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DEPRESSION LINKED TO FEAR AND MISUNDERSTANDING OF PALLIATIVE CARE IN CANCER PATIENTS

Avoidance or rejection of outpatient palliative care services by cancer patients is linked to greater severity of depressive symptoms, which was found more frequently among middle-aged and younger patients than among older adult patients. Older adults were not only less likely to be depressed, researchers found, but also more accepting of palliative care (PC) regardless of health factors. “Findings indicate that older adults with cancer are more likely to favor palliative care, with depression symptom severity accounting for age-

related differences,” write the authors of a *Journal of Palliative Medicine* report. “Given that palliative care can improve quality of life and reduce depression severity, clinicians should address patients’ fears to encourage utilization when indicated.” The authors suggest clinicians explore the presence of heightened emotional distress. “As our findings and others demonstrate that depression is associated with unfavorable attitudes toward utilizing palliative care, it may be helpful for clinicians to query patients about their emotional needs and address depression before discussing palliative care reluctance.”

Investigators analyzed responses of adult volunteers (n = 1,095) with a history of cancer who were recruited through the National Institutes of Health ResearchMatch tool, and who had completed one of two cross-sectional online surveys between 2015 and 2018. Participant age range was 26–93 years (mean age, 60.4 years; standard deviation [SD], 11.45), 56.5% female, and 93% identified as non-Hispanic White race.

Measures completed by participants included the Patient-Reported Outcomes Information System (PROMIS) Depression scale study;

the Palliative Care Attitudes Scale (PCAS) development study, 3-item emotional subscale; the SF-11 perceived health rating; and the Functional Assessment of Cancer Therapy-General (FACT-G) physical well-being subscale.

Overall

- Most common diagnoses among participants were prostate (34.1%), breast (23.3%), colorectal (17.5%), skin (15.3%), and lung (13.5%) cancers.
- Mean time since cancer diagnosis was 5.26 years (SD, 5.16).
- 66.1% had one or more comorbidities.
- 23.8% experienced moderate to severe depression.
- 52.3% expressed fear of PC as “opposed to” (17.5%) or “skeptical of/about” (34.8%).

Key findings

- Older participants had lower depression severity (Pearson $r = 20$; $P < 0.001$) and were less fearful of PC ($r = -0.11$; $P < 0.001$) than middle-aged and younger adults.

IN THIS ISSUE

Page 1. Depression Linked to Fear and Misunderstanding of Palliative Care in Cancer Patients

Page 3. Most Clinicians Favor Palliative Care for Interstitial Lung Disease Patients, But Refer Late

Page 4. Cancer Patients’ Poor Prognostic Understanding, Discordance with Oncologists’ Views Affect Outcomes

Page 5. Experienced Surrogates Identify Need for Better Role Preparation, More Advance Care Planning

Page 6. Dementia Dual Risk Factors: Simultaneous Cognitive and Gait Decline

(Continued on page 2)

- Participants who were more depressed were more fearful of PC ($r = 0.21$; $P < 0.001$).
- Longer time since diagnosis was associated with lower levels of depression ($r = -0.11$; $P < 0.001$) and being less fearful of PC ($r = -0.10$; $P < 0.001$).
- Higher education level was also associated with lower levels of depression ($r = -0.18$; $P < 0.001$), while participants with metastatic disease reported more severe depression ($r = 0.13$; $P < 0.001$).

“This research showed that older adults with cancer experienced lower depression symptom severity and, accordingly, less fear of palliative care,” write the authors. “Specifically, depression symptom severity accounted for 40% of the association between older age and decreased fear of palliative care. These findings directly contribute to understanding emotional barriers to palliative care.”

Early PC underutilized

Numerous organizations, such as the American Society of Clinical Oncology, the U.S. Institute of Medicine, and the World Health Organization, recommend providing PC — preferably, early in the disease course — to support patients and their families and to help relieve the illness’s physical and emotional symptoms, note the authors.

“Although research has demonstrated that palliative care is most impactful early in the disease course, many only initiate palliative care near the end of life or never utilize palliative care,” the authors write.

This underutilization of PC is due in part to well-documented fear and misconceptions among cancer patients, the authors note. Patients often conflate PC with end-of-life care and the unfounded fear that they and their clinicians would be “giving up” on curative treatment. A recent study also found that one in three cancer patients felt that PC visits would be “very” or “extremely” stressful, rather than supportive or comforting.

