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Serious illness care news & clinical findings | Issue Q4 2025

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REDESIGNING DEATH ROUNDS: A TOOL TO EASE RESIDENT DISTRESS IN END-OF-LIFE CARE

A recent study published in *MedEdPublish* highlights how a redesigned Death Rounds (DR) curriculum helped intensive care residents process the emotional challenges of caring for dying patients. The intervention aimed to reduce burnout, foster self-awareness, and strengthen team support.

Death Rounds, a conference first introduced at an urban academic hospital in 2016, provides a forum for residents to reflect on the emotional, ethical, and social aspects of patient death. Researchers at Case Western Reserve University and MetroHealth evaluated a modified DR format using surveys of internal medicine and medicine-pediatrics residents.

Program updates and findings

The new curriculum responded to resident feedback gathered through interviews. Key changes included:

- Shorter biweekly sessions, 30 minutes each
- Small-group breakouts
- Discussion prompt cards
- Multidisciplinary facilitators
- Attendance incentives

Surveys drew 32 responses pre-modification and 50 post-modification. **Among residents who attended DR, 81% agreed that the sessions were a worthwhile use of their time.** Significantly more DR attendees felt less distressed when caring for dying patients post-intervention ($P = 0.018$).

Residents who did not attend DR also reported they felt emotionally supported by their team after the changes (43% pre-test vs. 73% post-test, $P = 0.046$). The authors suggest that DR may contribute to a broader culture of support within the unit.

While DR attendees reported improvements in self-awareness and comfort with end-of-life conversations, fewer felt the program helped them develop coping strategies or feel less emotionally drained. The study identified these areas for further improvement.

Future direction of DR

The study promotes DR as a practical tool to enhance clinician well-being. The format's flexibility and low resource requirements make it adaptable to other clinical settings. However, the authors noted limitations, including small sample size, potential response bias, and lack of survey validation. They recommended additional research to explore long-term outcomes for residents and effects on patient care.

As one resident said, "It can be very difficult to deal with these emotions especially when still in duty...further discussion of these emotions and possibly coping mechanisms can really make a drastic difference."

Source: Fang S, Baumgardner L, et al. "Redesigning Death Rounds: Alleviating Distress for Residents in End-of-Life Care." MedEdPublish. 2025;14:31. https://doi.org/10.12688/mep.20212.2.

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INSIDE THIS ISSUE

Page 2. Enhancing End-of-Life Communication in Kidney Disease: The Underused Potential of Hospice Care

Page 3. Improving Transitions to Hospice Care for People with Dementia

Page 4. Racial Disparities in Palliative Care and Hospice Use Among Patients with Advanced Lung Cancer

Page 5. Physicians Reveal Personal End-of-Life Preferences in Cross-Continental Study

Page 6. Short Hospice Stays Common Among Certain Diagnoses and Settings, Study Finds

Page 7. The AHA Urges Early Palliative Integration for Critically Ill Heart Patients

ENHANCING END-OF-LIFE COMMUNICATION IN KIDNEY DISEASE: THE UNDERUSED POTENTIAL OF HOSPICE CARE

Despite well-established benefits, hospice services remain underutilized by patients with advanced kidney disease, according to a recent narrative review in the *Journal of Nephrology.* Only 20% of individuals with kidney failure elect hospice care, compared to 55% of cancer patients and nearly 40% with congestive heart failure.

The review supports integrating hospice and palliative care earlier in the dialysis journey to better align treatment with patient preferences, reduce symptom burden, and improve quality of life.

Hospice care provides interdisciplinary support for patients who choose to discontinue dialysis or who face a limited prognosis, ensuring that care remains focused on comfort and dignity. Still, barriers persist. Patients often overestimate their prognosis, while physicians may delay or avoid end-of-life discussions.

"Research indicates that the lack of engagement in prognosis discussions causes kidney failure patients to be reluctant to make treatment decisions during periods of clinical decline," the authors note. "Consequently, these patients often receive more intensive end-of-life care or fail to take advantage of hospice care."

