are needed to support people adjusting to their new roles and change in identity. Writing has proven to be useful for people adjusting to traumatic experiences. Translating experiences into language and constructing a coherent narrative of the event enables thoughts and feelings to be integrated, leading to a sense of resolution and less negative feelings associated with the experience. Using a writing therapy intervention tailored specifically for bereaved individuals in Western Australia, this study asked: "Does a writing therapy intervention reduce grief, lead to greater health and well-being and lead to greater self care for bereaved individuals?" The results indicate that for grief and General Health Questionnaire-30 (GHQ-30) scores, there was an overall improvement for all participants regardless of whether participants received the intervention or not. The results for the effect of writing therapy on self-care demonstrate that there is a greater increase in self-care for the intervention group than for the control group; however, this trend does not reach statistical significance. Writing therapy offers a useful, cost-effective, and private way of supporting bereaved individuals who may not practice self-care. The main limitation of the current research is the low number of participants, which limits the generalizability of the results. Future research could be directed toward evaluating the intervention for recently bereaved people or those identified by screening as being particularly vulnerable.