Improving research in palliative and end of life care: what, why, how, where, when, who?

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Outline

• Why do research in palliative care?
• Whose business is it?
• Landscape of research activity in France...
• Research designs and solutions for tomorrow
  – Fast track randomised trial
  – MORECare statement for complex interventions
  – The right outcomes
• Discussion and next steps?

Download presentation: www.tinyurl.com/parisCSI

Twitter @CSI_KCL
Why do research in palliative care?

- Evidence based practice to improve care quality
- Training opportunity, doing the trials of tomorrow
- Critical enquiry – finding out what works
- Recognition of the uncertainty of effectiveness underpinning many treatments
- To provide better care for patients and those close to them in the future .. AND NOW
The landscape of research in palliative care in France?

• Survey of 420 palliative care departments in 2014, 382 responses
• Only 92 (24.1%) involved in a research project during the last 5 years.
• Challenges as to why not:
  – Lack of time (80%), ...
  – Patient issues (47%) ...
  – Lack of methodological support (33%)
  – Lack of financial resources (30%)

But do you have time NOT to research?

No time for research? What is the basis for clinical decisions?

Evidence based medicine or one of the alternatives?

<table>
<thead>
<tr>
<th>Basis for clinical decisions</th>
<th>Marker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence</td>
<td>Randomised controlled trial</td>
</tr>
<tr>
<td>Eminence</td>
<td>Radiance of white hair</td>
</tr>
<tr>
<td>Vehemence</td>
<td>Level of stridency</td>
</tr>
<tr>
<td>Eloquence (or elegance)</td>
<td>Smoothness of tongue or nap of suit</td>
</tr>
<tr>
<td>Providence</td>
<td>Level of religious fervour</td>
</tr>
<tr>
<td>Diffidence</td>
<td>Level of gloom</td>
</tr>
<tr>
<td>Nervousness</td>
<td>Litigation phobia level</td>
</tr>
<tr>
<td>Confidence*</td>
<td>Bravado</td>
</tr>
</tbody>
</table>

*Applies only to surgeons.

Whose business is it? Do research active healthcare services deliver better healthcare? .... YES

Finnish Leukaemia Group 1979 – 1985 introducing clinical trials into 17 out of 21 hospital districts in Finland for the treatment of multiple myeloma matched to comprehensive Finnish registry data

“A natural experiment”. District Outcomes

Trial districts 24 → 38% R. Survival

Others 28 → 28% R. Survival


Pattern of care and impact of participation in clinical studies on the outcome in ovarian cancer, Du Bois et al, Int J Gynecol Cancer 2005, 15, 183. (Germany)

Cross-sectional relationship: research active hospitals appeared to have lower mortality.

PLOS One, 2015 (England)

Research Activity and the Association with Mortality

Baris A. Ozdemir1*, Alan Karthikesalingam1, Siddhartha Sinha1, Jan D. Poloniecki1, Robert J. Hinchliffe1, Matt M. Thompson1, Jonathan D. Gower2, Annette Boaz2, Peter J. E. Holt1
Patient, caregiver, health professional and researcher views and experiences of participating in research at the end of life: a critical interpretive synthesis of the literature

Marjolein H Gysels*, Catherine Evans and Irene J Higginson

Results: Of a total of 239 identified studies, 20 studies met the inclusion criteria, from: the US (11), the UK (6) and Australia (3). Most focused on patients with cancer (12) and were conducted in hospices (9) or hospitals (7). Studies enquired about issues related to: EoL care research in general (5), specific research methods (13), and trial research (2). The studies evaluating willingness to participate in EoL care research showed positive outcomes across the different parties involved in research. Factors influencing willingness were mainly physical and cognitive impairment. Participating in research was a positive experience for most patients and carers but a minority experienced distress. This was related to: characteristics of the participants; the type of research; or the way it was conducted. Participatory study designs were found particularly suitable for enabling the inclusion of a wide range of participants.

