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Original Research Article

Admission time regarding palliative care consultation among cancer and non-cancer inpatients: a cross-sectional study

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ABSTRACT

Background: Palliative care is a critical component of modern healthcare, yet disparities may exist in its application. A knowledge gap persists regarding the timing of palliative care consultation for non-cancer patients compared to cancer patients, particularly in non-academic hospital settings. This study aimed to address this gap.
Methods: A prospective, cross-sectional study was conducted at Phra Nakhon Si Ayutthaya Hospital. Data were collected from medical records and consultation logs of 136 inpatients referred for palliative care between September and November 2024. Participants were selected via quota sampling and divided into two equal groups: 68 cancer patients and 68 non-cancer patients.
Results: The median time from admission to palliative care consultation was 5.5 days for the cancer group and 7 days for the non-cancer group; this difference was not statistically significant (p=0.26). Similarly, no significant differences were found in the median total length of stay (10 vs. 11 days, p=0.59) or the median length of stay from consultation to discharge or death (3 vs. 2 days, p=0.11).
Conclusions: This study found no statistically significant difference in the timing of palliative care consultation between cancer and non-cancer patients in a regional hospital setting. However, non-cancer patients were more critically ill upon consultation, as indicated by lower performance scores and greater reliance on life support, suggesting that referrals still occur late in their illness trajectory.

Keywords: Admission time, Palliative care, Cancer, Non-cancer inpatients, Consultation

INTRODUCTION

Currently, palliative care for terminally ill patients is gaining significant importance. A survey by the world health organization (WHO) found that approximately 56.8 million people worldwide require palliative care annually; however, only 14% of those in need receive it. The majority of patients requiring palliative care suffer from chronic diseases, categorized into cancer patients (34%) and non-cancer patients (66%).[1] Historically, palliative care focused primarily on alleviating suffering and improving the quality of life for cancer patients. However, contemporary studies indicate that palliative care plays an increasing role in non-cancer patients.[2] Evidence suggests that palliative care in non-cancer patients reduces dyspnea, decreases emergency department visits, hospital admissions, and intensive care unit (ICU) admissions.[3] Furthermore, these patients are more likely to die at home rather than in the hospital, and caregiver burden is significantly reduced.[4,5]

Early palliative care consultation maximizes benefits for patients and reduces hospital costs.[6,7] However, a study from Switzerland revealed that the median length of hospital stay prior to palliative care consultation was 5 days for cancer patients and 12 days for non-cancer patients, a statistically significant difference ($p<0.01$).[8] Consequently, non-cancer patients experienced longer hospital stays and underwent more invasive procedures.[9]

In Thailand, data regarding palliative care consultation in non-cancer patients remains limited. A study conducted at the Faculty of Medicine, Chulalongkorn University, found that the median length of hospital stay before consultation was 9 days for cancer patients and 18 days for non-cancer patients, with non-cancer patients waiting significantly longer (p=0.001).[10] However, as this study was conducted in a university hospital dealing with complex diseases and distinct consultation systems compared to regional hospitals, the findings may not reflect the characteristics of patients in general settings.

Therefore, this study aims to compare the duration from hospital admission to palliative care consultation between cancer and non-cancer patients at Phra Nakhon Si Ayutthaya Hospital, a regional hospital with an established palliative care team. Additionally, the study aims to investigate patient characteristics influencing palliative care consultation.

Objectives

Objectives were to determine the median difference in the number of days from hospital admission to palliative care consultation between cancer and non-cancer patients admitted to Phra Nakhon Si Ayutthaya Hospital and to identify patient characteristics associated with palliative care consultation.

METHODS

Study design

This is a prospective cross-sectional study.

Population and sample

The study employed consecutive recruitment of all patients referred for palliative care consultation between September 2024 and November 2024.

Inclusion criteria

Patients aged 18 years or older admitted as inpatients at Phra Nakhon Si Ayutthaya Hospital, who received a palliative care consultation during the study period and met the criteria for palliative care were included.[11]

Exclusion criteria

Patients with incomplete data in medical records or consultation notes, or patients who had received palliative care prior to the current admission were excluded.

Sample size calculation

To study the median difference in hospital days before consultation, based on the hypothesis from a previous study which found a duration of 9 days for cancer patients and 18 days for non-cancer patients, a one-sided test was used with a significance level of 0.05 and a power of 0.95.[10] The ratio of non-cancer to cancer patients was set at 1:1. Calculated using Stata software, the required sample size was at least 48 patients per group. The data collection period was estimated at 3 months. Upon completion, 68 patients per group met the criteria, totaling 136 patients selected via Quota sampling.