The authors consider theirs “the first study to examine age as the primary independent variable with an *a priori* hypothesis about its association with palliative care attitudes, which suggests key implications for the

advancement of palliative care utilization.” The current research built on empirical findings coupled with the authors’ socioemotional selectivity theory, which “posits that as one’s perceived lifespan lessens, goals shift from desiring novelty and knowledge acquisition to optimizing emotional well-being,” suggests older adults may favor care that emphasizes comfort and quality of life.

Regarding the association of heightened symptoms of depression with recent cancer diagnosis, metastatic disease, and lower education level, the authors suggest that these findings may be explained by heightened emotional distress immediately following diagnosis, heavier symptom burden of metastatic disease, and greater difficulty in navigating the medical system found among those with less education, respectively. “As such, clinicians can use the current findings to more readily identify patients who are likely to fear palliative care,” they write.

Limitations pointed out by the authors include a sample that, although large and regionally diverse, was racially homogenous and included long-term cancer survivors and some with earlier-stage cancers. They suggest that along with more racially diverse samples, “future research should aim to determine whether our findings replicate within patients more recently diagnosed and a larger sample of those with worse prognoses and greater financial strain, who are among those most likely to benefit from early outpatient palliative care.”

Due to the significant portion of study participants that were either skeptical or fearful of PC, “direct interventions are needed to reduce patients’ fear and uncertainty surrounding it,” state the authors. “The findings of this study can inform materials used to disseminate palliative care information and patient-clinician conversations, which should be adapted to account for differing palliative care attitudes by age and depression status.”

Source: “Fear of Palliative Care: Roles of Age and Depression Severity,” *Journal of Palliative Medicine*; May 2022; 25(5):768–773; DOI: 10.1089/jpm.2021.0359. Alonzi S, Perry LM, Lewson AB, Mossman B, et al; Department of Psychology, Tulane University, New Orleans; Department of Psychology, Indiana University-Purdue University Indianapolis, Indianapolis; Department of Psychology, Loyola University New Orleans, New Orleans; Department of Palliative Medicine and Supportive Care, University Medical Center, New Orleans; Departments of Psychiatry and Medicine, Tulane Cancer Center, New Orleans.

MOST CLINICIANS FAVOR PALLIATIVE CARE FOR INTERSTITIAL LUNG DISEASE PATIENTS, BUT REFER LATE

While nearly all clinicians caring for patients with interstitial lung disease (ILD) at specialty centers have accurate knowledge of palliative care (PC) and express approval for its benefits, only two-thirds refer their patients to PC, the vast majority referring at disease progression, with only 2% doing so at diagnosis, according to a report published in *Chest*. The authors recommend the development of guidelines on optimal timing for PC referral and educational materials on PC availability for clinicians, patients, and their families.

“PC can and should be administered in parallel with curative care,” write the authors. “ILD providers are at the front line to recognize PC needs, and it is critical that ILD providers are attuned to the unmet needs of their patients and aware of available PC resources.” In addition to high mortality, ILD patients experience “poor quality of life with a profound symptom burden, similar to that of patients with lung cancer,” write the authors. Symptoms of refractory breathlessness, intense fatigue, and persistent cough are often present years before death. “PC is successful in improving breathlessness in chronic lung disease and can increase survival,” the authors note.

Professional organizations such as the American College of Chest Physicians and the American Thoracic Society strongly endorse PC, and state that “PC should be available to all patients at all stages of illness,” yet “PC involvement in ILD occurs infrequently and often late in the disease course,” write the authors. Investigators analyzed electronic survey responses submitted between October 2020 and January 2021 by ILD clinicians ($n = 128$) representing all 68 Pulmonary Fibrosis Foundation (PFF) care centers located in 34 U.S. states. Participants included physicians (61%), registered nurses (20%), and advanced practice providers (16%). 67% identified as White race; 35% had > 15 years of experience, while 29% reported ≤ 5 years of experience.

Findings

- Nearly 90% of respondents understood that PC is distinct from hospice care; 91% to 99% understood that PC includes symptom management, advance directives, psychological care, and spiritual care.
- 91% of respondents reported feeling comfortable discussing prognosis and disease trajectory, a slightly

lower percentage said they felt comfortable assessing a patient’s readiness for and acceptance of PC (88%).

- While 95% of all respondents agreed that addressing advance directives (ADs) is important, only 66% indicated that they themselves addressed ADs in the outpatient ILD clinical setting.
- 88% of respondents felt comfortable assessing the patient’s readiness for PC, but only 67% said they use PC services for their ILD patients. No significant differences in use of PC services were found between providers with >10 years and <10 years of experience.