Conclusion: The evidence explored within this study demonstrates that the ethical concerns regarding patient participation in EoL care research are often unjustified. However, research studies in EoL care require careful design and execution that incorporates sensitivity to participants’ needs and concerns to enable their participation. An innovative conceptual model for research participation relevant for potentially vulnerable people was developed.
Patient & Public Involvement at the heart of PC research: examples from Cicely Saunders Institute (CSI)

Engagement in the planning and design of the Institute, in all studies, plans..

https://www.youtube.com/watch?v=_St3Mbcekr5

Videos from several user representatives
Go to our You Tube channel to see
Soap Box Cynthia Benz:
https://www.youtube.com/watch?v=WvPEGfozVtI
https://www.youtube.com/watch?v=SebZ-83WG3I
https://www.youtube.com/watch?v=wYxvzWyAyyQ

Research carried out with or by members of the public/patients rather than to, about or for them
(INVOLVE 2012)
Study design: choice
Aim determines the design, essentially four (plus one) main categories of design

1. To explore, describe
   - **Descriptive** studies / surveys / quantitative or qualitative

2. To explore whether something is related to something else (**analytical**)
   - Quasi-experimental, analytical – e.g. cohort (longitudinal study with two groups different at the start), time-series, geographical, (case control) studies, natural experiment, mixed-methods

3. To make **sense of a situation**, develop new theory, model, relationships
   - Qualitative, grounded theory, ethnographic, mixed methods

4. To test whether something causes something else, or if a new service or treatment is effective
   - **Experimental** or intervention studies, can be mixed methods

- Systematic literature reviews – can combine the literature to describe or be analytical or can combine experiments
### Experimental studies, traditional options in randomisation

<table>
<thead>
<tr>
<th>Parallel design</th>
<th>Crossover trial</th>
<th>Cluster randomisation</th>
<th>Patient preference trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Individual patients as they are referred/ identified</td>
<td>• Patients randomly allocated to different treatment sequences</td>
<td>• Randomisation unit is group of individuals instead of individual patients</td>
<td>• Individual patients are randomised but those with a strong preference are not randomised but allocated preferred treatment</td>
</tr>
<tr>
<td>• Optimal and most common approach</td>
<td>• Simplest: AB/BA – half of patients receive treatment A, followed by control/B, half receive control/treatment B followed by A</td>
<td>• i.e. all patients in a health district or on a ward or GP practice</td>
<td>• BUT need large numbers, as analysis is really between the groups without preferences</td>
</tr>
<tr>
<td>• Challenges include – if ‘control’ group drop out more than intervention group, or people try to ‘substitute for intervention group’</td>
<td>• Only suitable for those interventions with short-term effect and can be difficult to work out wash out period</td>
<td>• Good especially if there is ‘education’ in the intervention</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• BUT need very large numbers</td>
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<tr>
<td></td>
<td></td>
<td>• May struggle to recruit in control</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• BUT need very large numbers</td>
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</table>

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How did we come to think of a fast-track randomised trial?

- Recommendations to extend palliative care to non-cancer conditions but little evaluation
- People severely affected by multiple sclerosis (MS) have unmet needs – symptoms, disability, effect on family
- Developing a new (short term) palliative care service for people severely affected by MS
Fast-track Randomised Controlled Trial (RCT)

- Names – *delayed-intervention, wait-list, delayed-start trial*
- All patients will eventually receive intervention, but some receive it later than others
- Patients are randomly allocated to intervention
- Pros – uses randomised design, but gets over problem of feeling some patients never receive service/treatment
- Cons – can’t use in short survival, some people may not want to wait
History of wait-list / delayed intervention

**RCT**


First successful ‘fast-track trial’ in palliative care among people with Multiple Sclerosis

Higginson et al
BMC Palliat Care 2008;7:7
We designed the study – aim to recruit 50 patients in one year
Second fast-track trial, early palliative care, triggered by Breathlessness

- Early palliative care integrated with respiratory services
- 16% improvement in QoL
- No difference in costs to health care

*Higginson et al. Lancet Respir Med 2014;2(12):978-87*

<table>
<thead>
<tr>
<th></th>
<th>Breathlessness support service group (n=42)</th>
<th>Control group (n=40)</th>
<th>Difference between breathlessness support service and control (95% CI)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary outcome (CRQ mastery)*†</td>
<td>4.15 (1.7)</td>
<td>3.57 (1.4)</td>
<td>0.58 (0.01 to 1.15)</td>
<td>0.048</td>
</tr>
<tr>
<td>Secondary outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRS breathlessness average 24 h†</td>
<td>5.38 (2.2)</td>
<td>5.71 (2.1)</td>
<td>-0.33 (-1.28 to 0.62)</td>
<td>0.49</td>
</tr>
</tbody>
</table>

**Fact sheet 2**
Information for patients

**Breathlessness Support Service**

**Managing breathlessness**

This information sheet helps you manage your long-term breathlessness. If your breathing is getting worse or you are experiencing breathlessness as a new feeling, it is important to seek medical advice from your GP.