Missed opportunities

Participants in ethnographic studies expressed strong preferences for shared decision-making and proactive guidance from clinicians. **As one patient was quoted, "I would hope that healthcare providers are sufficiently trained to inform patients at the right time what to expect. Not wait until the very last minute."** However, the review found that nephrologists often wait for patients to initiate such discussions.

Advanced care planning discussions are foundational to ensuring goal-concordant care, which in some cases may lead to earlier hospice enrollment for these patients. However, as the review suggests, many dialysis units lack routine processes for initiating discussions.

Hospice can act as a compassionate alternative to ongoing dialysis, particularly for older adults or those with declining function. Primary hospice care skills, like disclosing prognosis and integrating patients' values, should be part of nephrology training. "When physicians feel no longer comfortable continuing the discussion, managing refractory complications, or addressing cases of 'futility,' consultation with a [hospice or] palliative care specialist is recommended," the authors write.

> "[P]atients who decide to withdraw from treatment before death will experience a significant burden of physical and psychological symptoms. In such circumstances, hospice care plays a vital role in actively managing symptoms and providing emotional support and bereavement services to their families."
>
> —Mohadese Golsorkhi, et al,
> Psychiatry Department, Brookdale Medical Center, Brooklyn, NY.

Key benefits of hospice care

- Provides comfort-focused care after withdrawal from dialysis
- Manages symptoms such as pain, breathlessness, fatigue, and emotional and spiritual distress
- Supports families with bereavement services, including counseling and education
- Reduces unneeded hospitalizations and interventions
- Honors patient goals through advance directives and shared decisions

The authors of this review call for systemic reforms, including better prognostic tools, more robust communication training, and increased access to hospice and palliative care services. Without these improvements, many patients with advanced kidney disease may continue to miss the chance for a more peaceful, values-based end of life.

Source: Golsorkhi M, Ebrahimi N, Vakhshoori M, Norouzi S, Abdipour A. "Patient-Physician Communication in Advanced Kidney Disease: A Narrative Review." *Journal of Nephrology.* 2025;38:827–843. https://doi.org/10.1007/s40620-024-02176-3.

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IMPROVING TRANSITIONS TO HOSPICE CARE FOR PEOPLE WITH DEMENTIA

Nearly half of Medicare hospice recipients have Alzheimer's or related dementias, making timely and goal-concordant transitions to hospice critical to ensuring quality end-of-life care. An integrative review in *The Gerontologist* examined 14 articles published between 2000 and 2023, drawing insights from U.S.-based settings, including nursing homes, hospitals, and home health care.

Despite some promising findings, the authors underscore the urgent need for diverse, large-scale trials and better caregiver support to improve hospice access and outcomes for persons living with dementia (PLWD).

Clinical complexity and transition barriers

People with dementia often face unique barriers to hospice enrollment due to unpredictable disease trajectories and longer hospice stays, leading to multiple recertifications or discharges. The review notes that "many hospices have become wary of admitting persons living with dementia due to increased regulation from the Centers for Medicare and Medicaid Services."

Moreover, clinicians may be unprepared to communicate hospice benefits, and caregivers frequently lack knowledge about what hospice care entails. Cultural preferences, caregiver burden, and lack of understanding all contribute to delayed or missed referrals. The review emphasizes the need for "dementia illness counseling and serious illness communication" that accounts for the values and goals of both patients and caregivers.

Interventions to improve transitions

Four main interventions emerged from the review, including advance care planning (ACP) through video tools, checklist-based care management, and specialty palliative care triggered by hospitalizations. One promising example, the PRagmatic trial of Video Education in Nursing homes (PROVEN), demonstrated reduced hospital transfers among long-stay nursing home residents with advanced illness who viewed hospice-related ACP videos.

Another study introduced a preliminary checklist prompted by caregiver interviews to improve the hospice intake and transition process. Specialty palliative care—particularly when introduced early—was associated with increased hospice use, reduced burdensome transitions, and improved caregiver outcomes, though implementation varied and samples lacked racial and ethnic diversity.

