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## End-of-Life Care Physicians Share Strategies for Avoiding Burnout

Noting that “burnout has been well described among physicians in general,” researchers from the Mayo Clinic conducted a study of how burnout affects end-of-life care physicians.

With the number of medical school graduates entering into fellowships in Hospice and Palliative Medicine (HPM) increasing dramatically, the need to teach strategies for coping with the constant exposure to death and suffering that are an inherent part of the specialty continues to increase as well, the researchers write in their study published in the *Journal of Palliative Medicine*.

Characterizing burnout as emotional exhaustion, feelings of cynicism, and a lack of feelings of accomplishment, investigators asked HPM physicians:

- “How have you found ways to minimize stress, decompress, and get the most out of your work and your life?”
- “What advice would you have for a young physician starting a career in hospice and palliative care to maximally sustain energy and drive for years to come?”
- “What strategies, rituals, habits, ideas, etc. have you found to be useful, or moreover, essential for your own survival in this field?”

Among the 30 physicians (19 males and 11 females) who responded to the survey, the most common strategies reported for reducing stress and preventing burnout were:

- Taking care of themselves physically by exercising, eating a healthful diet, and getting enough rest.
- Cultivating supportive relationships at work.
- Maintaining a “transcendental perspective,” by praying, meditating, or attending religious services.
- Talking with colleagues, loved ones, and

### Mayo Clinic Study: How Physicians Avoid Burnout

- “Being part of a team – recognizing that you do not need to carry the burden alone.”
- “Faith activities including prayer for my patients, their families, and myself.”
- “I talk about how I’m feeling – including being mad, sad, or incompetent, with the people with whom I work.”
- “Celebrate the lives of the people you care for and understand that you will often need to grieve with them and their families.”

— *Journal of Palliative Medicine*

sometimes psychotherapists about work-related stress.

Based on their findings, researchers recommend that training for new HPM physicians includes advice for dealing with professional stress and preventing burnout. The training should focus on ways for physicians to develop their own methods of promoting wellness, with suggestions based on methods used by established physicians, the authors conclude.

Source: “Strategies for Avoiding Burnout in Hospice and Palliative Medicine: Peer Advice for Physicians on Achieving Longevity and Fulfillment,” *Journal of Palliative Medicine*; September 2009; 12(9):773-777. Swetz KM, et al, Division of General Internal Medicine, Department of Medicine, Mayo Clinic, Rochester, Minnesota.

# Conversations with Patients Can Reveal What Is Meant by ‘I Want Everything’

The statement “I want everything” has different meanings for different patients. According to the authors of a recent editorial published in the *Annals of Internal Medicine*, when a patient requests “everything,” the physician should initiate a dialogue to discover the patient’s treatment philosophy.

Patients could perceive “everything” as:

- Every treatment that is likely to prolong life without increased suffering.
- Every treatment that is likely to prolong life, even if suffering increases somewhat.
- Every treatment that is likely to prolong life by any length of time, regardless of any increased suffering.
- Every treatment that could possibly prolong life by any amount, regardless of any increased suffering.

## **FIND OUT WHAT “EVERYTHING” MEANS TO THE PATIENT**

Timothy E. Quill, MD, of the University of Rochester Medical Center, encourages physicians to ask questions that provide insight into the patient’s motivations:

- Fears of getting sicker, receiving less vigilant medical care, or being abandoned by medical professionals can lead to requests for “everything.” Ask:

“What worries you the most?”

“What are you most afraid of?”

“What have doctors said about your prognosis?”

“What is the hardest part for you?”

“What are you hoping for?”

- Lack of knowledge about the condition, the treatment received so far, or possible effects of proposed treatments can cause a patient to ask for all possible treatments. Besides asking questions, provide information about treatments and their potential effects. Ask:

“What are your most important goals?”

“What have others told you about the status of your disease?”

“What is your understanding of your condition/prognosis?”

“What have you been told about the possible impacts of the treatments?”

“Tell me more about what you mean by ‘everything.’”

- Spiritual and religious concerns sometimes lead patients to feel that extending life is more important than quality of life. Patients sometimes state that only God should decide when someone dies. Ask:

“Does your religion or faith provide any guidance in these matters?”

“How might we know when God thinks it’s your time?”

- Family dynamics can cause patients to ask for all possible treatments. Ask:

“How is your family handling this?”

“What do your children know?”

“Do you have a plan for dependents?”

“Have you discussed who will make decisions for you if you cannot?”

“Have you completed a will?”

