

Hospice Benefits and Phase I Cancer Trials

Ira Byock, MD and Steven H. Miles, MD

Annals of Internal Medicine
Vol. 138 No. 4 February 18, 2003, pp 335-337

Medicare denies hospice coverage to patients with terminal illnesses who enroll as participants in phase I studies, which assess the toxicity and dosing of potential treatments for incurable diseases. Federal regulations require patients to forgo curative therapies, and they interpret phase I agents as treatment for the terminal condition for which hospice care was elected. Thus, by enrolling as a participant in a phase I trial, a patient otherwise eligible for hospice is rendered ineligible. Private insurers have similar provisions for children and adults younger than 65 years of age. Such exclusions are not defensible on ethical or clinical grounds. Policymakers, insurers, and institutional review boards all have a role in resolving this problem.

The quality of end-of-life care in the United States is seriously deficient (1--6). Clinicians, researchers, and professional associations recognize the value of comprehensive palliative care, which is exemplified by hospice care for persons with life-limiting illness and their families (7, 8). Hospice offers palliative services to improve comfort and quality of life, including symptom assessment and management; care coordination and 24-hour continuity; assistance with medical decision making and completion of advance directives; patient-centered care planning; crisis prevention and early crisis management; social work and pastoral care; physical, occupational, speech, and other allied therapies as needed; caregiver support; volunteer services; and bereavement support for families. Recognizing the value of these coordinated services, the American Society of Clinical Oncology asserts that "provision of optimal end-of-life care requires access to and availability of state-of-the-art palliative care rendered by skillful clinicians, buttresses when necessary, by palliative care experts... Hospice is the best developed model for end-of-life care in the U.S. health care delivery system" . The American College of Physicians--American Society of Internal Medicine, American College of Surgeons, and American Academy of Pediatrics also strongly endorse access to palliative and hospice care (—10-12). A recent report by the National Cancer Policy Board, an advisory body to the Institute of Medicine and National Research Council, delineates barriers and challenges to integrating palliative care within oncology and calls on cancer researchers to "take a leadership role in modeling the best quality care from diagnosis to death for all Americans" (13).

Participation in Cancer Research and Hospice Eligibility

Medicare and insurers' policies that bar hospice care to patients with terminal illnesses who enroll as participants in Phase I clinical trials deserve urgent attention. Such patients would probably be eligible for the comprehensive palliative care that hospice provides. Phase I studies are preliminary research to determine the toxicity and tolerated doses of potential treatments, such as for currently incurable cancers; they are not designed, or intended, to have therapeutic effects. Phase II trials test the activity of potential treatment protocols against selected illnesses. Phase III trials evaluate the effectiveness of a new treatment against existing treatments. Ironically, entry criteria for phase I trials mirror disease state criteria for hospice admission; however, consenting to enter a phase I trial effectively renders a person ineligible for hospice care.

The 1982 statute that established the Medicare Hospice Benefit laid the foundation for this problem. It compels both patients and providers to choose between hospice services and disease-modifying treatments (14). Medicare regulations states that "An individual must waive all rights to Medicare payments for . . . any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected. . . . Only drugs . . . which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered" (15). Under the capitated per diem benefit, Medicare-funded hospice programs must assume the costs for diagnostic tests, treatments, and the subsequent complications of treatments directed against the patient's terminal illness. Although enrolling in a phase I trial and receiving hospice care may be technically possible, it is rarely, if ever, an option. To comply with the regulations or to remain fiscally viable, most hospice programs admit only patients who agree to forgo disease-modifying treatment.

The exact size of this problem is difficult to gauge. The National Institutes of Health, including the National Cancer Institute, do not keep records of the number or disease states of participants in phase I trials. Indirect evidence suggests that many patients who enroll in phase I clinical trials would be eligible for, and would accept, concurrent hospice care if it was affordable. Approximately 180 000 Medicare hospice benefit recipients die of cancer each year, including 75% of persons with liver or brain cancer and one third of persons with colon cancer (16). This is nearly half of all Medicare cancer deaths (17). One cancer center found median survival of 349 patients in phase I trials to be 6.5 months (18).