Hospice transition predictors for PLWD

- **Clinical indicators:** Functional decline, organ failure, use of intensive care, and prior palliative care.
- **Demographic factors:** Race, insurance status, and geographic region influenced access.
- **Caregiver-related factors:** Higher caregiver burden, emotional stress, and financial difficulty predicted increased hospice utilization.

These findings align with previous literature suggesting that both patient needs and caregiver distress play key roles in end-of-life decision-making. One study cited found that PLWD with caregivers reporting emotional difficulty were nearly six times more likely to use hospice than those with lower caregiver strain.

While the reviewed studies offer valuable insights, the evidence base remains limited in scope. Most were cross-sectional, with fewer longitudinal or randomized trials. The review also points to a need for greater inclusion of racially and ethnically diverse populations to better address disparities in hospice access.

The authors recommend more inclusive, population-based research and the development of "tailored interventions, policy initiatives, and clinical workflow and practice guidelines" to support effective hospice transitions in dementia care.

The authors conclude, "These interventions can help with better tracking and management of patient and family care preferences...and may result in better prediction of later illness decisions surrounding hospice care. Ultimately, the goal is to support caregivers as they make these difficult decisions about end-of-life care."

Source: Murali, K. P., Gogineni, S., Bullock, K., McDonald, M., Sadarangani, T., Schulman-Green, D., & Brody, A. A. (2025). "Interventions and Predictors of Transition to Hospice for People Living With Dementia: An Integrative Review." *The Gerontologist*, 65. https://doi.org/10.1093/geront/gnaf046.

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RACIAL DISPARITIES IN PALLIATIVE CARE AND HOSPICE USE AMONG PATIENTS WITH ADVANCED LUNG CANCER

Minority patients with advanced lung cancer were more likely to receive referrals and attend consultations for palliative care compared to their non-minority counterparts, according to a recent study published in *Cancer Medicine.* Despite these higher referral rates, disparities in hospice utilization and knowledge of care options persist.

The study enrolled 99 patients newly diagnosed with stage III or IV lung cancer at a New York City hospital between 2014 and 2018. Participants completed validated surveys in English or Spanish at baseline and during 4-, 8-, and 12-month follow-ups. Patient beliefs, care preferences, knowledge of services, and medical mistrust were measured and analyzed.

Key findings

Of the 99 participants, 55 identified as minority (Black and/or Hispanic). Compared to non-minorities, minority patients had:

- Lower education levels and income ($P < 0.001$)
- More negative beliefs about lung cancer (mean score 35.4 vs. 29.45; $P = 0.031$)
- Greater medical mistrust (mean score 26.4 vs. 23.84; $P = 0.028$)
- Less knowledge of palliative care (78.2% reported no knowledge vs. 36.3% of non-minorities; $P < 0.001$)
- Less favorable hospice beliefs (mean score 33.04 vs. 29.36; $P = 0.001$)

Despite these challenges, minority patients were significantly more likely to receive these referrals:

- Palliative care referral: 63.6% vs. 31.8% ($P < 0.001$)
- Palliative consult: 56.4% vs. 25% ($P = 0.003$)
- Hospice referral: 47.3% vs. 27.3% ($P = 0.04$)

Notably, hospice utilization was still not statistically different (32.7% vs. 18.2%; $P = 0.102$).

Patient beliefs and hospice care utilization

Patients who utilized palliative care had more negative beliefs about hospice ($P = 0.01$) and lung cancer ($P = 0.01$). Hospice users also held more negative lung cancer beliefs ($P = 0.043$). "Patients with less favorable beliefs about hospice and lung cancer were more inclined to utilize palliative care," the study noted.

In multivariable regression, two factors stood out for hospice use: Older patients (odds ratio [OR]: 1.07; 95% CI: 1.00–1.14) and those who held more negative lung cancer beliefs (OR: 1.05; 95% CI: 1.00–1.09) had a significantly higher chance of enrolling in hospice care.

Implications for equity in care

The study suggests that physicians might expect more challenges or hesitation when discussing serious illness with minority patients, which could prompt them to involve palliative care teams earlier in the care process. Yet even with referrals, systemic and cultural barriers remain. "Despite the higher rates of referral to hospice, our findings also highlight a concerning trend of underutilization of hospice among minority patients even when being referred," the researchers wrote.

