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## Stopping Statin Use in Terminally Ill Patients Found Beneficial

Discontinuing the use of statins (HMG Co-A reductase inhibitors) to lower cholesterol among adult patients in the late stages of life-limiting illness has been found to cause no harm; on the contrary, it appears to improve patients' quality of life and may even have life-extending benefits, according to the results of a study presented at the recent meeting of the American Society of Clinical Oncology.

"Our study found that patients who discontinued statins reported improvements in quality of life," says lead author Amy P. Abernethy, MD, PhD, director of the Center for Learning Health Care at the Duke Clinical Research Institute, Durham, NC. "This runs counter to the idea that discontinuing a treatment would cause people to somehow feel as if they were getting less care or inadequate care."

In the multicenter, unblinded pragmatic trial, older adults (mean age, 74 years) with advanced life-limiting illness (cancer, 49%), a life expectancy of greater than one month, and recent deterioration in performance status were randomized to discontinue (n = 189) or continue (n = 192) their statin medication. All participants had been taking statins for at least three months; 69% had used statins for more than five years.

### KEY FINDINGS

- Rate of death within 60 days after study enrollment was similar in both groups (discontinue, 23.8%; continue, 20.3%).
- The group discontinuing statins had longer median survival (229 days [90% CI, 186 to 332] vs 190 days [90% CI, 170 to 257]).
- Quality of life was significantly better among the discontinue group (McGill QOL, 7.11 vs 6.85;  $P = 0.037$ ).
- Those in the discontinue statins group

had fewer symptoms (Edmonton Symptom Assessment Scale, 25.2 vs 27.4;  $P = 0.128$ ) and took fewer medications overall (10.1 vs 10.8;  $P = 0.034$ ).

- Few participants in either group experienced cardiovascular events (13 vs 11).  
"Based on the study, for patients who are on medications for primary or secondary prevention — for example, those who have not just had a stroke or heart attack — and have a limited life expectancy of less than one year, I would recommend discussing with their physicians the potential to stop taking statins," says co-author Jean Kutner, MD, MSPH, professor of medicine, University of Colorado Denver.

Kutner adds that bringing up the subject of stopping unneeded medications has the added benefit of offering patients an opportunity for shared decision making.

"We tend to be so focused on which medications are effective to start, but there's no research on if and when to stop them," says Kutner. **"Especially in the context of end-of-life care, we believe there are many situations in which preventative drugs may be doing more harm than good."**

*Source: "Managing Comorbidities in Oncology: A Multisite Randomized Controlled Trial of Continuing versus Discontinuing Statins in the Setting of Life-Limiting Illness," Journal of Clinical Oncology; June 2014; 32:5s (supplement, Abstract LBA9514). Abernethy AP, Kutner J, et al, Palliative Care Research Cooperative Investigators; Duke University Medical Center, Durham, NC; and University of Colorado Denver.*

# Neurologists Offered Practical Introduction to Palliative Care

Palliative care has greatly expanded from its original roots in end-of-life care provided to patients with terminal cancer, and is increasingly considered appropriate for any patient living with advanced, progressive illness or multiple comorbidities. It is now “time for a paradigm shift” in neurology to embrace palliative care, according to an article published in *Neurology*, the official journal of the American Academy of Neurology.

“[P]alliative care has been successfully applied to chronic illnesses such as heart failure, chronic pulmonary disease, and end-stage renal disease,” write the authors. “Our goal...is to provide a practical starting point for neurologists to become more knowledgeable and comfortable with the principles of palliative medicine.”

The article provides an overview of the general principles of palliative care and explains the special needs of neurology patients and their families. Also included are an outline of resources neurologists might use to set up a palliative care team within a practice and suggested priorities for research and education to improve the quality of care.

## PALLIATIVE CARE SKILLS

“All physicians, including neurologists, should have familiarity and comfort with several fundamental palliative care skills,” the authors state. These include communicating bad news, nonmotor symptom management, advance care planning, and caregiver assessment. For more complex issues, referral to palliative medicine or hospice services may be appropriate.

**Communication:** For communicating bad news (beginning with diagnosis), the authors suggest using an approach like the SPIKES protocol (Set up the interview, assess the patient’s Perception, obtain the patient’s Invitation, give Knowledge, address Emotions, establish a Strategy and Summarize).

“It is critical that neurologists finalize the meeting with a follow-up, including what to do when the patient has had a chance to process the information and now has more spe-

## Palliative Care Augments Traditional Care by:

- Placing importance on planning for decline and death as a natural outcome and not as a failure of medical treatment.
- Emphasizing the relief of patient suffering.
- Transcending the historical patient-physician dyad by addressing caregiver strain and offering supportive services to family members, such as respite care and counseling.
- Assessing and treating medical, psychosocial, and spiritual issues. These include not only pathologic diagnoses, but also other sources of distress, such as normal reactions to living with a life-threatening, progressive, and/or disabling illness.”

