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SHOULD HOSPICES EMBRACE LEGALIZED MEDICAL MARIJUANA?

An article in *The Lancet United States of Health* blog asks, "How Should Hospices Handle Legalized Marijuana?" As medical marijuana gains ground, both culturally and scientifically, says the article, US hospice and palliative care providers are increasingly fielding questions from patients who want access to medical cannabis. This places hospices in a challenging position. The hospice and palliative care community seeks to place the needs of its patients first, in order to make their end-of-life experience as meaningful and pain-free as possible.

Medical cannabis remains a controversial – and federally illegal – choice. It is not recognized by federal authorizes as being a legitimate treatment option. With the vast majority of hospice funding tied to a federal agency, CMS via Medicare, it remains unclear what hospices can or should do in offering medical marijuana.

At present, twenty-five states and the District of Columbia have legalized medical cannabis. Four more states will vote on legalization very soon. **Scientific research on the health impacts of marijuana as a medical treatment is still in its infancy, says the article. "Tantalizing anecdotes suggest a variety of treatment applications calling out for further study."** Such applications could include treatment of pain, anxiety, and sleep disturbance. Marijuana also shows promise in treating nausea and loss of appetite – particularly common symptoms in dying patients.

In these challenging circumstances, how do hospice and palliative care teams evaluate the promise of medical marijuana? Robert Cole, associate medical director of Hospice of the East Bay in Pleasant Hill, California, "sees real value for cannabis as a palliative treatment for the symptoms experienced by his patients." In particular, he views great promise in medical marijuana as a safer alternative to the high-dose opioid painkillers that present such a problem

in terms of addiction and drug abuse. “The bottom line is that cannabis is a remarkable drug that does not produce some of the negative effects of opioids. Its potential benefit as an analgesic needs to be studied further,” Dr. Cole says.

In the midst of this very lively debate, where should hospice organizations stand? Will hospices embrace medical cannabis as a legitimate pain therapy? **In jurisdictions where state authorities have legalized it, will hospices move forward with providing medical marijuana to patients who desire it?**

The answers to these questions are not yet clear, notes the article, but they are certainly being considered. “‘We’re working on this issue, but it’s definitely a work in progress,’ says Jeri Conboy, director of Blessing Hospice & Palliative Care in Quincy, Illinois, a state that is now running a statewide pilot of medical marijuana.”

At present, the policy of Conboy’s parent hospital is to keep medical marijuana at arms’ length. They do not pay for medical marijuana, or participate in the patient’s qualification process. “‘For the hospice team,” says Conboy, “we can’t be present when medical marijuana is consumed. It is not part of hospice benefit services. But we ask about it, just as we ask if patients are taking herbal medications, and we explain the hospice’s position on the issue.’” Conboy reports that some staff members feel frustration at their inability to control this aspect of patient care.

It has been reported that a few hospices have taken a more active stance. A 2012 article published in the quarterly newsletter of the American Academy of Hospice and Palliative Medicine indicated that some hospice providers view medical cannabis as a viable palliative care treatment, even if they are quiet about this support on an institutional level.

Hospice and palliative care patients, says the article, look to their healthcare providers to give guidance on medical cannabis. This is a difficult conversation to have when many hospices don’t have official policies on the subject. **“As a hospice practitioner, I want to be able to enter into a conversation with my patients openly about all the options available,” says Cole. “I don’t want to overstate the benefits… But we should be able to lay it all out there for our patients without being worried about the response of the DEA.”** (*The Lancet*, 10/19, usa.thelancet.com/blog/2016-10-19-how-should-hospices-handle-legalized-medical-marijuana)

FACING BLAME FOR OPIOID EPIDEMIC, PHYSICIANS VOTE TO DROP PAIN AS THE “FIFTH VITAL SIGN”

The American Academy of Family Physicians (AAFP) has voted to eliminate pain scores as the “fifth vital sign.” This decision has come in part as a reaction to “being seen as a scapegoat for the nation’s opioid overdose epidemic.”

Tom Frieden, MD, MPH, director of the Centers for Disease Control and Prevention, has called the epidemic 'doctor-driven.' Yet many physicians find themselves in a difficult position. "Physicians in many specialties have explained that they feel pressure to overprescribe opioids, and do so to attain higher patient-satisfaction scores for themselves and their hospitals."

The idea of pain as a "fifth vital sign" was popularized several decades ago, when pain was more likely to be ignored or under-treated. The situation is different today, with opioid addiction ravaging vast swaths of the American heartland. Ironically, the emphasis on fighting pain could be seen as a catalyst for the overprescription of addictive drugs. "Many physicians blame the pharmaceutical industry for promoting opioid painkillers as a way to bring pain scores down."

