Polypharmacy in the Aging Patient: A Review of Glycemic Control in Older Adults With Type 2 Diabetes
Lipska K, Krumholz H, Soones T, Lee S

IMPORTANCE: There is substantial uncertainty about optimal glycemic control in older adults with type 2 diabetes mellitus. OBSERVATIONS: Four large randomized clinical trials (RCTs), ranging in size from 1791 to 11,440 patients, provide the majority of the evidence used to guide diabetes therapy. Most RCTs of intensive vs standard glycemic control excluded adults older than 80 years, used surrogate end points to evaluate microvascular outcomes and provided limited data on which subgroups are most likely to benefit or be harmed by specific therapies. Available data from randomized clinical trials suggest that intensive glycemic control does not reduce major macrovascular events in older adults for at least 10 years. Furthermore, intensive glycemic control does not lead to improved patient-centered microvascular outcomes for at least 8 years. Data from randomized clinical trials consistently suggest that intensive glycemic control immediately increases the risk of severe hypoglycemia 1.5- to 3-fold. Based on these data and observational studies, for the majority of adults older than 65 years, the harms associated with a hemoglobin A1c (HbA1c) target lower than 7.5% or higher than 9% are likely to outweigh the benefits. However, the optimal target depends on patient factors, medications used to reach the target, life expectancy, and patient preferences about treatment. If only medications with low treatment burden and hypoglycemia risk (such as metformin) are required, a lower HbA1c target may be appropriate. If patients strongly prefer to avoid injections or frequent fingerstick monitoring, a higher HbA1c target that obviates the need for insulin may be appropriate. CONCLUSIONS AND RELEVANCE: High-quality evidence about glycemic treatment in older adults is lacking. Optimal decisions need to be made collaboratively with patients, incorporating the likelihood of benefits and harms and patient preferences about treatment and treatment burden. For the majority of older adults, an HbA1c target between 7.5% and 9% will maximize benefits and minimize harms. JAMA 2016;315(10):1034-1045

Motivations, Satisfaction, and Fears of Death and Dying in Residential Hospice Volunteers
Nissim R, Emmerson D, O’Neill B, Marchington K, Draper H, Rodin G

Rationale: Studies conducted on hospice volunteers’ characteristics and experiences have been cross-sectional. We conducted a prospective study to examine changes in the volunteer experience over time in a cohort of volunteers during the first year of a new residential hospice. Method: Eighty-two active volunteers completed an online baseline survey, and of these, 39 completed a follow-up survey at 6 months. The survey included measures of motivations to volunteer, satisfaction with role and with the organization, and fear of death and dying. Results: Repeated measures analyses indicated that motivations to volunteer remained stable over time while volunteer satisfaction increased with time. Baseline level of fears of death and dying varied by age, volunteer role, and motivations to volunteer and decreased at 6 months. Conclusion: Volunteering in a residential hospice tends to be a satisfying experience that helps to allay fears about death and dying. Am J Hosp Palliat Med 2016;33(4):335-339
Family Members’ Experience with Hospice in Nursing Homes  
Gage L, Washington K, Oliver D, Kruse R, Lewis A, Demiris G

Research has documented numerous benefits and challenges associated with receipt of hospice care in nursing homes; however, study of this partnership from the perspective of residents’ family members has been limited. The purpose of this qualitative investigation was to explore family members’ experience with hospice services received in the nursing home setting. Researchers conducted a secondary data analysis of 175 family member interviews using a thematic analytic approach. Findings highlighted the critical role of communication in supporting residents and their family members. Care coordination, support and oversight, and role confusion also impacted family members’ experience of hospice care in the nursing home. Efforts directed at enhancing communication and more clearly articulating the roles of members of the health care team are indicated. *Am J Hosp Palliat Med* 2016;33(4):354-362

Doctors Discussing Religion and Spirituality: A Systematic Literature Review  
Best M, Butow P, Olver I