## **PROPOSE A PHILOSOPHY TO GUIDE TREATMENT OF THE PATIENT**

Consider both the patient’s verbal answers and non-verbal cues in response to the questions you’ve asked. Say: “Given what we know about your illness and what I’ve learned about your priorities, it sounds like you would prefer the following balance of burdens and benefits in your treatments...”

After you propose a philosophy of treatment, ask “Does that make sense to you?”

## **RECOMMEND A SPECIFIC PLAN OF TREATMENT**

Include recommendations for invasive treatments such as CPR and intubation, and explain how these therapies may or may not fit the patient’s treatment goals. To reduce the chances that the patient will feel abandoned, first discuss your recommendations for actions that should be taken, and then discuss what you do not recommend.

## **SUPPORT EMOTIONAL RESPONSES FROM PATIENTS AND THEIR FAMILIES**

Discussions about treatments for severe illness often elicit strong emotional reactions from patients and their families. First, acknowledge and legitimize the emotions. Then explore the reasons for emotional responses. Ask “What is the hardest part?”

Empathize with the patient by verbalizing how you think you would feel in their circumstances. Patients are often reassured when you reiterate your commitment to continue caring for them, regardless of what the future holds.

## **NEGOTIATE DISAGREEMENTS IN TREATMENT PLANS**

If the patient wants treatments that you believe are not appropriate or effective, try to negotiate a solution by:

- Restating the patient’s treatment philosophy.
- Looking for areas of agreement.
- Look for solutions that accommodate both your perspective and the patient’s, such as limiting the amount of time an invasive but potentially helpful treatment, such as mechanical ventilation, is used.

## **USE HARM REDUCTION STRATEGIES IF NEEDED**

After discussion, if a patient and family make it clear that they want all possible methods of extending life, regardless of the burden of treatment or the likelihood of success, their wishes should be honored. However, physicians should still use clinical judgment.

The authors conclude, “...patients rarely want ‘everything’ for its own sake. Rather, most patients want a specific outcome, and conversations about what they mean by ‘everything’ may allow exploration of their hopes and goals for these outcomes.”

Source: “Discussing Treatment Preferences with Patients Who Want ‘Everything,’” *Annals of Internal Medicine*; September 2009; 151(5):345-349. Quill TE, Arnold R, Back AL; University of Rochester Medical Center, Rochester, New York; University of Pittsburgh; University of Washington, Fred Hutchinson Cancer Research Center, Seattle, Washington.

## Researchers Develop Scale for Predicting Seven-Day Survival in Cancer Patients

Studies worldwide have shown that patients appropriate for hospice care receive better end-of-life care and improved quality of life when cared for by a hospice multidisciplinary clinical team. That is according to researchers who have developed a new prognostic tool that can help health care providers predict short-term survival for terminal cancer patients.

Predicting survival time is generally more accurate when dealing with longer-term predictions; there is a notable decline when predicting for the short term. As a result, many patients who can benefit from hospice are not being referred in a timely manner.

Investigators sought to predict, within the first 24 hours after admission to the hospice ward of a hospital, whether a patient would survive for 7 days. Their model encompasses five prediction criteria determined by multivariate logistic regression analysis:

- Cognitive status

- Edema
- Eastern Cooperative Oncology Group (ECOG) performance status
- Blood Urea Nitrogen (BUN) level
- Respiratory rate

The first three criteria have been shown in other studies to help predict survival time. The use of BUN level and respiratory rate are the major differences between this predictor model and others, researchers explain. An elevated BUN level indicates that the patient may have terminal azotemia, characterized by terminal dehydration, gastrointestinal bleeding, and other symptoms. A higher respiratory rate also decreases the chances that a patient will survive for at least 7 days.

The study included a total of 727 patients. The new predictor model accurately predicted which patients would survive for longer than 7 days in more than 90% of patients studied.

According to the researchers, “Accurate prediction of survival is vital in planning

*“Correct survival estimates in terminally-ill cancer patients help prevent inappropriate therapies, avoid actions that could worsen the patient’s quality of life, and allow for support for patients and families by timely referral to hospice care.”*

—Chiang, et al, *BMC Public Health*

effective palliative care and appropriately adjusting some medications. Timely referral [to hospice] was associated with greater satisfaction in both patients and their family members.”