Data collection

The researcher collected data from medical records and consultation notes for patients meeting the inclusion criteria.

Variables

Variables included gender, age, health insurance scheme, referring ward, principal diagnosis, primary cancer site (for cancer patients), reason for consultation, palliative performance scale (PPS) score at initial consult, living will declaration, type of initial opioid received, date of discharge or death, pain score, dyspnea score, mechanical ventilation status at consult, withdrawal of mechanical ventilation status, length of stay before consultation, total length of stay, length of stay from consultation to discharge/death, and discharge status (death, discharge home, referral).[12]

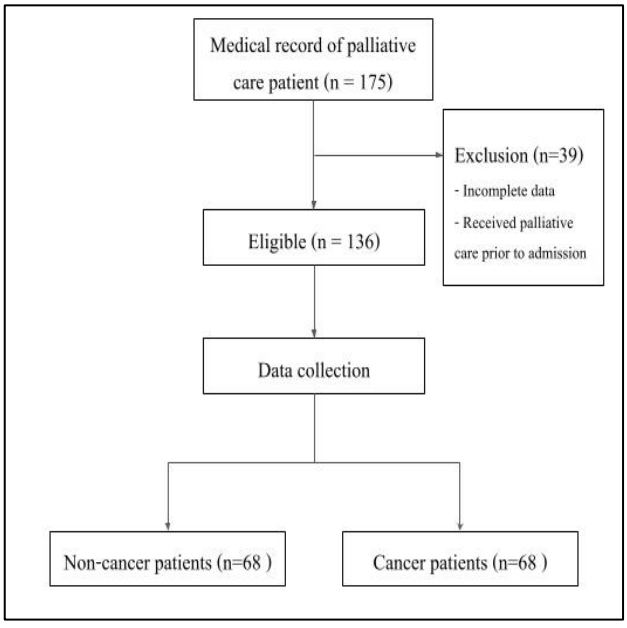

Figure 1: CONSORT diagram showing the flow of participants through the study.

Statistical analysis

Data were processed using statistical software.

Descriptive statistics

Binomial data (e.g., gender, age group, insurance, ward, diagnosis, reason for consult, PPS, living will, opioid type, discharge status, ventilation status) are presented as

percentages (%). Continuous data (e.g., age, pain score, dyspnea score, length of stay) are presented as mean±standard deviation (SD) or median and interquartile range (IQR).

Analytical statistics

Binomial data were analyzed using Chi-square test or Fisher's exact test. Continuous data were analyzed using Independent T-test or Mann-Whitney U test.

Ethical consideration

This study is an analytical study comparing time to consultation with minimal risk to patients, utilizing data from medical records without direct patient interaction. Permission was obtained from the Director of Phra Nakhon Si Ayutthaya Hospital. The study was approved by the human research ethics committee of Phra Nakhon Si Ayutthaya Hospital on August 28, 2024 (Project No. 0138/2567).

RESULTS

Demographic characteristics

A total of 175 inpatients were referred for palliative care consultation between September 2024 and November 2024. Thirty-nine patients were excluded (23 due to incomplete data, 16 due to prior palliative care history), leaving 136 participants. These were divided into 68 cancer patients and 68 non-cancer patients as the Table 1.

Gender

The 52.21% were male and 47.79% were female. The cancer group was predominantly female (60.29%), while the non-cancer group was predominantly male (64.71%), a statistically significant difference ($p<0.01$).

Age

The mean age of all participants was 67.95±15.21 years. The mean age was 65.04±14.54 years for the cancer group and 70.85±15.40 years for the non-cancer group. The non-cancer group was significantly older ($p=0.03$). Most participants (75.00%) were aged 60 years or older.

Health insurance

The majority used the universal coverage scheme (UCS) (80.15%). The proportion of UCS usage was significantly higher in the cancer group (92.65%) compared to the non-cancer group (67.65%) ($p<0.01$).

Wards

The most frequent referring wards were medicine (47.79%) and surgery (32.35%).

Diagnosis

For cancer patients, the top three primary sites were Gastrointestinal (42.65%), genitourinary (17.65%), and head and neck (16.18%). For non-cancer patients, the top diagnoses were Neurological diseases (36.76%), cardiovascular diseases (20.59%), and infectious diseases (17.65%).

Reason for consultation

The most common reason for both groups was advance care planning (ACP). Secondary reasons differed: cancer patients were referred for pain management, while non-cancer patients were referred for withdrawal of mechanical ventilation, a statistically significant difference ($p<0.01$).