At the AAFP 2016 Congress of Delegates, the outcome of the vote seemed to be a foregone conclusion. **"As soon as the title of the resolution was announced, several hundred delegates in the room clapped and cheered."** Mitzi Rubin, MD, who serves as president of the Georgia Academy of Family Physicians, calls the pain measures "subjective… [but] put in an objective category." There is no objective scale of pain, since each individual decides what is a "10" for them and what is a "4." **Dr. Rubin observed that making pain relief so central to the patient experience had backfired on many doctors, who found themselves excoriated online for failing to ease pain, "when we actually give very good care."**

"No one is suggesting that controlling pain is unimportant," says Matt Burke, MD, from Virginia. However, the importance given to pain scores "is an uncomfortable distraction and promotes inappropriate patient expectations." A number of physicians argue that the medical system should be measuring "functional status" rather than pain. "Can a patient work, walk, or take a bath without any assistance? One speaker recommended the Physical Functional Ability Questionnaire (FAQ5) as a measurement tool."

The AAFP is not alone in discarding pain as a "fifth vital sign." A few months ago, the House of Delegates of the American Medical Association came to a similar conclusion. Physicians nationwide are increasingly critiquing evaluation methods that equate pain management with the prescription of drugs. These complaints are having an effect. **"New and improved pain-management questions in development will 'remove any potential ambiguity' about the survey, CMS reported in July.** And to eliminate the financial pressure to overprescribe pain meds, the current pain questions will cease to be part of VBP calculations in 2018." (*Medscape*, 9/22, www.medscape.com/viewarticle/869169?nlid=109460_2981&src=wnl_dne_160926_mscpedit&uac=101002SK&impID=1203818&faf=1)

HOSPICE AND END-OF-LIFE NOTES

*** Eleven musical artists have joined forces to create the "LIV ON" album, which explores the artists' experiences of grief, and to express how they lived through it.** "It's like a conversation," said Sky, a Canadian singer/songwriter. "Each song deals with a different emotion that surrounds grief." (*Hospice Insider*, 10/7, thehospiceinsider.com/healing/artists-share-lessons-loss)

*** The US Supreme Court has denied Southeast Arkansas Hospice Inc.'s petition to the US Supreme Court to hear its case on the hospice cap.** The hospice had held "that Medicare's reimbursement cap amounted to 'unconstitutional taking,' a scenario in which federal regulations force private property to be used without compensation." (*McKnights,* 10/3, http://www.mcknights.com/news/supreme-court-declines-review-of-medicare-hospice-cap-case/article/526628/)

*** Hospice care fraud is coming under widespread scrutiny reports the *Columbus Dispatch*.** "While no one questions the cost for patients and families who truly need — and deserve — the services, some billing practices, including illegally charging for patients who are nowhere near the end of their days, have caught the attention of regulators." (*Columbus Dispatch*, 10/17, www.dispatch.com/content/stories/local/2016/10/17/health-care-hospice-care-fraud-under-scrutiny.html)

*** Talk about death and dying with your loved ones now, before it's too late, writes Marina Schauffler.** "In recent decades, American culture has opened to permit candid conversations about many topics once off the table – from gender identity and racism to addictions and disorders. But when it comes to end-of-life discussions, there's still strong resistance." (*Portland Press Herald*, 10/16, www.pressherald.com/2016/10/16/sea-change-talk-about-death-with-your-loved-ones-before-you-think-you-have-to/)

*** A report recently released in *JAMA Pediatrics* argues that when speaking with teenagers who have a life-threatening illness, telling the truth is the way to go.** (*CBS News*, 10/17, www.cbsnews.com/news/doctors-parents-how-to-talk-to-terminally-ill-teens-about-disease-death/)

*** Incomplete end-of-life forms are causing trouble for physicians who seek to honor patient wishes.** "A study of elderly patients' end-of-life forms found that 69% had at least one section left blank, and 14% indicated the patient wanted comfort measures only, but also that they wanted be sent to the hospital, receive intravenous fluids, and/or receive antibiotics. These inconsistencies would likely result in patients receiving unwanted emergency care." (*Medscape*, 10/14, www.medscape.com/viewarticle/870350)

*** The rise of "elder orphans" is an increasing problem in Chicago.** A new report reveals that almost one third of seniors in Chicago are living alone, without the company of family members or a spouse, and without assistance from adult children. This number is expected to grow as baby boomers age into elderhood. (*DNA Info*, 10/20, www.dnainfo.com/chicago/20161020/wicker-park/senior-citizens-living-alone-us-census-elder-orphans)

*** "Sky-high" discharge rates among hospices in Mississippi point to fraud, says *Mississippi Today*.** "More Medicare beneficiaries leave hospice care alive in Mississippi than in any other state in the country, an indication of the state's ongoing problems with Medicare fraud, according to government officials." (*Mississippi Today*, 10/20, mississippitoday.org/2016/10/20/mississippis-sky-high-hospice-discharge-rates-point-to-fraud/)

* **Paula Span, writing in *The New York Times,* examines VSED, the practice of voluntarily stopping eating and drinking.** She shares stories of patients' experiences and explores the issues related to the action. (*New York Times,* 10/21, http://www.nytimes.com/2016/10/25/health/voluntarily-stopping-eating-drinking.html?_r=0)