- **How are you breathing?**
  - Make yourself aware of how you are breathing.
  - When you breathe in, are you tensing your shoulders to lift your chest up?
  - To exhale, do you force the air out?
  - Are you breathing very rapidly?
  - When you need to move, do you find yourself holding your breath?

- **What can I do to help my breathlessness?**
  - **Relax**
  - When you are feeling breathless you may automatically start to use your chest, shoulder and neck muscles, hoping it will make breathing easier. These muscles are not meant to work continuously for long periods of time, so they will soon...
Complex Interventions and Palliative and End of Life Care

Palliative care – which are the “active ingredients”?

• Highly trained staff?
• Suitably designed premises & facilities?
• Ethos?
• Assessment process?
• Absence of competing demands and priorities in terms of patient mix?

Outcomes are complex, multiple and often interact or are acting in a changing situation (e.g. dying)
additional problems for evaluators, over and above usual practical and methodological difficulties, E.g.

• difficulty standardising the design and delivery of the interventions (e.g. treatment, service, pathway)
• and of the control group
• sensitivity to features of the local context, may not be replicated
• organisational and logistical difficulty of applying experimental methods to service or policy change
• length and complexity of the causal chains that link intervention with outcome
Why does it matter?

Consequences of failing to recognise you are dealing with complex interventions:

• Failed studies – when the intervention has an effect
• Positive studies – but no one knows what the active ingredients are – ‘evaluating a ‘black box’ and so it can’t be reliably replicated elsewhere
• Results which don’t apply to anywhere else
• Results which can’t be implemented
• Dangerous implementation, failing to recognise key components that are needed, and missing them
• Cutting costs by policy makers to implement without key ingredients, because not shown they are important
Which of the following are ‘complex interventions’ in the context of palliative care?

• A new community palliative care service?
• A new outpatient clinic?
• A new rehabilitation intervention – e.g. physiotherapy plus education?
• A new care pathway for a care home?
• A new set of advance directives?
• A new analgesic for pain?
• A new antidepressant for depression?
Development for palliative care: Methods Of Researching interventions and services in palliative and End of life Care (MORECare)

- Palliative and End of Life Care research presents its own unique problems
- MRC made a call through the Methodological Research Programme to evaluate this
- Collaboration between King’s College London, University of Manchester, University of Edinburgh and University of Aberdeen with international Delphi exercises and consultation

For all results see: www.tinyurl.com/cicelymorecare
Training see: www.tinyurl.com/MORECareCourse
MORECare: Three systematic reviews


Results from Evans, C et al, *Palliat Med. 2013 Dec;27(10):885-98*

Most studies were feasibility context of MRC Framework for development and complex interventions.

Many studies also descriptive, repeat ‘admiring’ the problems, rather than finding ways to solve them?

Craig et al 2008, MRC
Off-Label Medication Use in the Inpatient Palliative Care Unit

Jung Hye Kwon, MD, Min Ji Kim, MD, Sebastian Bruera, MD, Minjeong Park, PhD, Eduardo Bruera, MD, FAAHPM, and David Hui, MD, MSc

- 201 patients, palliative care unit
- Of 6276 prescription events, **2199 (35%)** were “off-label” (i.e. use pharmaceutical drugs for an unapproved indication/ route)
- Most common indications for off-label prescribing were: delirium (36%) and breathlessness (20%).