PPS at consult

The 78.68% of patients had a PPS score of ≤30% at the time of consultation. The proportion of patients with PPS ≤30% was significantly higher in the non-cancer group (97.06%) compared to the cancer group (60.29%) ($p<0.01$).

Living will

The 77.21% of participants had signed a living will, with similar proportions in cancer (72.06%) and non-cancer (82.35%) groups ($p=0.15$).

Opioids

The most common initial opioid for cancer patients was oral Morphine sulfate (44.12%), whereas for non-cancer patients, it was intravenous morphine sulfate (54.41%).

Ventilation status

At consultation, significantly more cancer patients did not require mechanical ventilation (83.82%) compared to non-cancer patients (47.06%) ($p<0.001$). Withdrawal of mechanical ventilation was significantly more common in the non-cancer group ($p<0.01$).

Time from admission to palliative care consultation

The median time from hospital admission to palliative care consultation for cancer and non-cancer patients was 5.5 days and 7 days, respectively. This difference was not statistically significant ($p=0.26$). The median total length of hospital stay was 10 days for cancer patients and 11 days for non-cancer patients.

The median length of stay from consultation to discharge or death was 3 days for cancer patients and 2 days for non-cancer patients. Neither of these differences was statistically significant as the Table 2.

Discharge outcomes

Overall, 53.68% of patients died in the hospital. The non-cancer group had a significantly higher in-hospital mortality rate compared to the cancer group (64.71% vs 42.65%, p=0.01). Conversely, cancer patients were discharged home at a significantly higher rate than non-cancer patients (48.53% vs 26.47%, p<0.01) (Table 3).

Table 1: Demographic and clinical characteristics of study participants, (n=136).

Demographic and clinical characteristics	Total, (n=136) (%)	Cancer patients, (n=68) (%)	Non-cancer patients, (n=68) (%)	P value
Gender				
Male	71 (52.21)	27 (39.71)	44 (64.71)	<0.01[A]
Female	65 (47.79)	41 (60.29)	24 (35.29)	
Age (in years)				
Mean (SD)	67.95 (15.21)	65.04 (14.54)	70.85 (15.40)	0.03[B]
Median (IQR)	68 (59-80)	65 (57-75)	71 (63-82)	
Age group (in years)				
<60	34 (25.0)	23 (33.82)	11 (16.18)	0.02[A]
≥60	102 (75.0)	45 (66.18)	57 (83.82)	
Health insurance				
Universal coverage scheme (UCS)	109 (80.14)	63 (92.65)	46 (67.65)	<0.01[A]
Social security scheme (SSS)	5 (3.68)	2 (2.94)	3 (4.41)	1.00[C]
Civil servant medical benefit scheme (CSMBS)	17 (12.5)	3 (4.41)	14 (20.59)	<0.01[A]
Others	5 (3.68)	0 (0)	5 (7.35)	0.06[C]
Ward				
Medical	65 (47.80)	29 (42.65)	36 (52.94)	0.23[A]
Surgical	44 (32.35)	20 (29.41)	24 (35.30)	0.46[A]
Stroke unit	2 (1.47)	0 (0)	2 (2.94)	0.50[C]
Obstetrics and gynecology	6 (4.41)	6 (8.82)	0 (0)	0.03[C]
Intensive care unit (ICU)	7 (5.15)	2 (2.94)	5 (7.35)	0.44[C]
Others	12 (8.82)	11 (16.18)	1 (1.47)	<0.01[A]
Diagnosis of non-cancer patients				
Pulmonary disease	10 (14.71)		10 (14.71)	
Neurological disease	25 (36.76)		25 (36.76)	
Kidney disease	3 (4.41)		3 (4.41)	
Cardiovascular disease	14 (20.59)		14 (20.59)	
Infectious disease	12 (17.65)		12 (17.65)	
Gastrointestinal disease	4 (5.88)		4 (5.88)	
Primary sites of cancer of cancer patients				
Lung	6 (8.82)	6 (8.82)		
Breast	4 (5.88)	4 (5.88)		
Gastrointestinal	29 (42.65)	29 (42.65)		
Genitourinary	12 (17.65)	12 (17.65)		
Head and neck	11 (16.18)	11 (16.18)		
Hematological	4 (5.88)	4 (5.88)		
Unknown	2 (2.94)	2 (2.94)		
Reasons for consultation				
Symptom control				
Pain	16 (11.76)	16 (23.53)	0 (0)	<0.01[A]
Dyspnea	16 (11.76)	6 (8.82)	10 (14.70)	0.29[A]
Others	3 (2.21)	2 (2.94)	1 (1.47)	1.00[C]
Withdrawal ET tube	15 (11.03)	1 (1.47)	14 (20.59)	<0.01[A]
Advance care planning	86 (63.24)	43 (63.24)	43 (63.24)	1.00[A]
PPS before admission consult				
>30%	29 (21.32)	27 (39.71)	2 (2.94)	<0.01[A]
≤30%	107 (78.68)	41 (60.29)	66 (97.06)	

Continued.

