
HOSPICE NEWS NETWORK

What the Media Said about End-of-Life Care This Week

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A Service of State Hospice Organizations

STUDY REVEALS THAT SOME HOSPICE PRACTICES CHANGE AS A RESULT OF RESEARCH FEEDBACK

A recent study from the University of Wisconsin-Madison examined whether the clinical practice of hospices changed as a result of receiving individualized feedback about their participation in research studies. One hundred seventy hospices had taken part in a study of written materials used to prepare families for death. Each received feedback on their materials and the type of information they presented to patients and families. A year later, the UW-M study examined three questions: “(1) Did anyone at the hospice recall receiving the research results? 2) Were the findings shared with the hospice staff? and, (3) Did the findings influence clinical practice in the hospice?”

Ninety-seven of the hospices responded, and 65 completed the second survey about receiving and using the materials. Just over half said they had received the feedback (50.8%), 13.8% did not, and 35.4% didn't know.

All hospices who remembered receiving the feedback had shared it with staff – most with both administration and clinical staff. Of those, 78.8% had made changes in how they prepared families for death – 12 of them made changes to both written materials and clinical practice, seven each to written materials only and clinical staff only.

The article concludes, “The findings of this study suggest that providing feedback to agencies or individuals who participate in some descriptive studies may be used to promote improvements in clinical care. Most of the agencies that recalled receiving the results of the study reported changes to practice, and many of those changes were directly influenced by the results that they received. We need to explore how provision of individualized research results may aid in improving clinical practice.” (*Journal of Palliative Medicine*, 2011,14(2), dx.doi.org/10.1089/jpm.2010.0181)

TREATING DIABETES MELLITUS AT END OF LIFE

In “An Approach to Diabetes Mellitus in Hospice and Palliative Medicine,” the authors say, “As the patient with diabetes approaches end-of-life, there comes a time when tight glycemic control can not only prove of questionable benefit, but has the potential to cause harm. The medical literature offers little guidance on managing these complications appropriately.” The article identifies three classes of diabetic patients nearing the end of life, and proposes a specific framework to guide management of their care.

The increased morbidity of terminal patients with tight glyceamic control “often manifests itself as typical symptoms of hypoglycemia, including diaphoresis, anxiety, tremors, weakness, palpitations, and, in extreme situations, seizure.” A “prognosis-based system of triage” can help guide the shift from “prevention of long-term complications to patient comfort and individualized goals of care.”

Stable patients with advanced disease may live several months to more than a year. The authors write, “Practitioners must use this stage to begin a dialog with patients and caregivers about reducing the intensity of glyceamic control. Instruction should focus on the acute prevention of hypoglycemia and maintenance of reasonable prevention of hyperglycemia with levels less than the renal threshold of glucose, which is generally agreed to be around 180mg/dL. Patients should be warned of the signs of hypoglycemia, but with the understanding that hypoglycemia unawareness occurs more frequently in the elderly and those with multiple co-morbidities.”

Patients with Type I diabetes will still require insulin, but long-acting insulin should be used with caution because of the risk of prolonged hypoglycemia. Patients who have renal disease have decreased ability to clear insulin, so should receive lower doses. Doses should also be reduced in patients with liver failure. Patients may eat a “pleasure-based diet ... with a limit on highly concentrated carbohydrates.” Type I patients should continue with finger stick glucose tests, and Type II patients only in specific situations.

Patients with advancing underlying disease or organ failure need prevention of hypoglycemia more than glyceamic control, and the signs of dehydration and hypoglycemia should be discussed the patients and caregivers. A plan of care for treatment of these symptoms should be established. Type I patients may need to decrease their insulin, and Type II patients should decrease both insulin and sulfonylureas. “Many oral hypoglycemic dosages must be discontinued or attenuated” if the patient has renal or hepatic failure. Diet restrictions should be loosened in order to encourage patients to eat. Type II patients generally do not continue with finger-stick glucose monitoring, and Type I patients only use them if a management decision needs to be made.

In actively dying patients, “Most practitioners ... would simply withdraw all oral hypoglycemics and stop insulin in most cases of Type I and Type II patients with diabetes. At this point, care is focused on patient comfort and preparatory bereavement counseling for caretakers and patients, where appropriate.”