While off-label may be appropriate at times, also can lead to:
- Poor understanding and documentation
- Poor consent process, lacks efficacy of on label, may miss adverse events
Complexity in palliative care—What is a complex intervention?

an intervention (e.g. treatment, service) with several interacting components

• Components may act both independently and interdependently

• Can be difficult to know which are the “active ingredients”

• Often highly context specific

• Often have multiple outcomes (intended and unintended)
MORECARE recommendations, studies must move from descriptive to actual testing

1. **Theory, development and modelling – try to understand mechanism of intervention**
   - **If successful**

2. **Feasibility of intervention AND study design and mechanism / active ingredients**
   - **If successful**

3. **Evaluation-with comparison- use randomised trial or appropriate alternative. Assess outcomes and intervention processes**
   - **If successful**

4. **Rollout and monitor results of wide implementation**

Consider implementation implications at each step.
Evaluating Complex Interventions

**Question:** How many hats does it take to evaluate complex interventions in EoL&PC?

**Answer:** Many ... here are the ones we looked at in more detail for the MORECare project

- Statistical Analysis
- Health economic assessment
- Ethics
- Mixed Methods Research
- Outcome measurement
- MRC Guidance
Main guidance, plus 4 papers and an abstract from the TEC

Mostly open access
# MORECARE STATEMENT: 36 points

<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction/background</strong></td>
</tr>
<tr>
<td>1. Present theoretical framework for the intervention and levels of need established</td>
</tr>
<tr>
<td>2. Present objectives appropriate to the level of intervention development</td>
</tr>
<tr>
<td><strong>Design</strong></td>
</tr>
<tr>
<td>3. Indicate and justify stage in MRC guidance for development and evaluation of complex interventions, e.g. feasibility, preliminary evaluation, efficacy / cost effectiveness and wider effectiveness</td>
</tr>
<tr>
<td>4. Feasibility stages should test both feasibility of the intervention and of methods of evaluation, including outcome measurement</td>
</tr>
<tr>
<td>5. Justify methods, considering appropriate use of existing data sets and secondary analysis as these may produce rapid information</td>
</tr>
<tr>
<td>6. Justify methods of empirical studies considering mixed methods, observational studies and randomised trials</td>
</tr>
<tr>
<td><strong>Study team</strong></td>
</tr>
<tr>
<td>7. Ensure involvement from: (i) consumers, patients and caregivers; (ii) relevant clinicians; (iii) relevant methodologists to develop study questions, questionnaires and procedures; and (iv) researchers familiar with the challenges in EoLC studies</td>
</tr>
<tr>
<td>8. Ideally involvement should be well established and continuing, beyond a specific study, with joint meetings or rotations between clinical and research staff</td>
</tr>
</tbody>
</table>

*Main: BMC Medicine 2013; 11:111*

*Social care:*
• It is **ethically desirable** to undertake research into palliative and end of life care and **can be unethical not too.**

• **Collaborate with patient and caregivers** in the design of the study and any ethical aspects to incorporate their comments.

• **Attend** the ethics committee meeting **with a caregiver or patient**, as a means to help the committee better understand the patient point of view.

• Ensure **proportionality** in patient and caregiver **information sheets**, appropriate to the study design and level of risk, as excessive information in itself can be tiring/distressing for very ill individuals.

• **Allow for reflection and comment** in the questionnaires?

• Create a **Research Ethics Network** for Palliative and End of Life care to further and disseminate best practice.

• **Train those working in on ethics and governance** committees in the specific issues and wishes of patients in palliative and end of life care and their families.

• **Review and amend the law** regarding consent so that **advance consent** for studies other than clinical trials of medicinal products applies.

Mixed Methods

- ensure appropriate multi-disciplinary skills mix or training of team define the theoretical paradigm, method of integrating results and safeguards to ensure rigor at the outset

- plan investigation carefully to avoid undue burden of qualitative and quantitative questionnaires – perhaps dividing data collection or selecting questions and/or samples appropriately

- take into account any potential therapeutic effect of qualitative interviews where participants can express their feelings, if these are similar to components of the intervention

- ensure research nurses or those collecting data are appropriately trained in qualitative data collection

**J Palliat Med. 2013 Dec;16(12):1550-60.**
Outcome measurements

**Some challenges**

When should the primary outcome or end point be measured? A trade off between attrition and time for the intervention to have an effect.

Choose an outcome measure that is validated in one setting or several?