Demographic and clinical characteristics	Total, (n=136) (%)	Cancer patients, (n=68) (%)	Non-cancer patients, (n=68) (%)	P value
Living will declaration				
Signed	105 (77.21)	49 (72.06)	56 (82.35)	0.15[A]
Not signed	31 (22.79)	19 (27.94)	12 (17.65)	
Current pain score, median (IQR)	0 (0-4.25)	3.5 (0-6)	0 (0-1)	<0.01[D]
Current dyspnea score, mean (SD)	3.55 (2.61)	3.21 (2.73)	3.90 (2.46)	0.12[B]
Type of opioids at first visit				
Morphine sulfate IV	60 (44.12)	23 (33.83)	37 (54.42)	0.02[A]
Morphine sulfate oral	35 (25.73)	30 (44.12)	5 (7.35)	<0.01[A]
Morphine sulfate SC	10 (7.35)	4 (5.88)	6 (8.82)	0.74[C]
Morphine portable infusion	4 (2.94)	0 (0)	4 (5.88)	0.12[C]
Fentanyl patch	1 (0.74)	1 (1.47)	0 (0)	1.00[C]
Others	7 (5.15)	4 (5.88)	3 (4.41)	1.00[C]
None	19 (13.97)	6 (8.82)	13 (19.12)	0.08[A]
Type of opioids at discharge or death				
Morphine sulfate IV	55 (40.44)	21 (30.88)	34 (50.00)	0.02[A]
Morphine sulfate oral	49 (36.03)	36 (52.94)	13 (19.12)	<0.01[A]
Morphine sulfate SC	21 (15.44)	9 (13.24)	12 (17.65)	0.48[A]
Morphine portable infusion	9 (6.61)	1 (1.47)	8 (11.76)	0.03[C]
Fentanyl patch	1 (0.74)	1 (1.47)	0 (0)	1.00[C]
Others	0 (0)	0 (0)	0 (0)	
None	1 (0.74)	0 (0)	1 (1.47)	1.00[C]
ETT status				
Withdrawal of mechanical ventilation	30 (22.06)	6 (8.82)	24 (35.29)	<0.01[A]
Patients with prolonged mechanical ventilation	17 (12.50)	5 (7.35)	12 (17.65)	0.07[A]
Who not required mechanical ventilation	89 (65.44)	57 (83.83)	32 (47.06)	<0.01[A]

*A: Chi-square test; B: Independent T-test; C: Fisher's exact test; D: Mann-Whitney test

Table 2: Comparison of time to consultation and length of hospital stay.

Topics	Total, (n=136) (%)	Cancer patients, (n=68) (%)	Non-cancer patients, (n=68) (%)	P value
Primary outcome, median (IQR)				
Number of days from admission to palliative care consultation	6.5 (2-11.25)	5.5 (2.75-10)	7 (2-13.5)	0.26[A]
Secondary outcome, median (IQR)				
Length of stay in hospital (days)	10 (5-19)	10 (5-17)	11 (5.75-22)	0.59[A]
Number of days from palliative care consultation to discharge	3 (1-5.25)	3 (1-6.25)	2 (1-5)	0.11[A]

*A: Mann-Whitney test

Table 3: Discharge status of participants.

Topics	Total, (n=136) (%)	Cancer patients, (n=68) (%)	Non-cancer patients, (n=68) (%)	P value
Status				
Died during hospitalization	73 (53.68)	29 (42.65)	44 (64.71)	0.01[A]
Discharge				
Home	51 (37.50)	33 (48.53)	18 (26.47)	<0.01[A]
Refer to other hospital	12 (8.82)	6 (8.82)	6 (8.82)	1.00[A]