PC referral and timing

- 23% of respondents reported that they rarely referred patients to PC. Of these, 66% said they did not refer because there were no PC services at their institution, 24% felt comfortable providing PC in their clinic, and 17% said they had insufficient time to address PC.
- Other determinants of rarely referring to PC included a lack of local PC availability ($P < 0.01$), lower levels of comfort discussing prognosis or disease trajectory ($P = 0.03$), and lower likelihood of viewing the discussion of ADs as important ($P = 0.02$).

Of the 67% who reported referring patients to PC, 80% referred at objective and/or symptomatic progression, 54% did so at objective disease progression, 42% referred at patient hospitalization, and only 2% referred at initial ILD diagnosis. The researchers also identified four potential barriers to the timely provision of PC: lack of consistently used, validated instruments to assess ILD symptom burden; lack of an established optimal timing for PC referral; unclear need for specialized PC delivery; and providers’ perceived lack of local access to PC.

“Development of guidelines on optimal timing of PC referral may prompt providers to consider earlier referral,” suggest the authors. This is particularly important in light of a recent study finding that a substantial proportion (one-half) of idiopathic pulmonary fibrosis patients were admitted to an ICU prior to their third clinic visit and most subsequently died there. “For those patients who are able to be discharged from the ICU, 3-month mortality is 95%,” the authors note.

(Continued on page 7)

CANCER PATIENTS' POOR PROGNOSTIC UNDERSTANDING, DISCORDANCE WITH ONCOLOGISTS' VIEWS AFFECT OUTCOMES

Poor prognostic understanding of life expectancy among older patients with advanced, incurable cancer was associated with lower likelihood of hospice use. Further, discordance between patients and oncologists regarding life expectancy estimates was linked to greater odds of hospitalization within six months of the study start, according to a report published in *JAMA Network Open*.

"Patients with incurable cancers who perceive their cancers as curable or overestimate their survival may be more willing to accept life-extending therapy, may have a lower likelihood of having a do-not-resuscitate order, and may be less likely to receive or want hospice care at the end of life," write the authors. "Therefore, ensuring that patients with advanced cancers have an accurate understanding of their prognosis (or promoting acceptance of their prognosis) is essential for treatment decision making, advance care planning, and psychological support."

Investigators conducted a secondary analysis of a randomized clinical trial, using data collected from U.S. community oncology practices ($n = 31$) on 541 patients aged ≥ 70 years with a diagnosis of incurable stage III or IV solid tumor or lymphoma who were receiving or considering any line of cancer treatment from 2014 to 2017. All patients had at least one impaired domain in the geriatric assessment from the primary study. The follow-up period was at least one year.

Overall, the mean age of patients was 76.6 years, 49% female, 90% were self-reported White race, and 52% had at least some college education. The most common cancer types were lung (25%) and gastrointestinal cancer (24%). The definition of "incurable" was based on the judgment of the patients' oncologists, who were also enrolled in the study. Respondents were asked at enrollment about their beliefs regarding curability ("What do you believe are the chances the cancer will go away and never come back with treatment?"). Response options were 100%, $> 50\%$, 50%, $< 50\%$, and 0%. Answers other than 0% were thought to reflect poor prognostic understanding.

Participants were also asked to estimate life expectancy ("Considering your/the patient's health, and your/the patient's underlying medical conditions, what would you estimate your/the patient's overall life expectancy to be?"). Answers of > 5 years reflected poor prognostic

understanding. Additional options included 0–6 months, 7–12 months, 1–2 years, and 2–5 years. Any difference between the oncologist and patient in the numerical responses in either category was considered discordant.

Key findings

- 59% of older adult patients with advanced cancer had poor prognostic understanding of curability.
- 41% of patients had poor prognostic understanding regarding life expectancy.
- 60% of patient-oncologist dyads were discordant regarding curability.
- 72% of dyads were discordant regarding life expectancy.

"Most discordances were due to patients estimating a higher chance of curability (89%) and greater life expectancy (87%) than oncologists," write the authors. Further, among those patients with poor prognostic understanding regarding life expectancy, 80% also had poor understanding regarding curability ($P < 0.001$). Among those with poor understanding regarding curability, 53% also had poor prognostic understanding of life expectancy estimates ($P < 0.001$).