Should I use staff, patient, observer, or proxy/caregiver reported measures?
## Outcomes – top recommendations

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Median (1&lt;sup&gt;st&lt;/sup&gt; - 3&lt;sup&gt;rd&lt;/sup&gt; quartile)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measurement properties</strong></td>
<td></td>
</tr>
<tr>
<td>... easy to administer and interpret (e.g. short and low level of complexity)</td>
<td>8 (7-9)</td>
</tr>
<tr>
<td>... applicable across care settings to capture change in outcomes by location</td>
<td>8 (7-9)</td>
</tr>
<tr>
<td>... responsive to change over time and capture clinically important data</td>
<td>8 (7.8-8)</td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td></td>
</tr>
<tr>
<td>Time points require clear identification to establish a baseline</td>
<td>7 (6-9)</td>
</tr>
<tr>
<td>Time points need to be established before conducting the evaluation.</td>
<td>7 (5-8)</td>
</tr>
<tr>
<td>When prospective measurement is used, end points should correspond to when the</td>
<td>7 (6-8)</td>
</tr>
<tr>
<td>effect of the intervention is expected to take place.</td>
<td></td>
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</tbody>
</table>

**Other properties**

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Median (1&lt;sup&gt;st&lt;/sup&gt; - 3&lt;sup&gt;rd&lt;/sup&gt; quartile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>... Valid and reliable in the relevant population</td>
<td>8 (7-9)</td>
</tr>
<tr>
<td>... Use a measure that can be integrated into clinical care</td>
<td>8 (7-9)</td>
</tr>
<tr>
<td>... Data from patients and proxy measures should be differentiated in the dataset.</td>
<td>8 (7-9)</td>
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</tbody>
</table>

The tools. Build on what we have and improve: Palliative care outcome scale (POS) developments

POS²: Chinese
Dutch German
Italian Spanish
Khmer Punjab
Urdu Portuguese

POS-S³: Chinese
POS-S MS
POS-S Renal
POS-S Parkinson

APCA African POS⁴:
Afrikaans AsiXhosa
isiZulu KwaZulu
Luganda Luo +5 other dialects

MyPOS IPOS⁵:
French German
Italian Polish
Portuguese Swedish
Turkish + 4 ongoing new validations

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STAS¹: Dutch French Spanish
Italian Polish Chinese Japanese
IPOS version professionnelle

Nom du patient: ..............................................  Date: ..............................................

Q1. Quels ont été les principaux problèmes du patient* au cours de la semaine passée?
1. __________________________________________
2. __________________________________________
3. __________________________________________

Q2. Veuillez cocher la case qui décrit le mieux à quel point le patient a été affecté par chacun des symptômes suivants au cours de la semaine passée.

<table>
<thead>
<tr>
<th>Symptôme</th>
<th>Pas du tout</th>
<th>Légèrement</th>
<th>Modérément</th>
<th>Beaucoup</th>
<th>Extrêmement</th>
<th>Je ne peux pas évaluer (p. ex., patient inconscient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Douleur</td>
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<tr>
<td>Peine à respirer</td>
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<tr>
<td>Faiblesse ou manque d'énergie</td>
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<tr>
<td>Nausée (sensation que vous allez vomir)</td>
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<tr>
<td>Vomissements</td>
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<td>Faible appétit</td>
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<tr>
<td>Constipation</td>
<td></td>
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<td></td>
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<tr>
<td>Bouche sèche ou douloureuse</td>
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<tr>
<td>Somnolence</td>
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<tr>
<td>Mobilité réduite</td>
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</table>

Veuillez énumérer tous les autres symptômes non mentionnés ci-dessus, et cochez la case qui décrit le mieux à quel point ces symptômes ont affecté le patient au cours de la semaine passée.
1. _________                      |            |            |            |          |             |                                                     |
2. _________                      |            |            |            |          |             |                                                     |
3. _________                      |            |            |            |          |             |                                                     |

Au cours de la semaine passée:

<table>
<thead>
<tr>
<th></th>
<th>Pas du tout</th>
<th>Peu</th>
<th>Parfois</th>
<th>La plupart du temps</th>
<th>Toujours</th>
<th>Je ne peux pas évaluer (p. ex., patient inconscient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3. S'est-il senti anxieux ou inquiet concernant sa maladie ou son traitement?</td>
<td></td>
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<td></td>
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<tr>
<td>Q4. Est-ce qu'un membre de sa famille ou de ses amis n'est senti anxieux ou inquiet à son sujet?</td>
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<tr>
<td>Q5. Pensez-vous qu'il se soit senti déprimé?</td>
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<tr>
<td>Q6. Fait-il du sport?</td>
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<tr>
<td>Q7. Le patient a-t-il pu parler de son ressenti avec sa famille ou ses amis autant qu'il voulait?</td>
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<tr>
<td>Q8. Le patient a-t-il eu autant d'information qu'il le souhaitait?</td>
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</tbody>
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*Pour faciliter la lecture du document, le masculin générique est utilisé pour désigner les deux sexes.
Statistical Considerations – all strong agreement with high consensus

Attrition is to be expected and if you don’t have attrition you may have the wrong population in the study

Define and report different types of attrition, consider how timing of data collection effects attrition.

Taxonomy of missing data to understand different types –
ADD – attrition due to death; ADI – attrition due to illness;
AaR – attrition at random

Investigate patterns of missing data and/or the conduct of the study to identify the cause of missing data, to inform choice of imputation method.

A clear statistical analysis plan required that identifies how to deal with missing data

Development of a Patient-Reported Palliative Care-Specific Health Classification System: The POS-E

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Key Points for Decision Makers

We propose a new palliative care health-state classification system termed Palliative Care Outcome Scale (POS)-E.

POS-E classifies palliative care states as a combination of seven dimensions.

The dimensions are pain, other symptoms, anxiety, depression, family anxiety, feeling good about oneself and practical matters.

Results Following Rasch and factor analyses, a classification system of seven items was derived. Each item had two to three levels. Rasch threshold map helped identify a set of 14 plausible health states that can be used for the valuation of the instrument to derive a preference-based index.

Conclusion Combining factor analysis and Rasch analysis with psychometric criteria provides a valid method of constructing a classification system for a palliative care-specific preference-based measure. The next stage is to obtain preference weights so the measure can be used in economic evaluations in palliative care.
Big data: Better use of existing data sets for comparative analysis

Changing Patterns in Place of Cancer Death in England: A Population-Based Study
Wei Gao1*, Yuen K. Ho1, Julia Verme3, Myer Glickman1, Irene J. Higginson1, on behalf of the GUIDE Care project
1 King’s College London, School of Medicine, Cancer Studies Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom, 2 South West Public Health Observatory, Exeter, United Kingdom, 3 Life Events & Population Survey Division, Office for National Statistics, Newport, Wales, United Kingdom

Use of hospital palliative care according to the place of death and disease one year before death in 2013: a French national observational study

Predictors of emergency department attendance by people with dementia in their last year of life: Retrospective cohort study using linked clinical and administrative data
MORECare e-learning – the methods of conducting research in palliative care

1: Introduction to complex intervention
2: Selection of outcome measure
3: Use of outcome measure
4: Missing data, Attrition and response shift in palliative care
5: Mixed Methods
6: Ethics

www.tinyurl.com/MORECareCourse
Dissemination of research vital – is there an issue re: French palliative care research visibility?

- Challenge of visibility of articles published in French in journals which are not indexed in PubMed (even less without keywords or abstract in English)
- Limited number of abstracts from France at the successive EAPC?
- Limited number of abstracts submitted from France to PC journal in English (e.g. Palliative Medicine etc)
Take Home Messages

• Research is central to palliative care, but it also must address ‘big’ questions – find solutions rather than admiring the problem.. generate evidence not opinion...
• Innovate, understand and evaluate new/existing models of care, treatments
• Have the right tools – measures, methods, and use these in clinical care and research
• Build future capacity, skills, infrastructure, collaborations, education

• The future challenges for palliative care needs integration of research, education and clinical care..
• Because much more to do – still many symptoms and problems that need further research and analysis, and growing need
• MORECare eLearning can help to develop skills
• Consider the impact and target group of your study when deciding to publish in French or English

• Our science is the science that puts the person before their disease