The authors emphasized the need for targeted interventions. "Future research should prioritize understanding and addressing facilitators and barriers to palliative care referral among minoritized persons," they wrote. Education, policy changes, and culturally responsive care were among the proposed strategies.

Source: Edmonds, M. C., Mazor, M., Jain, M., et al. (2025). "Drivers of Palliative Care and Hospice Use Among Patients with Advanced Lung Cancer." *Cancer Medicine*, 14:e70518. https://doi.org/10.1002/cam4.70518.

> "Minority patients with advanced lung cancer were more likely to receive a palliative care referral and specialty level consultation when compared to non-minority patients. Our work highlights the importance of proactive referral processes in facilitating access to palliative and hospice services, particularly among younger patients."
>
> —Megan C. Edmonds, et al, School of Public Health, Virginia Commonwealth University, Richmond, Virginia.

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PHYSICIANS REVEAL PERSONAL END-OF-LIFE PREFERENCES IN CROSS-CONTINENTAL STUDY

In a cross-sectional study published in the *Journal of Medical Ethics,* researchers surveyed 1,157 physicians (spanning eight jurisdictions across North America, Europe, and Australia) on their personal end-of-life care preferences. The results show broad support for symptom relief and avoidance of life-prolonging interventions, with notable variations depending on legal, cultural, and professional factors.

Physicians overwhelmingly rejected aggressive life-sustaining measures in scenarios involving terminal cancer or advanced Alzheimer's disease. Only 0.5% considered cardiopulmonary resuscitation a good option in the cancer scenario, and just 0.2% did so for Alzheimer's. In contrast, 93.6% and 90.9% favored intensified alleviation of symptoms in cancer and Alzheimer's scenarios, respectively.

Assisted dying vs. palliative sedation

When asked about assisted dying, 54.2% of physicians considered euthanasia a good or very good option in the cancer scenario, and 51.5% did so in Alzheimer's. The legal status of assisted dying in each physician's jurisdiction strongly influenced preferences.

"Physicians practising in a jurisdiction with a legal option for both euthanasia and physician-assisted suicide were more likely to consider euthanasia a (very) good option for both cancer (OR 3.1, 95% CI 2.2 to 4.4) and Alzheimer's (OR 1.9, 95% CI 1.4 to 2.6)," wrote the authors. In Belgium, where euthanasia has been legal since 2002, support was highest—80.8% of physicians favored euthanasia in a cancer scenario. By contrast, only 37.9% in Italy and 37.4% in the U.S. endorsed euthanasia for cancer and Alzheimer's.

Not all clinicians were aligned in their preferences. "Compared with palliative care physicians, GPs and other medical specialists were less likely to consider palliative sedation a good or very good option," the study noted. Palliative care physicians preferred palliative sedation (70.3%) and were less likely to support euthanasia (39.1%), physician-assisted suicide (31.8%), or using medications to hasten death (19.0%); whereas 60.4% of medical specialists and 55.8% of GPs favored euthanasia in the cancer scenario.

Religiosity, case volume linked to preferences

Religious beliefs were another significant factor. "Non-religious physicians were more likely to consider physician-assisted suicide or euthanasia a preferable option than religious physicians," the authors reported. 71.8% of non-religious physicians supported euthanasia, compared to 40.1% of religious counterparts.

Interestingly, physicians who treated more end-of-life patients annually were *less* likely to favor assisted dying. Among those treating fewer than five such patients per year, 63.1% preferred euthanasia vs. 50.4% of those treating five or more.

Despite the clarity of personal preferences, the ethical implications remain complex. "Whether physicians' personal preferences should influence their clinical practice is a question of key concern," the authors stated, adding that many physicians feel ambivalent about sharing personal views to avoid biasing patients. Still, research cited in the study suggests patients value hearing what their physicians would choose in similar situations. This underscores the delicate balance between professional neutrality and authentic, compassionate care.

