The Australian and New Zealand Society of Palliative Medicine and the Australasian Chapter of Palliative Medicine

Top 5 low-value practices and interventions

1. Do not delay discussion of and referral to palliative care for a patient with serious illness just because they are pursuing disease-directed treatment

Palliative care provides an added layer of support to patients with life-limiting disease and their families. Symptomatic patients can benefit regardless of their diagnosis, prognosis or disease treatment regimen. Studies show that integrating palliative care with disease-modifying therapies improves pain and symptom control, as well as patient quality of life and family satisfaction. Early access to palliative care has been shown to reduce aggressive therapies at the end of life, prolong life in certain patient populations, and significantly reduce hospital costs.

Evidence:

- Greer JA, Pirl WF, Jackson VA, et al. Effect of early palliative care on chemotherapy use and end-of-life care in patients with metastatic non-small-cell lung cancer. J. Clin. Oncol. Feb 2012
- Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N. Engl. J. Med. Aug 2010
- Bakitas M, Lyons KD, Hegel MT, et al. Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial. JAMA. Aug 2009
- Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. J. Palliat. Med. Mar 2008
- Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. Arch. Intern. Med. Sep 2008

2. Limit routine use of antipsychotic drugs to manage symptoms of delirium [NEW]

Effective screening, reversing the precipitants of delirium and providing a variety of supportive non-pharmacological interventions are crucial to addressing delirium in patients in palliative care settings.
Treatment with antipsychotic drugs should only be considered if patients with delirium are in distress and the cause of distress cannot be addressed through non-drug strategies. Although antipsychotics are commonly used in the management of delirium in palliative care patients, recent evidence on mild- to moderate-severity delirium suggests that antipsychotics are associated with both increased symptoms of delirium and reduced patient survival.

Evidence:

- Agar, Lawlor, et al, Efficacy of Oral Risperidone, Haloperidol, or Placebo for Symptoms of Delirium Among Patients in Palliative Care. JAMA Intern. Med. Jan 2017
- Bush, Tierney, Lawlor, Clinical Assessment and Management of Delirium in the Palliative Care Setting. Drugs. Oct 2017
- Clinical Care Standards on Delirium. Australian Commission on Safety and Quality in Health Care. Jul 2016

3. Do not use oxygen therapy to treat non-hypoxic dyspnoea

Oxygen is frequently used to relieve shortness of breath in patients with advanced illness. However, supplemental oxygen does not benefit patients who are breathless but not hypoxic. Supplemental flow of air is equally as effective as oxygen under these circumstances. The use of a fan for facial air streaming can also be effective.

Evidence:

- Chronic obstructive pulmonary disease (COPD) evidentiary framework. Ont. Health Technol. Assess. Ser. 2012
- Abernethy AP, McDonald CF, Frith PA, et al. Effect of palliative oxygen versus room air in relief of breathlessness in patients with refractory dyspnoea: a double-blind, randomised controlled trial. Lancet. Sep 2010
- Uronis HE, Currow DC, McCrory DC, Samsa GP, Abernethy AP. Oxygen for relief of dyspnoea in mildly- or non-hypoxaemic patients with cancer: a systematic review and meta-analysis. Br. J. Cancer. Jan 2008
- Philip J, Gold M, Milner A, Di Iulio J, Miller B, Spruyt O. A randomized, double-blind, crossover trial of the effect of oxygen on dyspnoea in patients with advanced cancer. J. Pain Symptom Manag. Dec 2006

4. Target referrals to bereavement services for family and caregivers of patients in palliative care settings to those experiencing more complicated forms of grief rather than as a routine practice [NEW]

There is no empirical basis for the practice of offering routine referrals to bereavement services to family and care givers of patients in palliative settings. Most bereaved family and carers are resilient and only a small proportion of individuals will develop pathological responses that might not resolve without professional help.
Evidence suggests psychosocial interventions are more effective for people with more complicated forms of grief. Grief is considered complicated when an individual's ability to resume normal activities and responsibilities is persistently disrupted after six months of bereavement. Six months is seen as the appropriate minimum threshold for complicated grief since studies show that most people integrate bereavement into their lives by this time.

Evidence:

- Schut, Stroebe, Interventions to enhance adaptation to bereavement. J. Palliat. Med. 2005
- Schut, Stroebe, Effects of support, counselling and therapy before and after the loss: can we really help bereaved people? Psychol. Sep 2010
- Zech, Ryckebosch-Dayez, Delespaux, Improving the efficacy of intervention for bereaved individuals: toward a process-focused psychotherapeutic perspective. Psychol. Belg. Sep 2010
- Hall, Beyond Kübler-Ross: Recent developments in our understanding of grief and bereavement. InPsych. Dec 2011
- Wittouck et al, The prevention and treatment of complicated grief: a meta-analysis. Clin. Psychol. Review. Sep 2011

5. To avoid adverse medication interactions in cases of polypharmacy, do not prescribe medication without conducting a drug regimen review

Older patients disproportionately use more prescription and non-prescription drugs than other populations. Evidence shows that such polypharmacy increases the risk of adverse drug reactions and hospital admissions. Medication review with follow up is therefore recommended for optimising prescribed medication and improving quality of life in older adults with polypharmacy.

Evidence:

- Lu et al, Effect of polypharmacy, potentially inappropriate medications and anticholinergic burden on clinical outcomes: a retrospective cohort study. Can. Med. Assoc. J. Mar 2015
- Scott et al Reducing Inappropriate Polypharmacy: The Process of Deprescribing, JAMA Intern. Med. May 2015
- Jodar-Sanchez et al, Cost-Utility Analysis of a Medication Review with Follow-Up Service for Older Adults with Polypharmacy in Community Pharmacies in Spain: The conSIGUE Program, PharmacoEconomics. Mar 2015
- Fried et al, Health outcomes associated with polypharmacy in community-dwelling older adults: a systematic review. J. Am. Geriatr. Soc. Dec 2014
- Hajjar et al, Polypharmacy in elderly patients. Am. J Geriatr. Pharmacother. Dec 2007