22% of oncologists thought a cure was possible (with 4.5% of oncologists selecting a possibility of $\geq 50\%$), even though all study patients had incurable, advanced cancer based on the oncologists' judgment. "Reasons for this selection are unclear," write the authors, "but it is possible that oncologists want to retain a sense of hope and there were insufficient response options (e.g., 1%–10%) to capture this hopefulness, or that, in some cancers previously designated as incurable (e.g., oligometastatic colon cancer), a small chance of curability may be possible."

Outcomes: hospitalization and hospice use

- Patient-oncologist discordance regarding life expectancy was associated with greater odds of hospitalization within the first 6 months of study enrollment (adjusted odds ratio [aOR], 1.64; 95% confidence interval [CI], 1.01 to 2.66) in multivariable analyses.
- Poor understanding regarding life expectancy estimates was associated with lower odds of hospice use within 6 months (aOR, 0.30; 95% CI, 0.16 to 0.59).

(Continued on page 7)

EXPERIENCED SURROGATES IDENTIFY NEED FOR BETTER ROLE PREPARATION, MORE ADVANCE CARE PLANNING

According to a report published in the *Journal of Palliative Medicine*, 73% of experienced surrogate decision makers emphasized the importance of advance care planning (ACP) and expressed the desire for additional preparation for their role, including guidance in learning the patient's wishes, in communicating preferences to clinicians, and in advocating knowledgeably for the patient.

"Surrogate decision making is required in up to 76% of cases at the end of life," write the authors, "making it a vital component of how care is delivered and how patients may experience their final stages of life. However, in many cases surrogates are afforded little preparation or guidance, resulting in surrogate distress."

Discussions of ACP between seriously ill or older adults and their potential surrogates can greatly improve the surrogate's knowledge of the patient's values and preferences regarding various health states and medical interventions, note the authors. Yet, as a recent study has shown, less than 25% of older, seriously ill adults have engaged in such discussions with their potential surrogates.

Investigators analyzed responses of 69 adults recruited from San Francisco hospitals, support groups, and community centers to participate in 13 semi-structured focus groups on their experiences with and opinions about ACP and medical decision making. "In a unique aspect of this study, participants were asked about the 'advice they would give others' in similar situations," the authors write.

Participants were initially divided into two groups: the "surrogate" group (58%), persons aged ≥ 18 years who had made medical decisions for others; and the "patient" group, those aged ≥ 65 years who had made medical decisions for themselves. Many participants had experienced both roles, and surrogate "advice" from both groups was included. Because of known health disparities in ACP and because participants were from diverse demographic backgrounds, separate focus groups were then conducted for individuals by their self-identified race/ethnicity.

Overall

- Mean surrogate age was 63 years (± 13.5), 55% female.
- 85% were English speaking; 15% spoke Spanish.
- 22.5% self-reported as having limited health literacy.

- 40% self-identified as Black American; 27.5% as Asians/Pacific Islanders; 17.5% as White; and 15% as Hispanic/Latinx.

Findings regarding surrogates' identified needs

The surrogates' support for early ACP was strong. Many reported feeling unprepared for the role into which they were sometimes suddenly thrust, by an acute medical crisis or rapid health change, and expressed regret that they had not previously known or discussed the patient's wishes. ("What we should have done was...sit down with the family and say, 'this is what Mom and Dad want.'") Those who had engaged in ACP conversations reported feeling confident that their decisions aligned with the patient's. ("We had it all spelled out. It made it a lot easier.")

Major themes emerged involving the lack of, but need for, surrogates' own preparation plus guidance in:

- Initiating ACP conversations with the patient: ("We didn't brood. We don't talk about dying; we talk about the future," shared one surrogate.)
- Learning the patient's values and preferences: what and how to ask
- Communicating with clinicians and advocating choices: ("Having a good doctor who saw value in counseling was important because I met many doctors who just tell you, then walk out of the room.")
- Making informed surrogate decisions

'Unique and complex' decision making

Surrogates are tasked with making decisions while balancing familiarity with the patient's preferences, understanding of the patient's values and wishes to apply substituted judgment as conditions change, and consideration of what may be in the patient's best interest at the time of decision making, note the authors.