A shared commitment to patient comfort

Across jurisdictions, the clearest point of agreement was a shared preference for comfort-focused care. Over 90% of physicians supported intensified symptom alleviation. Meanwhile, support for life-sustaining practices like mechanical ventilation, tube feeding, or CPR was consistently below 5%.

"These ethically and emotionally complex end-of-life issues draw attention to the challenges physicians face balancing their roles as individuals with personal convictions and as professionals committed to patient autonomy and equitable care," the authors concluded.

Source: Mroz S, Dierickx S, Chambaere K, et al. "Physicians' Preferences for Their Own End of Life: A Comparison Across North America, Europe, and Australia." *J Med Ethics*. Published online ahead of print June 10, 2025. doi:10.1136/jme-2024-110192.

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SHORT HOSPICE STAYS COMMON AMONG CERTAIN DIAGNOSES AND SETTINGS, STUDY FINDS

A new study published in *Palliative Medicine Reports* sheds light on the complex interplay of patient, provider, and system factors influencing hospice length of stay (LOS), highlighting opportunities to improve the timeliness of referrals and care at the end of life.

Researchers at Mayo Clinic reviewed 2,072 adult patients referred to nonprofit hospice agencies in Olmsted County, Minnesota, between 2013 and 2017. They found a median hospice LOS of just 18 days. Strikingly, 31.4% of patients died within a week of enrollment, while only 15.3% remained in hospice longer than 90 days.

Diagnosis primary predictor of LOS

The primary diagnosis at hospice admission emerged as a key predictor of LOS. Stroke was linked to the shortest median stay (just four days), while heart disease was associated with the longest, at 26 days. Compared to cancer, patients with stroke had 6.45 times greater odds of a short stay, while those with dementia, heart disease, and lung disease were more likely to experience long hospice stays over 90 days.

"These findings reflect the bimodal distribution of prognosis of chronic diseases such as heart failure and chronic obstructive pulmonary disease," the authors noted, "the less predictable course of these conditions as compared with cancer, and the lack of integration of palliative care services into cardiovascular and pulmonary specialties as into oncology practices."

> "[The review] demonstrates that patients who are residents of long-term care facilities, have a nurse practitioner or physician assistant as referring provider, are referred by a male provider, or have a diagnosis other than cancer have greater odds of experiencing a short hospice length of stay."
>
> —Eliza Thompson, et al, Department of Medicine, Mayo Clinic School of Graduate Medical Education, Rochester, Minnesota.

Other key influences on LOS

The study found that patients residing at long-term care (LTC) facilities had "greater odds of short hospice LOS and lower odds of a long hospice LOS than patients living in the community." The authors suggested this may reflect the misconception that LTC residents already receive adequate supportive services.

While LTC residents may receive adequate care from the facility, the authors emphasized that hospice offers *additional* layers of care that are beneficial at the end of life including, "close monitoring for and treatment of pain and discomfort, psychological and spiritual support for patients and caregivers, and more." Referral sources also influenced outcomes:

- Patients referred by advanced practice providers (APPs, such as NPs or PAs) had 1.73 times greater odds of a short hospice LOS compared to those referred by attending physicians.
- Referrals from female clinicians were linked to significantly longer stays with 37% lower odds of enrollment under 7 days than patients referred by male clinicians.

Practice and policy implications

The study supports broader efforts to integrate hospice and palliative care into all specialties—not just oncology—and increase training for APPs in hospice referral and eligibility. It also highlights the promise of home-based programs like the Palliative Care Homebound Program, which was associated with a median hospice LOS of 43 days, compared to just nine days for hospital referrals.

"Increased awareness about hospice eligibility and referral requirements, support for advance care planning, and integration of palliative care into primary care and subspecialty practices may be effective strategies to improve hospice LOS," the authors concluded.

Source: Thompson E, Sanchez Pellecer D, Hanson GJ, et al. "Patient, Provider, and Health System Determinants of Hospice Length of Stay." *Palliative Medicine Reports*. 2025;6(1):144–152. doi:10.1089/pmr.2024.0077.

