INTERVIEW

Jennifer S Temel, MD

Dr Temel is Associate Professor of Medicine at Harvard Medical School and Clinical Director of Thoracic Oncology at Massachusetts General Hospital in Boston, Massachusetts.

Tracks 1-12

Select Excerpts from the Interview

Tracks 1-2, 4, 11

DR LOVE: Would you comment on the paper you published on early palliative care for patients with metastatic NSCLC (Temel 2010)?

DR TEMEL: This study started from my clinical observation that the traditional model of an oncologist taking care of a patient with advanced disease was not sufficient. An oncologist does a great job of managing cancer, but patients and their families go through so much more when facing a cancer diagnosis. Palliative care was a growing specialty when we started this research 10 years ago, so we hypothesized that palliative care could play a complementary role in caring for patients receiving standard oncology treatment.

We randomly assigned approximately 150 patients with newly diagnosed metastatic NSCLC to standard care or the same approach integrated with early palliative care. Patients assigned to the palliative care arm met with a palliative care physician or nurse practitioner at least monthly during their clinical course. The palliative care clinicians evaluated the patient and focused on the issues that were most salient for the patient and family at that time.

3.1

Phase III Study Investigating Early Palliative Care in Metastatic Non-Small Cell Lung Cancer

	Standard care alone	Early palliative care with standard care	*p*-value
Quality of life* (n = 47, 60)	91.5	98.0	0.03
Depressive symptoms (n = 47, 57)	38%	16%	0.01
Aggressive end-of-life care (n = 56, 49)	54%	33%	0.05
Median overall survival (n = 74, 77)	8.9 mo	11.6 mo	0.02

* Assessed by the Functional Assessment of Cancer Therapy — Lung scale (scores range from 0 to 136; higher scores indicate better quality of life)

CONCLUSIONS: "Among patients with metastatic non-small-cell lung cancer, early palliative care led to significant improvements in both quality of life and mood. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival."

Temel JS et al. *N Engl J Med* 2010;363(8):733–42.

The results indicated that patients on the palliative care arm experienced improvement in their quality of life, had lower rates of depression and were more likely to assess their illness and prognosis accurately. With such a small population, the study was not powered for survival, but a median increase in survival of more than 2 months was observed in the palliative care arm (Temel 2010; [3.1]; Kelley 2010; [3.2]) Previous studies also suggest that palliative care can affect survival (Bakitas 2009).

DR LOVE: What role does the palliative care clinician play?

DR TEMEL: The biggest role that the palliative care clinician plays is helping patients and families cope with a life-threatening illness (Irwin 2013; [3.3]). It is incredibly challenging for patients to find the right balance between planning for the future and living each day to the fullest.

Patients need to know about the effects of chemotherapy on life expectancy and quality of life. Palliative care clinicians are more comfortable and experienced in giving patients the information they need and helping them make decisions about their care.

DR LOVE: How do you approach end-of-life care decisions for patients with metastatic NSCLC?

3.2

Editorial: Palliative Care — A Shifting Paradigm

"The study by Temel et al represents an important step in confirming the beneficial outcomes of a simultaneous care model that provides both palliative care and disease-specific therapies beginning at the time of diagnosis. This study is an example of research that shifts a long-held paradigm that has limited access to palliative care to patients who were predictably and clearly dying. The new approach recognizes that life-threatening illness, whether it can be cured or controlled, carries with it significant burdens of suffering for patients and their families and that this suffering can be effectively addressed by modern palliative care teams. Perhaps unsurprisingly, reducing patients' misery may help them live longer. We now have both the means and the knowledge to make palliative care an essential and routine component of evidence-based, high-quality care for the management of serious illness."

Kelley AS, Meier DE. *N Engl J Med* 2010;363(8):781–2.

DR TEMEL: Unfortunately, most conversations about end-of-life care happen when patients are in the hospital. Oncologists should initiate conversations about end-of-life care preferences earlier in the ambulatory care setting and make sure that these preferences are documented and accessible.

These are difficult conversations to have. I believe the appropriate way to handle end-of-life care discussions is to ask patients about their resuscitation preferences. I explain to them that if a life-threatening event occurs, the chance of them having a good quality of life would be small, so I do not recommend heroic measures, and that usually develops into a conversation about the appropriate timing for initiation of hospice care.

DR LOVE: How do you deal with the grief associated with treating patients who are terminally ill?

DR TEMEL: One of the best things about being an oncologist is that you develop incredibly close relationships with patients. My approach to dealing with grief might be a little different from others, but I'm comfortable with showing some emotion.

The thoracic oncology group at Massachusetts General Hospital conducts a yearly memorial service for the families of the patients who have passed away within the previous year. This helps the caregivers, and I believe it is important for us to have that time and space to think about all the patients who have passed away and about the families that we miss. ■

3.3

Early Palliative Care (EPC) and Metastatic Non-Small Cell Lung Cancer: Potential Mechanisms of Prolonged Survival

- As a result of EPC, patients may experience improved quality of life and mood, develop a more realistic understanding of their disease and goals of therapy, and enhance adaptive coping behaviors, all of which in turn can influence treatment adherence and end-of-life decisions.
- The authors hypothesize that EPC has the potential to have an impact on overall survival by directly affecting the patient's well-being and experience of suffering, increasing social support, improving understanding of the illness and informing decision-making, which subsequently contribute to less aggressive care at the end of life and earlier referral to hospice.

Irwin K et al. *Chronic Respir Dis* 2013;10(1):35-47.

SELECT PUBLICATIONS

Bakitas M et al. **Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: The Project ENABLE II randomized controlled trial.** *JAMA* 2009;302(7):741-9.

Irwin K et al. **Early palliative care and metastatic non-small cell lung cancer: Potential mechanisms of prolonged survival.** *Chronic Respir Dis* 2013;10(1):35-47.

Kamal AH et al. **Integrating technology into palliative care research.** *Curr Opin Support Palliat Care* 2012;6(4):525-32.

Kelley AS, Meier DE. **Palliative care — A shifting paradigm.** *N Engl J Med* 2010;363(8):781-2.

Neal JW et al. **The SELECT study: A multicenter phase II trial of adjuvant erlotinib in resected epidermal growth factor receptor (EGFR) mutation-positive non-small cell lung cancer (NSCLC).** *Proc ASCO* 2012;**Abstract 7010**.

Pirl WF et al. **Depression and survival in metastatic non-small-cell lung cancer: Effects of early palliative care.** *J Clin Oncol* 2012;30(12):1310-5.

Temel JS et al. **Early palliative care for patients with metastatic non-small-cell lung cancer.** *N Engl J Med* 2010;363(8):733-42.