"This makes surrogate decision making unique and complex," the authors write, as surrogate responsibilities include not only knowing and adapting the patient's wishes to new circumstances, but also advocating and communicating with medical professionals. "As a result, surrogates often report anxiety, depression, and distress, which has the potential to influence medical decisions,

(Continued on page 7)

DEMENTIA DUAL RISK FACTORS: SIMULTANEOUS COGNITIVE AND GAIT DECLINE

A decline in older adults' gait speed coupled with a decline in cognitive test scores was associated with a higher risk of dementia than either a decline in gait speed only or in cognition only. Dementia risk was highest among those with both gait decline and memory decline, with a nearly 25-fold increase in risk, according to a report published in *JAMA Network Open*. "These results highlight the importance of gait in dementia risk assessment and suggest that dual decline in gait speed and a memory measure may be the best combination associated with accurate assessment of future dementia risk," write the authors.

Investigators analyzed data on a cohort of 16,855 relatively healthy, community-dwelling older adults (mean age, 75 years; women, 56%) from the U.S. and Australia who participated in ASPREE (ASpirin in Reducing Events in the Elderly), a randomized clinical trial of low-dose aspirin conducted from 2010 to 2017. Participants were free of dementia, cardiovascular disease, or physical disability at baseline, and were expected by their practitioners to live 5 years or longer. Gait speed was measured by having participants complete two 3-meter walks, with an additional meter at the end to accommodate slow-down, at years 0, 2, 4, 6, and at the close-out visit. Gait decline was defined as a decline in gait speed of ≥ 0.05 meter/second per year across the study.

Cognitive measures included tests for global cognitive function (3MS [Modified Mini-Mental State]), memory (HVLRT [Hopkins Verbal Learning Test-Revised]), processing speed (SDMT [Symbol Digit Modalities]), and verbal fluency (COWAT-F [Controlled Oral Word Association Test]), conducted at years 0, 1, 3, 5, and at close out. Cognitive decline was defined as being in the lowest tertile of annual change on the tests. Participants were classified as "dual decliners" (decline in gait and cognition), "gait decliners" (decline in gait only), "cognitive decliners" (decline in any cognitive measure), or "nondecliners" (those with < 0.05 m/s decline in gait speed and in the highest two tertiles in 3MS).

Findings

- Dementia risk was highest among gait plus memory decliners (hazard ratio [HR], 24.7; 95% confidence interval [CI], 16.3 to 37.3) compared with nondecliners.
- Second-highest dementia risk compared with

nondecliners was among global-cognition/gait decliners (HR, 22.2; 95% CI, 15.0 to 32.9), followed by verbal-fluency/gait decliners (HR, 4.7; 95% CI, 3.5 to 6.3), and processing-speed/gait decliners (HR, 4.3; 95% CI, 3.2 to 5.8).

Overall, dual decliners in each of the four cognitive measures had significantly higher dementia risk than did cognitive decliners or gait decliners (with the exceptions of dual decliners in processing speed and verbal fluency).

- Memory dual decliners had a greater risk of dementia than gait decliners (HR, 6.4; 95% CI, 4.2 to 9.8) and cognitive decliners (HR, 3.3; 95% CI, 2.6 to 4.1).
- Global-cognition dual decliners had greater risk of dementia than gait-only decliners (HR, 5.5; 95% CI, 3.8 to 8.1) and cognitive-only decliners (HR, 3.1; 95% CI, 2.5 to 3.9).
- Verbal-fluency dual decliners had greater dementia risk than cognitive-only decliners (HR, 3.8; 95% CI, 2.8 to 5.2) but not gait-only decliners.
- Processing-speed dual decliners had greater risk than cognitive-only decliners (HR, 3.3; 95% CI, 2.4 to 4.4) but not gait-only decliners.

"By presenting specific comparisons between dual decline and cognitive decline groupings in this study, we have been able to specifically illustrate the additional benefit of a combined gait-cognition measure beyond cognitive testing alone," point out the authors. The authors caution that although their study cohort was large, it was also healthier at baseline and year 2 than the general elderly population (aged ≥ 70 years), so the results may not be generalizable to less-healthy groups. "Our findings suggest that serial measurement of gait along with a simple test of memory would be more sensitive to future dementia risk than either measure alone," the authors conclude. "Such a test appears feasible in primary health clinics." A commentary on the report also suggests adding annual assessments of gait speed and cognition to the Medicare Annual Wellness Visit.

Source: "Association of Dual Decline in Cognition and Gait Speed with Risk of Dementia in Older Adults," *JAMA Network Open*; May 2, 2022; 5(5):e2214647; DOI: 10.1001/jamanetworkopen.2022.14647. Collyer TA, Murray AM, Shah RC, Callisaya ML; Peninsula Clinical School, Monash University, Frankston, Victoria, Australia; Hennepin Healthcare and University of Minnesota, Minneapolis; Department of Family Medicine and Rush Alzheimer's Disease Center, Rush University Medical Center, Chicago.