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THE AMERICAN HEART ASSOCIATION URGES EARLY PALLIATIVE INTEGRATION FOR CRITICALLY ILL HEART PATIENTS

The American Heart Association (AHA) has issued a new scientific statement in its journal, *Circulation,* urging earlier and more consistent integration of palliative care in the management of critically ill patients with cardiovascular disease (CVD), particularly those treated in cardiac intensive care units (CICUs).

According to the statement, cardiac ICU patients now commonly present with both advanced cardiac conditions and non-cardiac comorbidities such as sepsis or renal failure. The unpredictable nature of CVD progression makes it difficult to determine prognosis or when to initiate palliative services.

As a result, patients frequently experience delayed or inadequate palliative care integration. "Patients with CVD experience acute exacerbations, hospitalizations, and increasing loss of patient function and image, with 30% of patients with severe CVD reaching end of life during hospitalization," the authors noted.

Primary and specialty palliative care models

AHA's statement distinguishes between primary palliative care—delivered by the patient's primary team—and specialty palliative care, which involves a dedicated palliative care team for complex cases. The authors recommend a tiered approach to identify high-risk patients and triage them appropriately.

"Implementing a tiered structure to palliative care assessment and intervention requires a systematic approach to screening for palliative care needs and triaging based on complexity," they wrote. While heart failure has the most robust data supporting palliative interventions, the statement calls for expanded use in other cardiac populations such as patients with:

- Valvular disease
- Refractory arrhythmias
- Adult congenital heart disease
- History of cardiac arrest

The CICU setting also presents ethical challenges regarding withdrawal of life-sustaining treatment and device deactivation. "Deactivation of implantable cardiac defibrillators is recommended as a measure to minimize potential suffering," the authors stated.

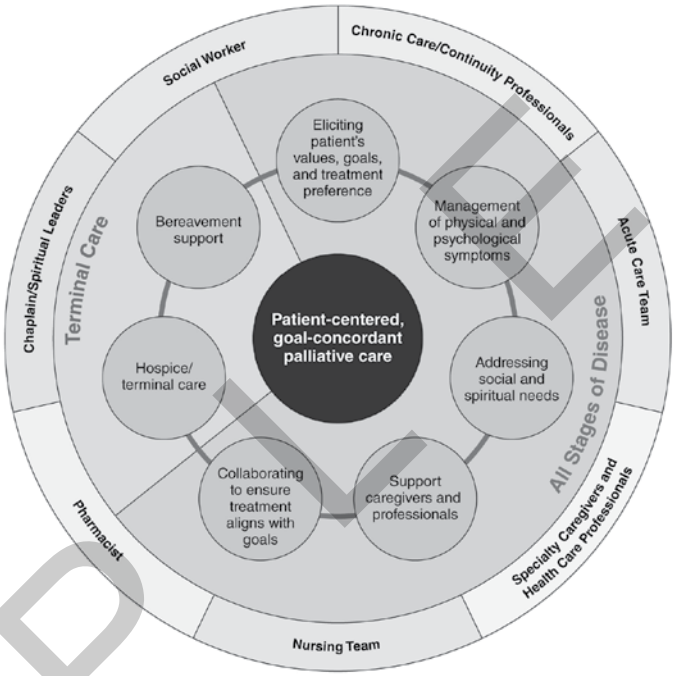

Figure 1. Principles for patient-centered goal-concordant palliative care in patients with critical cardiovascular illness (Bohula E, et al, 2025).

Current barriers and future integration

The authors assert one of the most urgent needs is education. "Despite the millions of patients with unmet palliative care needs... most residency and cardiology fellowship training programs provide trainees with fragmented formal training and variable exposure to the fundamentals of palliative care." Only 10% of fellows and no faculty surveyed reported required or elective palliative training during cardiology fellowships.

The AHA calls for training initiatives, standardized communication strategies (such as early family meetings), and institutional models that combine primary and specialty palliative care. **"Integration of palliative care principles in the routine cardiovascular care is necessary to address the complex needs of these patients during a health care crisis or at the end of life,"** the authors conclude.