Background: Discussion of religion and/or spirituality in the medical consultation is desired by patients and known to be beneficial. However, it is infrequent. We aimed to identify why this is so. Aim: We set out to answer the following research questions: Do doctors report that they ask their patients about religion and/or spirituality and how do they do it? According to doctors, how often do patients raise the issue of religion and/or spirituality in consultation and how do doctors respond when they do? What are the known facilitators and barriers to doctors asking their patients about religion and/or spirituality? Design: A mixed qualitative/quantitative review was conducted to identify studies exploring the physician’s perspective on discussion of religion and/or spirituality in the medical consultation. Data sources: We searched nine databases from inception to January 2015 for original research papers reporting doctors’ views on discussion of religion and/or spirituality in medical consultations. Papers were assessed for quality using QualSyst and results were reported using a measurement tool to assess systematic review guidelines. Results: Overall, 61 eligible papers were identified, comprising over 20,044 physician reports. Religion and spirituality are discussed infrequently by physicians although frequency increases with terminal illness. Many physicians prefer chaplain referral to discussing religion and/or spirituality with patients themselves. Such discussions are facilitated by prior training and increased physician religiosity and spirituality. Insufficient time and training were the most frequently reported barriers. Conclusion: This review found that physician enquiry into the religion and/or spirituality of patients is inconsistent in frequency and nature and that in order to meet patient needs, barriers to discussion need to be overcome. *Palliat Med* 2016;30(4):327-337
Primary Care Physicians’ Knowledge And Attitudes Regarding Prescription Opioid Abuse and Diversion
Hwang C, Turner L, Kruszewski S, Kolodny A, Alexander C

Objectives: Physicians are a key stakeholder in the epidemic of prescription opioid abuse. Therefore, we assessed their knowledge of opioid abuse and diversion, as well as their support for clinical and regulatory interventions to reduce opioid-related morbidity and mortality. Materials and Methods: We conducted a nationally representative postal mail survey of 1000 practicing internists, family physicians, and general practitioners in the United States between February and May 2014. Results: The adjusted response rate was 58%, and all physicians (100%) believed that prescription drug abuse was a problem in their communities. However, only two-thirds (66%) correctly reported that the most common route of abuse was swallowing pills whole, and nearly one-half (46%) erroneously reported that abuse-deterrent formulations were less addictive than their counterparts. In addition, a notable minority of physicians (25%) reported being “not at all” or “only slightly concerned” about the potential for opioid diversion from the licit to the illicit market when this practice is common at all levels of the pharmaceutical supply chain. Most physicians supported clinical and regulatory interventions to reduce prescription opioid abuse, including the use of patient contracts (98%), urine drug testing (90%), requiring prescribers to check a centralized database before prescribing opioids (88%), and instituting greater restrictions on the marketing and promotion of opioids (77% to 82%). Despite this, only one-third of physicians (33%) believed that interventions to reduce prescription opioid abuse had a moderate or large effect on preventing patients’ clinically appropriate access to pain treatment. Discussion: Although physicians are unaware of some facets of prescription opioid-related morbidity, most support a variety of clinical and regulatory interventions to improve the risk-benefit balance of these therapies. Clin J Pain 2016;32(4):279-284

Anticholinergic Drug Burden in Persons with Dementia Taking a Cholinesterase Inhibitor: Effect of Multiple Physicians