◀ INTERSTITIAL LUNG DISEASE (from page 3)

ILD mortality varies by disease pathology, with a median survival of five years in patients with progressive fibrosing ILD. Acute exacerbation portends 6- to 12-month mortality, the authors note. “Nevertheless, there is often a lack of preparedness for death by both patients and providers, contributing to increased distress.”

Specialist PC

Patients with progressive, irreversible disease despite therapy are most appropriate for PC referral, observe the authors. “In addition to PC referral for the most aggressive ILD phenotypes, we recommend specialist PC involvement for those patients with poorly controlled symptoms, regardless of disease phenotype.”

Although some PC needs may be competently met by primary ILD specialists, “there remains a strong role for specialist PC,” the authors state. They recommend collaboration between ILD and PC providers, employing a multidisciplinary team approach to care. In addition

to understanding and addressing barriers to PC referral, “educational resources may be key to improving PC delivery to the ILD population,” suggest the authors.

Most respondents agreed that educational tools, such as handouts about long-term prognosis and disease trajectory (88%) or PC options for patients and caregivers (93%) would help. The authors also recommend development of clear instructions for clinicians to determine local PC availability. “While ILD providers reassuringly demonstrate knowledge and interest in PC involvement, no current system exists to facilitate and monitor response to referral,” conclude the authors. “Future research is desperately needed to address barriers to the provision of PC in order to enhance access to a critical service in the management and care of patients with ILD.”

Source: “Provider Perspectives on and Access to Palliative Care for Patients with Interstitial Lung Disease,” *Chest*; Epub ahead of print, March 17, 2022; S0012-3692(22)00442-1; DOI: 10.1016/j.chest.2022.03.009. Gersten RA, Danoff SK, et al, on behalf of the Pulmonary Fibrosis Foundation; Division of Pulmonary and Critical Care Medicine, Johns Hopkins University, Baltimore; Pulmonary Fibrosis Foundation, Chicago.

◀ CANCER PATIENTS' POOR PROGNOSTIC UNDERSTANDING (from page 4)

“Older individuals with poor understanding of the outlook of their cancer may be less likely to utilize resources such as hospice services that can address the needs of patients nearing the end of life and their families,” says lead author Kah Poh “Melissa” Loh, MBBCh, BAO, MS, geriatric oncology specialist at the Wilmot Cancer Institute. “Individuals are also more likely to receive care that may not be consistent with their priorities,” adds Loh. “The study tells us that we need better ways to help people understand terrifying news.”

Study limitations include the recruiting of mostly non-Hispanic, well-educated patients, although prior research has shown that poor prognostic understanding and

discordance are more likely to be found among minority racial/ethnic populations, note the authors. The findings of a high prevalence of poor prognostic understanding and discordance highlight the need for “multimodal interventions,” suggest the authors. “These interventions should aim at improving communication about prognosis with appropriate support provided.”

Source: “Association of Prognostic Understanding with Health Care Use among Older Adults with Advanced Cancer: A Secondary Analysis of a Cluster Randomized Clinical Trial,” *JAMA Network Open*; February 1, 2022; 5(2):e220018; DOI: 10.1001/jamanetworkopen.2022.0018. Loh KP, Seplaki CL, Mohile SG, et al; James P. Wilmot Cancer Institute, Division of Hematology/Oncology, Department of Medicine, University of Rochester Medical Center; and Department of Public Health Sciences, University of Rochester School of Medicine and Dentistry, both in Rochester, New York.

◀ EXPERIENCED SURROGATES IDENTIFY NEED (from page 5)

potentially at the cost of the patient’s preferences and best interests.” The authors note that prior research validates their findings, showing “higher quality communication between surrogates and patients, and between surrogates and clinicians, improves both patient and surrogate outcomes.” They also point out study results may aid in

developing interventions to meet the needs of ethnically diverse populations.

Source: “Surrogate Decision Makers Need Better Preparation for Their Role: Experienced Surrogates,” *Journal of Palliative Medicine*; June 2022; 25(6):857–863; DOI: 10.1089/jpm.2021.0283. Bakke BM, Sudore RL, et al; Division of Geriatrics, School of Medicine, University of California, San Francisco, San Francisco; Des Moines University College of Osteopathic Medicine, Des Moines, Iowa; San Francisco Veterans Affairs Health Care System, San Francisco.



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