The article also discusses the action and contraindications of diabetic medications, including insulin, sulfonylureas, meglitinides, biguanides, thiazolidinediones, alpha-glucosidase inhibitors, and newer therapies such as exenatide, pramlintide, and sitagliptin. The authors note that corticosteroids commonly used in palliative care may “unmask preexisting diabetes or cause diabetes in certain patient populations.” While not an “absolute contraindication” for using corticosteroids, the physician should be aware that antidiabetic therapy may need to be increased, particularly in Type II patients.

The authors conclude that “Understanding the pathophysiology of diabetes and having a thorough knowledge of the medications appropriate for use in the end-of-life patient with diabetes should act as a framework for discussions with patients and caregivers and in formulating an appropriate plan of care.” (*Journal of Palliative Medicine*, 2011,14(1), www.liebertonline.com/doi/pdfplus/10.1089/jpm.2010.0191)

RESEARCH & RESOURCE NOTES

* **Doctors from the newly-formed Palliative Care Research Group say that “physicians are split ... on whether to stop prescribing statins and many other medications for chronic conditions when caring for patients with terminal illnesses.”** The group has a clinical trial starting late this year to investigate the effects of discontinuing statins in terminally ill patients. A spokesman said, “It’s a safety question. These people are dying; we don’t want to make them die faster. These people have important work to do on this earth, and we want to make sure we’re not hurting anybody.” The second study will investigate osteoporosis drugs. (*American Medical News*, 1/11, www.ama-assn.org/amednews/2011/01/10/prsb0111.htm)

* **A National Institute of Health analysis has found that medical expenditures for cancer are expected to increase 27% by 2020 – to at least \$158 billion.** The highest costs are expected to be with “breast cancer (\$16.5 billion), followed by colorectal cancer (\$14 billion), lymphoma (\$12 billion), lung cancer (\$12 billion) and prostate cancer (\$12 billion).” **According to the article, the new projections are higher than prior ones “largely because the researchers used the most recent data available — including Medicare claims data through 2006, which include payments for newer, more expensive, targeted therapies.”** Additionally, costs were analyzed by phase of care, “which revealed the higher costs of care associated with the first year of treatment and last year of life.” More information is available at costprojections.cancer.gov. (*NIH News*, 1/12, www.nih.gov/news/health/jan2011/nci-12.htm)

* **The full results of the research study of advance directives in long-term nursing home patients** (see *HNN*, 1/11) are now online at the link below. (*NCHS Data Brief*, 1/2011, www.cdc.gov/nchs/data/databriefs/db54.htm)

* **Specialist palliative day care centers are relatively common in the United Kingdom. A recent survey examined the reasons that professionals make referrals to palliative day care: 1) Physical well-being; 2) Psychological well-being; 3) Social well-being; 4) Continuity of care; 5) Introduction to hospice, and 5) Caregiver respite.** The researchers conclude, “Referrers value the multiprofessional team, the holistic approach to care as useful to managing difficult, complex, and persistent problems in patients wishing to be cared for in the community. Additional benefits include a helpful introduction to hospice services and much needed regular respite for caregivers.” (*Journal of Palliative Medicine*, 2011,14(2), www.liebertonline.com/doi/pdfplus/10.1089/jpm.2010.0372)

* **“Demographic and Clinical Determinants of Having Do Not Resuscitate Orders in the Intensive Care Unit of a Comprehensive Cancer Center”** reports on ICU patients who either had DNR orders on admission or DNR orders written during their stay, and ICU patients who did not have DNR orders. **Of the one-third of patients who had advance directives, 89.7% were white, 10.3% non-white. Only 15.2% of patients had DNR orders during the study.** The older the patient, the more likely they were to have DNR orders, but the differences were not significant. “Non-white patients with cancer who were admitted to the medical unit (compared with their white counterparts) were 83% less likely to be designated as DNR.” (*Journal of Palliative Medicine*, 2011,14(1), www.liebertonline.com/doi/pdfplus/10.1089/jpm.2010.0165)