— Adapted from Boersma et al, *Neurology*

cific questions,” they write. “This practice is particularly helpful to support the patient and minimize feelings of abandonment.”

**Symptom assessment and management:** Nonmotor symptoms have been found to be more function-limiting for the patient than motor symptoms and have more effect on caregiver burden and overall quality of life. “Some issues may not be readily treatable but should still be closely followed because they may require additional support or affect advance care planning.”

**Advance care planning:** Patients often expect the physician to initiate this discussion and report greater satisfaction with care when end-of-life discussions have occurred. The authors suggest that neurologists have information and documents specific to their region readily available and keep an updated copy of completed forms with the patient’s records.

**Caregiver support:** Caregivers who do not feel distress and are well supported have lower mortality rates, note the authors. Caregiver assessment should include questions about not only their ability to provide adequate patient care, but also about their self-care. “The very act of asking caregivers how they are doing is often met with gratitude” and can provide important personal validation.

## REFERRAL TO SPECIALTY PALLIATIVE AND HOSPICE CARE

“While traditional approaches emphasize the preservation of function and prolongation of life, palliative care draws additional

attention to the relief of suffering and places importance on planning for decline and death as an expected and natural outcome, rather than as a failure of medical treatment,” the authors write. It is thus an augmentation of traditional care. [See sidebar.]

## BARRIERS TO REFERRAL

Barriers to appropriate referral of neurologic patients to palliative care services and hospice can include:

- Lack of training in fundamental palliative care skills
- Fear of diminishing the patient’s hope
- Unsatisfactory prognosis predictors for specific illnesses
- Limits of Medicare hospice guidelines

The article includes a table with hospice eligibility guidelines for neurologic disorders such as dementia, stroke, coma, and others. However, the authors warn that the Medicare hospice guidelines are often overly conservative compared with newer empiric criteria for patients with amyotrophic lateral sclerosis and dementia. Guidelines for patients living with less common conditions such as Parkinson’s disease and multiple sclerosis are “nonspecific or nonexistent,” they note.

## SUGGESTED ‘RED FLAGS’ FOR HOSPICE REFERRAL INCLUDE:

- Frequent hospital admissions (such as for pneumonia, falls, and urinary tract infection)

Continued on Page 3

# Most Physicians Would Enroll in Hospice if Terminally Ill, But Often Delay Discussing Hospice with Patients

Most physicians surveyed in a multi-regional study reported that they would choose hospice care for themselves if terminally ill with cancer. Yet, only about one-quarter would discuss hospice “now” with cancer patients with a four-to-six-month life expectancy, according to a research letter published in *JAMA Internal Medicine*.

“Having timely discussions with terminally ill cancer patients to establish goals for end-of-life care is important to maximize the quality of patient care,” says lead author Garrett M Chinn, MD, MS, of the Division of General Medicine, Massachusetts General Hospital in Boston. He suggests an effort among physicians to conduct these discussions earlier in the disease trajectory.

“We know that patients facing terminal illness often wish to spend their remaining days at home, surrounded by loved ones. Since end-of-life care in the U.S. often

stands in stark contrast to these preferences, it’s important to identify factors that may facilitate cost-effective care that supports patient preferences,” he notes.

Investigators analyzed survey data gathered from physicians (n = 4368) caring for patients enrolled in the CanCORS (Cancer Care Outcomes Research and Surveillance) study, a multiregional, population- and health-system-based cohort study measuring the quality of care delivered to more than 10,000 patients newly diagnosed with lung or colorectal cancer between 2003 and 2005.

Physicians were asked whether they would personally enroll in hospice if they were terminally ill with cancer. They were also asked when they would discuss hospice with an asymptomatic patient with advanced cancer whom they believed to have four to six months to live: “now,” “when the patient first develops symptoms,” “when there are no more non-palliative treatments to offer,” “only if the patient is admitted to the hospital,” or “only if the patient and/or family bring it up.”

## KEY FINDINGS:

- Most physicians strongly (64.5%) or somewhat (21.4%) agreed that they themselves would enroll in hospice if terminally ill.
- However, only 26.5% reported they would discuss hospice “now” with a patient who had four to six months of life remaining.
- Nearly half (48.7%) of physicians said they would wait to discuss hospice until there were no more non-palliative options to offer.
- Others said they would wait until the patient had symptoms (16.4%), was hospitalized (4.1%), or until the patient/family brought up the subject (4.3%).
- In adjusted analysis, physicians who strongly agreed they would personally enroll in hospice were more likely than others to report discussing hospice

“now” (odds ratio [OR], 1.7; 95% confidence interval [CI], 1.5 to 2.0).

“Physicians should consider their personal preferences for hospice as a factor as they care for terminally ill patients with cancer,” write the authors. “Physicians with negative views of hospice may consider pursuing additional education about how hospice may help their patients.”