*Source: “A Proposed Prognostic 7-Day Survival Formula for Patients with Terminal Cancer,” BMC Public Health, September 2009; 9:365. Chiang JK, Lai NS, Wang MH, et al; Department of Family Medicine, Department of Natural Biotechnology, Department of Allergy, Immunology, and Rheumatology, Department of Nursing, Buddhist Dalin Tzu Chi General Hospital, Chiayi, Taiwan, Republic of China.*

## Early Physician Communication May Lead to More Hospice Use Among Metastatic Lung Cancer Patients

A team of investigators from Harvard Medical School and other Boston institutions reports that only 53% of patients in a recent study indicated that they had discussed hospice with a health care professional within 7 months of being diagnosed with metastatic lung cancer.

Surprisingly, patients with the most severe symptoms and those who preferred pain relief over attempts to extend life were no more likely than other patients to have had discussions regarding hospice, researchers note. Their findings are published in the American Medical Association’s *Archives of Internal Medicine*.

Investigators state, “Incorporating a systematic assessment of patients’ need for pal-

liative care and hospice services into routine practice could help to foster earlier communication between physicians and patients regarding hospice. Interventions to increase communication regarding patients’ prognoses and goals of care may promote greater use of hospice for appropriate patients.”

Researchers evaluated data for 1517 patients diagnosed with stage IV lung cancer by interviewing patients and surrogates and examining patient medical records.

Among the 510 patients who participated directly in interviews, about half indicated that they preferred pain and symptom relief over life-extending treatments. However, approximately 75% of these patients reported no hospice discussions with clinicians.

Certain groups found to be less likely to have hospice discussions included patients who were non-English speaking and those who had undergone chemotherapy.

Although about three-fourths of the patients who had hospice discussions reported that the health care provider had recommended hospice, many of these discussions took place very close to the time of the patient’s death, limiting the benefits that patients and their families could derive from hospice, researchers conclude.

*Source: “Discussions with Physicians About Hospice Among Patients with Metastatic Lung Cancer,” Archives of Internal Medicine, May 25, 2009; 169(10):954-962. Huskamp HA, et al, Department of Health Care Policy, Harvard Medical School, Boston.*

## MONTGOMERY HOSPICE CORE VALUES:

- **UNCONDITIONAL COMPASSION:** Compassionate care, partnered with professional excellence, is the heart of our service.
- **DIGNITY OF THE DYING:** We affirm the right of our patients to be treated with respect, and to be honored as unique individuals.
- **DEDICATION:** We are committed and privileged to ease the burdens and challenges that our patients and families face.
- **COLLABORATION:** Mutual respect, empathy and trust unite us in providing care.



Nonprofit.  
Medicare & Joint Commission  
Accredited.



## Terminally-III Patients at Risk Of Undertreatment or Overtreatment of Dyspnea

The most standard method of assessing a patient's level of suffering from dyspnea is self-report. However, as a patient nears death, the deterioration of consciousness and/or cognitive function inhibits the patient's ability to respond to clinician questions. These patients may still experience significant suffering even though they are unable to communicate their distress and are exceptionally vulnerable to overtreatment or undertreatment of symptoms.

This is according to the findings of a study conducted by a team of Detroit researchers in which data was collected from 89 patients at risk for dyspnea due to a diagnosis of chronic obstructive pulmonary disease, pneumonia, heart failure, or lung cancer.

Among this cohort very few patients were cognitive and alert. Forty-eight patients (54%) were unable to elicit even a simple "yes" or "no" answer when asked if they were short of breath. Of this group, only 49% (n=20) were able to quantify their distress by pointing to a visual analogue scale.

The number of "no" responses was low (n = 19). Men were less likely than women to report negative emotions, fear while

dyspneic, and symptom morbidity.

An analysis of the data showed that a decreased ability to self-report was related to:

- Decreased consciousness:  $p < 0.01$
- Decreased cognition:  $p < 0.01$
- Nearness to death:  $p < 0.01$
- Female gender:  $p < 0.01$
- Dementia diagnosis:  $p < 0.01$

Researchers suggest that other methods are needed to assess dyspnea symptoms in patients who cannot self-report. While in some cases family caregivers have been able to accurately assess distress levels, surrogate reports should be used with caution, write the authors. One assessment tool that could hold promise is a respiratory distress observation scale under evaluation, they state.

"As cognition or consciousness decline it is imperative that other standards be applied...to avoid under-recognition and overtreatment or undertreatment [of dyspnea]," the authors conclude.

Source: "Patients Who Are Near Death Are Frequently Unable to Self-Report Dyspnea," Journal of Palliative Medicine; Campbell ML, Templin T, Walch J, Department of Nursing Administration, Palliative Care Service, Detroit Receiving Hospital, Detroit; College of Nursing, Wayne State University, Detroit.