PALLIATIVE CARE NOTES

* **A study published in *Journal of Palliative Medicine* has indicated that a home-based palliative care program generated significant cost savings.** "A home-based palliative care (HBPC) program for individuals with advanced illnesses was associated with a $12,000 reduction in the mean total cost of care per person, fewer hospital admissions and emergency room visits, and greater use of hospice during the final three months of life." (*JPM*, 8/30, online.liebertpub.com/doi/full/10.1089/jpm.2016.0265)

* **Advance care planning codes could be pivotal in improving patient quality of life at the end of life.** An article in *Journal of Palliative Medicine* says, "For the first time, healthcare is experiencing a dramatic shift in billing codes that support increased care management and care coordination. ACP, chronic care management, and transitional care management codes are examples of this newer recognition of the value of these types of services. ACP discussions are an integral component of comprehensive, high-quality palliative care delivery." (*JPM*, 9/28, online.liebertpub.com/doi/pdfplus/10.1089/jpm.2016.0202)

* **Palliative care and hospice are two distinct things, and knowing the difference is important.** A writer from Roanoke thanks Dr. Michael Camardi for his suggestion that they pursue palliative care, and notes the patient's initial confusion about this recommendation. **"I thought you were giving me a death sentence because I thought palliative care was hospice."** (*Roanoke Times*, 10/18, www.roanoke.com/life/health/age-matters-the-challenge-of-palliative-care/article_6468fa81-4465-5668-913e-bf6ab1e57b50.html)

OTHER NOTES

* **Arthur Caplan, an end-of-life bioethicist, writes with co-authors about the dangers of expanding access to euthanasia in the Netherlands.** "If the Dutch Cabinet gets what it wants, citizens who feel they have a 'completed life' soon will be able to request public support for help in ending their lives. It is a frightening precedent that other nations ought not follow, and a policy the Dutch ought to reject." (*Chicago Tribune*, 10/17, www.chicagotribune.com/news/opinion/commentary/ct-euthanasia-assisted-suicide-dutch-netherlands-perspec-1018-jm-20161017-story.html)

* **An "Aid in dying" bill has passed the New Jersey Assembly. The bill would still require Senate approval, and Governor Chris Christie has promised to veto the bill if it arrives on his desk.** "The controversial bill passed by a 41-28 vote with five abstentions." (*NJ*, 10/20,

www.nj.com/politics/index.ssf/2016/10/aid_in_dying_legislation_for_terminally_ill_assemb.html)

*** The debate around "death with dignity," while important, is a hard one.** The editors of the *Concord Monitor* suggest that they have arrived at their own conclusions, writing: "This newspaper's editorial board has not yet taken a formal position on right-to-die legislation because passage of such a law has appeared so remote. Were we to, it would almost certainly be yes, terminally ill adults should, as a matter of personal freedom, have the ability to make that decision." (*Concord Monitor*, 10/13, www.concordmonitor.com/NH-death-with-dignity-5347138)

*** Will Washington, DC, be the next locality to legalize physician-assisted suicide? DC's city government is wrestling with the "death with dignity" debate.** "Pending legislation would allow consenting doctors to help terminally ill District residents hasten the end their lives and provide another option for those who are out of options." (*Washington Times*, 10/17, www.washingtontimes.com/news/2016/oct/17/dc-council-wrestles-with-dealth-with-dignity/)

*** The "right to die" debate in Washington, DC, is hitting resistance from some in the city's large African-American community.** A recent article in the *Washington Post* addressed the issue in "Right-to-die law faces skepticism in nation's capital: 'It's really aimed at old black people.'" "Although the law has been enacted in a handful of states with a mostly white population, it faces particular opposition in the nation's capital, home to a large African American community. In national surveys, African Americans have consistently stood against assisted suicide." (*Washington Post*, 10/17, www.washingtonpost.com/local/dc-politics/right-to-die-law-faces-skepticism-in-us-capital-its-really-aimed-at-old-black-people/2016/10/17/8abf6334-8ff6-11e6-a6a3-d50061aa9fae_story.html)

*** John Stonestreet, president of the Chuck Colson Center for Christian Worldview, urges Colorado residents to vote against physician-assisted suicide in that state.** His opinion column was published in *USA Today.* If PAS becomes legal, says Stonestreet, "We will be telling those with terminal illness that they shouldn't burden anyone else with their care. We will be telling those in the medical community that killing is a form of care. And we will be telling vulnerable students, veterans and others that death is a solution they should consider."
(*USA Today*, 10/18, www.usatoday.com/story/opinion/2016/10/18/suicide-colorado-prop-106-euthanasia-column/91964372/)

*** Should Floridians vote to legalize medical marijuana? The Tampa Bay Times says, "yes."** "Across the nation, medical marijuana is embraced as a safe, effective way to treat chronic pain and serious illness. Yet the Florida Legislature stubbornly refuses to act and has turned its back on the majority of Floridians who support its use. That leaves no other option but for voters to take action, and they should amend the Florida Constitution to legalize the use of marijuana for limited medical situations." (*Tampa Bay Times*, 10/14, web.tampabay.com/opinion/editorials/times-recommends-vote-yes-on-medical-marijuana-amendment-2/2298041)

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