END-OF-LIFE PLANNING NOTES

- * **Dr. Howard Brody, Director of the Institute for the Medical Humanities at the University of Texas Medical Branch at Galveston, reviews the confusing “ping-pong ball” that Medicare payment for end-of-life conversations has been. He then discusses the recent evidence that early discussion of end-of-life options is linked to better care and better quality of life.** He concludes, “The bottom line seems to be that, while politicians are slapping the ping-pong ball around, the evidence is growing that having a discussion sooner rather than later with your trusted personal physician about your plans for late in life could pay off tremendously. Will Medicare step up and encourage physicians to have those discussions by providing fair reimbursement?” (*Houston Chronicle*, 1/13, www.chron.com/disp/story.mpl/editorial/outlook/7380726.html)
- * **Casey Dowd, *Fox Business News* writer, encourages baby boomers to have healthcare proxies and living wills. He says the boomers “can-do” attitude has gotten them through this far, and will get them through the end of life.** “Will panels ultimately decide whether we live or die? Will we have to be reminded by our doctors every year that death is around the corner? Can we trust our kids not to pull the plug at the first sign of a sniffle? Who knows. But we’re the boomers, and we made our mark on the world by how we lived. Let’s prove we also know how to go out in style.” (*Fox Business*, 1/14, www.foxbusiness.com/personal-finance/2011/01/14/baby-boomer-death-right-die-death-panel-robery-quinlan-baby-boomer-retire/)
- * **Though advance directives are not perfect, they can “ease the stress of life-or-death medical decisions.”** Experts say that the surrogate decision-maker “deserves more attention and support,” and that “too often, hospital staff and clinicians want to move into the decision-making phase without taking into account the family members’ need to come to terms with the situation.” Douglas White, of the program on ethics and decision-making in critical illness at the University of Pittsburgh, says that though physicians may not be comfortable with prognosis, his research has found that “more than 90 percent of family members would like to receive prognostic information in the ICU.” Kathy Brandt, NHPCO vice-president, says that the most effective surrogates ask questions and are not intimidated by physicians. (*The Washington Post*, 1/14, www.washingtonpost.com/wp-dyn/content/article/2011/01/14/AR2011011405037.html)
- * **A *Critical Care Medicine* article on partial DNR orders describes them as designed “based on the patient’s anticipated need for resuscitation and are intended to manage dying in a tolerable manner based on what the decision maker believes is ‘best.’”** The authors say a partial DNR order “contradicts this ‘best’ management intention because it is impossible for the decision maker, or care providers, to anticipate all possible prearrest and arrest situations.” They say, “Discouraging partial do-not-resuscitate(s) order may help promote more accurate and comprehensive advance care planning.” (*Critical Care Medicine*, 2011,39(1):14-18, dx.doi.org/10.1097/CCM.0b013e3181feb8f6)
- * **Gail Sheehy says that the term “end-of-life planning” has “become a political weapon, deliberately used to frighten people into believing their government is out to deny them life-extending treatment when bureaucrats decide they're too old and sick to deserve it.”** So she suggests we plan for the “**In-Between Stage — the years between optimum health and hospice.**” Sheehy writes, “Palliative care, in my view, is the future of care for those of us entering the In-Between Stage. Its aim is to treat symptoms and relieve suffering, and it can be offered when we are first diagnosed with a serious illness. It’s not the same as hospice, which is available only in

the last six months of life.” (*USA Today*, 1/11, www.usatoday.com/yourlife/parenting-family/caregiving/2011-01-11-passages11_ST_N.htm)

* **An editorial in the Syracuse *Post-Standard* says, “In caving to those who oppose paying doctors who discuss end-of-life treatment options with Medicare patients, the Obama administration missed an opportunity to encourage people to take charge of their own medical care. ... Just because Medicare won’t reimburse doctors for end-of-life consultations is no reason to end the conversations.”** (*The Post-Standard*, 1/13, blog.syracuse.com/opinion/2011/01/keep_talking_end-of-life_discu.html)

PAIN NOTE

* **The FDA will cap the amount of acetaminophen in painkillers at 325 milligrams per capsule.** Acetaminophen, found in “Tylenol, Nyquil and thousands of other medicines used to treat headaches, muscle aches and sore throats,” is also found in prescription medicines. It is dangerous when taken in high doses, such as when patients combine two or more pain relievers. The FDA deputy director for new drugs said, “The risk of liver injury primarily occurs when patients take multiple products containing acetaminophen at one time and exceed the current maximum dose of 4,000 milligrams within twenty-four hour period.” (*AP Financial Wire*, 1/13; *The New York Times*, 1/14 www.nytimes.com/2011/01/14/health/policy/14fda.html)

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