current medical training in patient communication is inadequate and suspect that many physicians could benefit from an improved understanding of Bayesian statistics. However, these solutions are not mutually exclusive. There is no reason why the health care system could not both improve physician training as well as implement the simple steps we have proposed to limit unsolicited diagnostic information. These steps would not be a panacea and would not be applicable to every clinical situation. But, as we have discussed in our article,[1] to rely entirely on physicians' and patients' ability to process information would be to ignore a vast body of literature demonstrating that humans are not always rational creatures and that, consequently, suspicious information is hard to ignore, even when people know that it is in their best interests to do so.[2] And yes, we still perform physical examinations on our patients!

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Palliative Care Units: The Best Option for the Most Distressed

In a recent issue of the *Archives*, Casarett et al[1] have conducted a survey of bereaved family members of patients who died in 77 Department of Veterans Affairs Hospitals.[1] The authors observed increased satisfaction with care among relatives of patients who died in the palliative care unit compared with those seen by palliative care consultation teams, who were in turn perceived to have better end-of-life care compared with patients who died without palliative care involvement. This gradient effect of palliative care involvement is an important contribution to our body of knowledge.

The authors have not mentioned one important bias for this type of comparison. In most clinical settings where palliative care units are available, only patients with a higher level of physical and/or emotional symptom burden or those with severe family distress are transferred to a palliative care unit. The Edmonton Regional Palliative Care Program has consistently observed a higher level of physical and emotional distress among patients transferred to the palliative care unit.[2] We have also made similar observations at the M.D. Anderson Cancer Center Palliative Care Program.[3,4] If this also turned out to be true for the study by Casarett et al,[1] the findings reported would be even more remarkable—the palliative care unit was able to more effectively address the end-of-life care needs of patients and families compared with other settings despite a higher distress level.

The most scientifically rigid approach to compare a palliative care unit with a consultation team would be a randomized controlled trial. However, such a study could raise serious ethical concerns if patients in severe distress were allocated to an intervention of lower level of intensity when there is good evidence to support palliative care unit admissions.

This study also showed that patients with cancer were more likely to use palliative care units at the end of life compared with patients with other life-limiting diseases.[1] Unfortunately, only a small proportion of comprehensive cancer centers and community-based cancer centers in the nation have inpatient palliative care units.[5] On the basis of the results of this article and our increasing body of knowledge, we are hopeful that the existence of fully staffed palliative care units will soon become a regulatory and ethical mandate for all acute care hospitals.

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In reply

Drs Bruera and Hui make a valid point regarding the challenges of measuring the impact of palliative care interventions in observational studies. There is always the concern that assignment to receive an intervention (in this case, either palliative care consultation or care in a palliative care unit) is not random. If patients with greater needs or more complex problems are more likely to receive the intervention, the result may be an underestimate of the intervention's effectiveness. Although to some extent this risk can be mitigated by propensity score adjustment, it is still possible that other, unmeasured characteristics differ among the treatment groups. Nevertheless, in the absence of randomized controlled trials, which would be difficult or impossible in the

setting of an evaluation of palliative care units, observational studies with appropriate adjustment for nonrandom selection offer an efficient alternative design. Further research is needed to determine how these methods can be made more robust, ensuring that their results are sufficient to guide clinical care and policy.

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Images From Our Readers

Winter morning at Naini bridge, Allahabad, India.

Courtesy of: Rajiv Agarwal, MD, Richard L. Roudebush VA Medical Center, Indiana University School of Medicine, Indianapolis.