OBJECTIVES: To explore the association between the number of physicians providing care and anticholinergic drug burden in older persons newly initiated on cholinesterase inhibitor therapy for the management of dementia.
PARTICIPANTS: Community-dwelling (n = 79,067, mean age 81.0, 60.8% female) and long-term care residing (n = 12,113, mean age 84.3, 67.2% female) older adults (≥66) newly dispensed cholinesterase inhibitor drug therapy.
MEASUREMENTS: Anticholinergic drug burden in the prior year measured using the Anticholinergic Risk Scale. RESULTS: Community-dwelling participants had seen an average of eight different physicians in the prior year. The odds of high anticholinergic drug burden (Anticholinergic Risk Scale score ≥ 2) were 24% higher for every five additional physicians providing care to individuals in the prior year (adjusted odds ratio = 1.24, 95% confidence interval = 1.21-1.26). Female sex, low-income status, previous hospitalization, and higher comorbidity score were also associated with high anticholinergic drug burden. Long-term care facility residents had seen an average of 10 different physicians in the prior year. After a sensitivity analysis, the association between high anticholinergic burden and number of physicians was no longer statistically significant in the long-term care group. CONCLUSION: In older adults newly started on cholinesterase inhibitor drug therapy, greater number of physicians providing care was associated with higher anticholinergic drug burden scores. Given the potential risks of anticholinergic drug use, improved communication among physicians and an anticholinergic medication review before prescribing a new drug are important strategies to improve prescribing quality. J Am Geriatr Soc 2016;64(3):492-500
Characterizing the Hospice and Palliative Care Workforce in the U.S.: Clinician Demographics and Professional Responsibilities

Context: Palliative care services are growing at an unprecedented pace. Yet, the characteristics of the clinician population who deliver these services are not known. Information on the roles, motivations, and future plans of the clinician workforce would allow for planning to sustain and grow the field. Objectives: To better understand the characteristics of clinicians within the field of hospice and palliative care. Methods: From June through December 2013, we conducted an electronic survey of American Academy of Hospice and Palliative Medicine members. We queried information on demographics, professional roles and responsibilities, motivations for entering the field, and future plans. We compared palliative care and hospice populations alongside clinician roles using chi-square analyses. Multivariable logistic regression was used to identify predictors of leaving the field early. Results: A total of 1365 persons, representing a 30% response rate, participated. Our survey findings revealed a current palliative care clinician workforce that is older, predominantly female, and generally with less than 10 years clinical experience in the field. Most clinicians have both clinical hospice and palliative care responsibilities. Many cite personal or professional growth or influential experiences during training or practice as motivations to enter the field. Conclusion: Palliative care clinicians are a heterogeneous group. We identified motivations for entering the field that can be leveraged to sustain and grow the workforce. *J Pain Symptom Manage* 2016;51(3):597-603

Relationships between Personal Attitudes about Death and Communication with Terminally Ill Patients: How Oncology Clinicians Grapple with Mortality
Rodenbach R, Rodenbach K, Tejani M, Epstein R

Highlights: Communication styles with dying patients include direct and indirect approaches. Most clinicians express a conditional acceptance of their own mortality. A reciprocal relationship exists between personal views about death and patient care. Some clinicians’ attitudes facilitate open conversations with patients about death. Self-awareness and communication training are key to improving end-of-life care. Abstract: Clinician discomfort with death may affect care of patients but has not been well-studied. This study explores oncology clinicians’ attitudes surrounding their own death and how these attitudes both affect and are affected by their care of dying patients and their communication with them. *Patient Educ Couns* 2016;99(3):356-363

Rise of Concurrent Care for Veterans with Advanced Cancer at the End of Life
Mor V, Joyce N, Cote D, Gidwani R, Ersek M, et al

Unlike Medicare, the Veterans Health Administration (VA) health care system does not require veterans with cancer to make the “terrible choice” between receipt of hospice services or disease-modifying chemotherapy/radiation therapy. For this report, the authors characterized the VA’s provision of concurrent care, defined as days in the last 6 months of life during which veterans simultaneously received hospice services and chemotherapy or radiation therapy. Concurrent receipt of hospice and chemotherapy or radiation therapy increased among veterans dying from cancer without reductions in the receipt of cancer therapy. This approach reflects the expansion of hospice services in the VA with VA policy allowing the concurrent receipt of hospice and antineoplastic therapies. *Cancer* 2016;122:782–790