Source: Bohula EA, Landzberg MJ, Menon V, et al. "Palliative and End-of-Life Care During Critical Cardiovascular Illness: A Scientific Statement From the American Heart Association." *Circulation.* 2025;151:e1075–e1090. doi:10.1161/CIR.0000000000001334

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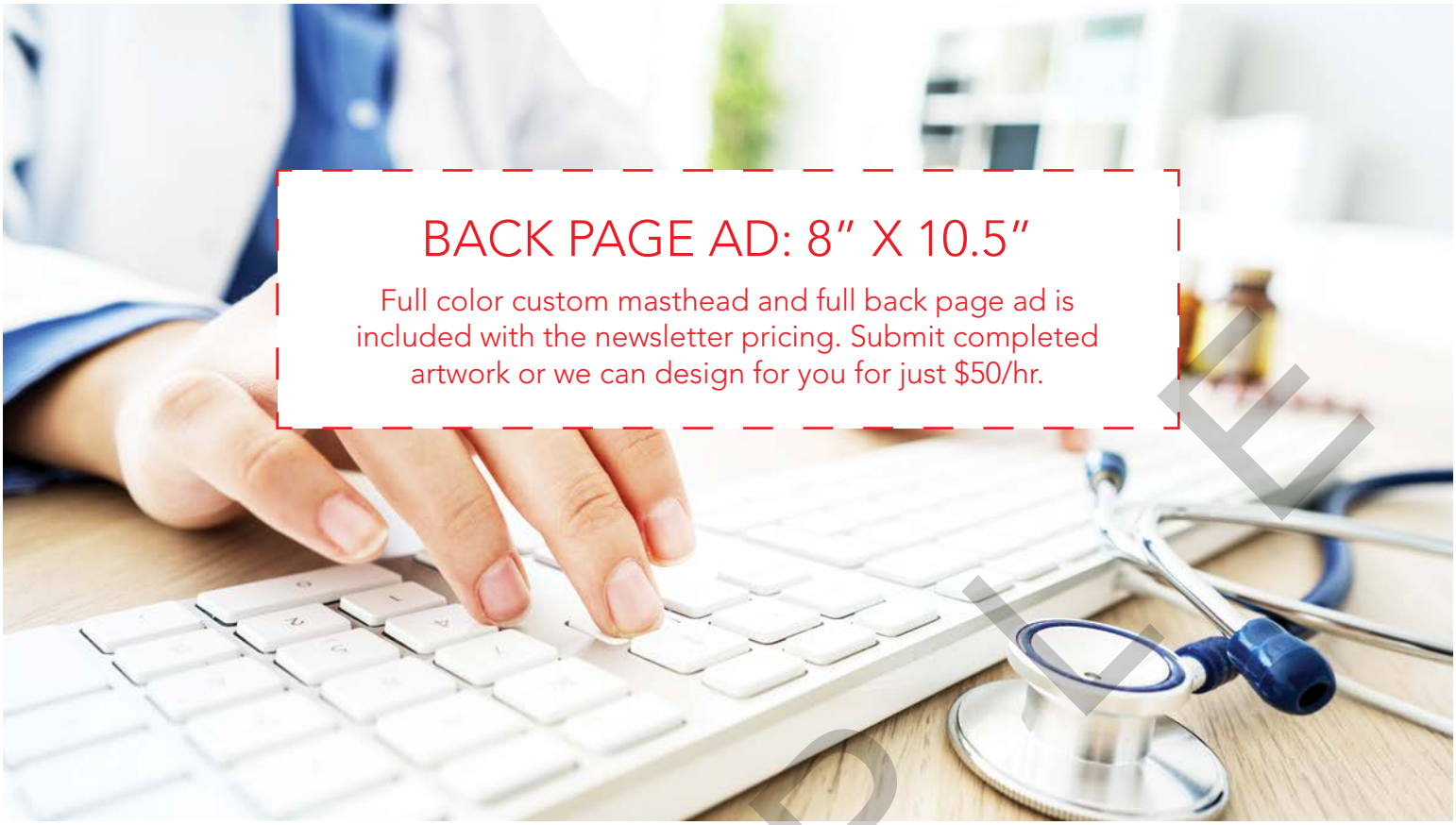

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