*A: Chi-square test

DISCUSSION

This study compared the time from admission to palliative care consultation between cancer and non-cancer patients and found no significant difference (5.5 days vs 7 days). This finding contradicts a previous study from the faculty of medicine, Chulalongkorn University, which reported a significantly shorter time for cancer patients (9 days) compared to non-cancer patients (18 days).[10] The shorter duration for non-cancer patients

observed in this study (7 days vs 18 days in the prior study) may be due to the composition of the non-cancer group, which was predominantly diagnosed with neurological diseases (36.76%), including stroke. In such cases, prognosis can be determined based on the severity of brain injury, allowing for earlier consultation compared to infectious diseases where prognosis is less linear and requires monitoring of antibiotic response.[13-16]

In this study, the overall median time to consultation (6.5 days) was shorter than in the previous study (11 days).[10] While age, reasons for consultation, PPS levels, and cancer sites were similar to the previous study, the difference may be attributed to the setting.[17] As a regional hospital, the consultation system is less complex, and there is integrated multidisciplinary understanding of palliative care. In contrast, university hospitals manage more complex diseases, and patients/families often have higher expectations for curative treatment, leading to more complex consultation processes.[18]

Regarding reasons for consultation, ACP was the primary reason for both groups, consistent with prior studies.[10,19] The equal proportion suggests the medical team recognizes the importance of ACP for all patients. However, cancer patients were referred more frequently for pain management. This may be due to the disease trajectory or cancer treatment-related pain requiring opioid optimization.[20] Conversely, a Swiss study found that both groups suffer from comparable pain and dyspnea burdens.[8] Our results may imply that physical symptom management in non-cancer patients is still being overlooked by referring teams.

Data on PPS at consultation showed that the majority of patients were referred when PPS was ≤30%, indicating a severe condition with a survival of approximately one month.[19] The proportion of patients with PPS ≤30% was significantly higher in the non-cancer group, suggesting a delay in referral for this group, as they are consulted only when in a critical state, unable to care for themselves, or imminent death. This aligns with previous findings.[10]

Regarding mechanical ventilation, non-cancer patients underwent withdrawal of life support significantly more often than cancer patients, consistent with a study from Ramathibodi Hospital.[21] This is likely because non-cancer patients were frequently diagnosed with neurological conditions or stroke involving acute respiratory failure, necessitating ventilator support, which was subsequently withdrawn upon entering palliative care.

There was no difference in total length of stay or length of stay after consultation between the two groups. However, the post-consultation stay was shorter than in the previous study.[10] This may be due to the decision-making process for critically ill patients and the preference of patients or families to receive terminal care at home or a community hospital.[8,10,22]

Discharge data revealed that non-cancer patients had significantly higher in-hospital mortality. This is expected as they were referred with lower PPS (≤30%) and higher rates of ventilation withdrawal. Additionally, the overall in-hospital mortality was lower than in the previous study, likely because some patients were discharged to die at home according to their wishes, though out-of-hospital death data was not collected in this study.[10]

Strengths and limitations

The primary strength of this study is its setting in a regional hospital, where data regarding palliative care is currently limited. Consequently, the findings are representative of the general population receiving palliative care services in regional hospital settings. Secondly, the sample size was sufficient for both cancer and non-cancer groups; the study recruited a larger number of participants than the calculated requirement to enhance the reliability of the data.

A limitation of this study is that data were collected exclusively from medical records and consultation notes without direct patient interviews. This resulted in a lack of comprehensive data in certain areas, particularly regarding family dynamics and psychosocial aspects.

Clinical implications

This study demonstrated no significant difference in the timing of palliative care consultation between cancer and non-cancer patients. This suggests that treating teams currently recognize the importance of palliative care for both groups equally. Furthermore, it highlights the critical role of interdepartmental communication and the necessity of fostering a shared understanding of palliative care among multidisciplinary teams. However, the application of these findings should take into consideration the specific characteristics of the elderly population and the context of a regional hospital level.

CONCLUSION

The study found no significant difference in the time from hospital admission to palliative care consultation between cancer (5.5 days) and non-cancer (7 days) patients. Secondary outcomes, including total length of stay and stay after consultation, also showed no difference. However, non-cancer patients were characterized by more severe conditions (lower PPS), a higher rate of mechanical ventilation withdrawal, and a higher rate of in-hospital mortality compared to cancer patients.

Recommendations

As this was a quantitative study, future research should consider employing qualitative methods-interviewing patients, family members, and referring physicians-to gain in-depth insights into the decision-making processes and the rationale behind the timing of palliative care

consultations. Additionally, future studies should expand the sample size and include multiple centers across different hospital levels. This would improve the accuracy and representativeness of the data and allow for a comparative analysis of patients in varying healthcare settings.

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