Patients with advanced, incurable illness often do not understand the choices that are available to them. Many people who would qualify for hospice care under Medicare understand little about hospice services or eligibility (16,19). Although potential participants in phase I studies are routinely informed that this kind of research is not therapeutic and their participation represents an altruistic contribution to medical science and future patients, many participants are motivated by the hope that the research will benefit them (20, 21, 22, 23). It is unlikely that many patients who are potential study participants understand that enrolling in a phase I trial will prevent access to reimbursed hospice coverage. We are unaware of any informed consent documents that disclose the implications of research participation for hospice enrollment and benefits. Kodish and colleagues (24) found that institutional review boards do not scrutinize phase I trials more rigorously than research that may directly benefit the patient. A recent analysis by Horng and colleagues of the description of benefits and risks listed within consent forms for Phase I oncology trials did not find the risk of losing hospice eligibility among those

disclosed to participants, nor did the authors comment on the omission. (25) Lack of familiarity with these Medicare regulations on the part of patients, providers, and institutional review boards may harm patients' access to palliative care as an unintended consequence of participating in research.

A. An Ethical and Legal Perspective

There are legal and ethical reasons against excluding persons in phase I trials from hospice care. The Belmont Report (26), the founding document for review board policy in the United States, states that "Risks should be reduced to those necessary to achieve the research objective. . . ." and charges review committees to be "extraordinarily insistent on the justification of the risk." The Belmont Report further says that relevant risks "must be thoroughly arrayed in . . . the informed consent process." Regulations codify this duty (27). Given the value of hospice care, barring hospice care to otherwise hospice-eligible patients participating in phase I studies cannot be justified as necessary to achieve a research objective.

Regulations that effectively exclude patients in phase I studies from hospice benefits conflict with the intent of a federal initiative to assure Medicare coverage for the health care costs associated with clinical trials (28). The initiative responds to an Institute of Medicine finding that inconsistent Medicare reimbursement contributes to inadequate research on elderly persons (29). Although the Institute of Medicine did not address hospice reimbursement policy and phase I trials, it did suggest forgiving clinical costs that participants would not incur by electing ordinary clinical care (29). The National Institutes of Health says that informed consent should disclose "that additional costs may be incurred by the patient's participation in the study" (30).

B. Proposed Solutions

Reform of Medicare regulations, private insurance policies, informed consent practices, and institutional review board oversight of this problem is needed. Medicare and health insurers' reimbursement policies must be expanded to cover hospice services for participants in phase I research. The Centers for Medicaid & Medicare Services could issue an administrative rule exempting hospice providers from costs associated with phase I trials, including complications of the experimental protocols. Medicare Part A benefits would continue for services provided in the course of a phase I trial.

Institutional review boards and research institutions have a role to play in addressing this problem. They can work with investigators and private and public research donors to secure hospice funding for participants enrolled in Phase I trials. Institutional review boards should ensure that potential research participants understand the effect of enrollment in a clinical trial on reimbursement and eligibility for hospice services and know that they may withdraw from a study at any time in order to receive such services if they so desire.

Resolving this barrier to hospice reimbursement may yield benefits beyond correcting a troubling clinical and ethical dilemma. Providing hospice care to incurably ill persons while evaluating experimental treatments may also improve the quality of research. Suffering can cause patients to withdraw from research trials and may even shorten survival. Undertreated physical and emotional distress can confound the assessment of the effects of potential therapeutic agents on quality of life. Extending specialized palliative care in the form of hospice to research participants may enable them to complete research protocols (31) thereby contributing to clearer research findings. Such potential salutary effects of palliative care on cancer trials themselves should be monitored. In any case, there is no justification for denying reimbursement for hospice care from those who participate in Phase I clinical trials. Ensuring full access to hospice care for participants who choose at the end of their own lives to advance the future care of others is the least we should do.

Grant Support: By Promoting Excellence in End of Life Care, a national program of the Robert Wood Johnson Foundation. Dr. Miles received support from the Project on Death in America of the Open Society Institute of the Soros Foundation.

Requests for Single Reprints: Ira Byock, MD, The Practical Ethics Center, University of Montana, 1000 East Beckwith Avenue, Missoula, MT 59812; e-mail, ibyock@aol.com.

Current author addresses are available at www.annals.org .

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