Female physicians and those practicing in managed care settings were more likely to agree that they would enroll in hospice if terminally ill with cancer (OR, 1.80; 95% CI, 1.49 to 2.18; and OR, 1.30; 95% CI, 1.12 to 1.51, respectively). Compared with primary care physicians and oncologists, radiation oncologists (OR, 0.57; 95% CI, 0.42 to 0.76) and surgeons (OR, 0.65; 95% CI, 0.55 to 0.78) were less likely to agree they would personally enroll in hospice.

“Our results suggest that most doctors would want hospice care for themselves, but we know that many terminally ill cancer patients do not enroll in hospice,” says senior author Nancy Keating, MD, MPH, associate professor, the Harvard Medical School Department of Health Care Policy, Boston. “In the overall CanCORS study, only about half of the patients who died of metastatic lung cancer had ever discussed hospice care with their physician.”

While physicians’ personal preferences may have an important influence on the timing of hospice discussions, there may be other barriers preventing physicians from having end-of-life care discussions, notes Chinn. He suggests that these barriers may include a lack of knowledge about guidelines for end-of-life care for such patients, cultural and societal norms, and the continuity and quality of communication with patients and their family members.

Source: “Physicians’ Preferences for Hospice If They Were Terminally Ill and the Timing of Hospice Discussions with Their Patients,” *JAMA Internal Medicine*; March 2014; 174(3):466-468. Chinn GM, et al; Division of General Medicine, Department of Medicine, Massachusetts General Hospital and Harvard Medical School, Boston.

## Neurologists (from Page 2)

- Unexplained weight loss
- Dysphagia
- Restricted activities of daily living
- Increased somnolence
- Rapid decline in function

“Research suggests that patients are referred to hospice too infrequently or too late,” write the authors. Only 30% of patients with advanced dementia are enrolled in hospice, they note. According to the Medicare Payment Advisory Commission, 25% of hospice stays in 2010 and 2011 were for only five days or less.

Source: “Palliative Care and Neurology: Time for a Paradigm Shift,” *Neurology*; Epub ahead of print, July 2, 2014; DOI: 10.1212/WNL.0000000000000674. Boersma I, Miyasaki J, Kutner J, Kluger B; Departments of Neurology, Psychiatry, and Internal Medicine, University of Colorado Anschutz Medical Campus, Aurora; and Department of Neurology, University of Alberta, Edmonton, Canada.



## WHEN TO REFER TO HOSPICE

Call us if your patient exhibits the following indicators:

- Physical / functional decline
- Weight Loss >10% in last 6 months
- Multiple comorbidities

When life expectancy can be measured in weeks or months, hospice is usually the best option. For patients with **liver disease**, look for the following indicators:

- Endstage cirrhosis, not a candidate for liver transplant
- Serum albumin <2.5g/dl
- Ascites despite maximum diuretics
- Hepatorenal syndrome
- Encephalopathy with asterixis, somnolence, coma

Call us any time, any day.

**Geoffrey Coleman, MD**  
Medical Director  
Montgomery Hospice



## AMEN: Clinicians Offered Conversational Tool When Patients Are Hoping for a Miracle

When a patient faced with a poor prognosis states the expectation of a miracle, rather than ignore, deflect, or debate the issue, clinicians can use the statement as an opportunity to further the conversation and enhance the connection between provider and patient, according to a scripted tool presented in an article published in the *Journal of Oncology Practice*.

The AMEN conversational protocol, developed by a team of clinicians from the Sidney Kimmel Cancer Center at Johns Hopkins, Baltimore, aims to help clinicians maintain the trust of patients/families who insist on futile interventions or refuse to receive medical information by fostering open, honest communication as the care plan is being discussed.

### HOW TO SAY 'AMEN'

- Affirm the patient/family's belief and validate their hope. *"I am hopeful, too."*
- Meet the patient/family where they are. *"I join you in wishing (or praying) for a miracle."*
- Educate the patient/family as their medical provider. *"I'd like to speak to you about some medical issues."*
- No matter what: Assure the patient/fam-

ily that you and the medical team will remain committed to them throughout the duration of their care. *"No matter what happens, we will be with you each step of the way."*

Using this approach can help normalize what is often viewed as religious — an expressed belief in miraculous healing — by framing it in the concept of hope, which can then become the meeting place between provider and patient, note the authors. "We want to do our best to preserve hope, dignity, and faith while presenting the medical issues in a non-confrontational and helpful way."

The desired outcome, the authors add, is not total agreement between the parties, but the continued engagement of the provider and patient, so that the patient/family continue to feel validated and valued, while the physician can proceed with communicating important medical information in a collaborative rather than adversarial vein.

Source: "AMEN in Challenging Conversations: Bridging the Gaps between Faith, Hope, and Medicine," *Journal of Oncology Practice*; Epub ahead of print, May 6, 2014; DOI: 10.1200/JOP.2014.001375. Cooper RS, Ferguson A, Bodurtha JN, Smith TJ; The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Baltimore.