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LETTER TO THE EDITOR

## A call for simple and rational palliative medicine psychotropic prescribing guidelines: Response to Barnhorst et al. (*Palliative & Supportive Care*, Volume 6, Number 1, 2008)

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I was delighted to see an attempt at the development of a hospice formulary for psychotropic medications by Barnhorst et al. (2008). I applaud the attempt to make a concise list of medications targeted at specific symptoms as a guide and educational tool, as well as pointing out the pitfalls of some medication choices, especially that of delirium. However, in working at an organization that provides hospice care to over 2000 patients a year in an acute-care setting and over 4000 a year in home-care or long-term care settings, I think several improvements could be made.

First a more thorough assessment of the target audience is needed. Clinicians will vary in their knowledge and skills about the assessment, diagnosis, and management of psychiatric issues as they relate to patients with life-threatening illnesses (Irwin & Ferris, 2008). Nonpalliative-care physicians and other members of the general health care team will need to achieve and maintain basic core competencies in the psychiatric aspects of palliative medicine. This group is likely best served by a short-list (one or two medications per target symptom) prescribing guideline. Hospice and palliative medicine experts and other members of hospice and palliative care team need advanced training and expertise in the psychiatric aspects of palliative medicine. This group would be best served by an expanded list and can serve as consultants to the previous group. Palliative care *psychiatry* specialists will require advanced training and expertise in the psychiatric aspects of palliative medicine and be able to counsel their

colleagues on the all of the nuances and choices available for all psychiatric target symptoms.

Second, medications should be targeted at symptoms as part of a diagnosis, not to symptoms alone. Is the fatigue from cancer or is it due to depression? Is the insomnia due to pain or is it a primary insomnia? Is the agitation due to dementia or delirium? If delirium, is drug therapy the cause? By first diagnosing, then targeting symptoms, appropriate interventions (including discontinuing or rotating medications if appropriate) can be chosen, costs can be reduced, and poly-pharmacy can be minimized.

Third, the medications on the list should have an evidence base for their proposed targets. For depression in patients with advanced, life-threatening illnesses, the current pharmacologic treatment options for depression consist of the usual armamentarium of more than 24 antidepressants with at least seven different mechanisms of action (Stahl, 1998). However, an appropriate antidepressant trial is considered 4–6 weeks, and multiple trials will likely be necessary to find one that works (Trivedi et al., 2006; Thase et al., 2007); however, hospice patients often die before adequate trials and discovery of effective medications have occurred. With the average time on hospice service being less than 60 days (median less than 21 days) in the United States (National Hospice and Palliative Care Organization, 2007), current standard antidepressant trials oftentimes do not adequately address the needs of hospice patients suffering from depression. Although all of the antidepressants should be on the palliative care psychiatry specialists' list, likely only stimulants should be on the short list (Homsy et al., 2000; Menza et al., 2000; Rozans et al., 2002; Sood et al., 2006), with the thought of getting further psychiatric

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consultation. Tricyclics and MAO inhibitors should be left to experienced consultants.

An accurate diagnosis associated with agitation is very important, as the treatment of agitation varies depending on the etiology, context, and goals of care, such as reversible versus irreversible delirium, dementia, or schizophrenia (Schneider et al., 2006; S.A. Irwin, G.T. Buckholz, & F.D. Ferris, manuscript in preparation). For agitation associated with delirium, no evidence exists for improved efficacy with atypical (second or third generation) antipsychotics (Breitbart et al., 1996; Sipahimalani & Masand, 1998; Han & Kim, 2004; Skrobik et al., 2004), and these medications have the disadvantage of being much more expensive and having limited routes of administration. The American Psychiatric Association guidelines for delirium management suggest first-generation antipsychotics for the treatment of agitation in the context of delirium (Rundell et al., 1999; Cook, 2004). When agitation occurs with a delirium that is irreversible, a shift to management with benzodiazepines may be more appropriate (Bottomley & Hanks, 1990; Stiefel et al., 1992; Breitbart & Cohen, 2000; Morita et al., 2003; Ferris, 2004; Rousseau, 2004, 2005; Levenson, 2005). With a few exceptions, benzodiazepines should not be used first-line in patients receiving hospice or palliative care due to increased risk of delirium, falls, memory problems, and withdrawal syndromes. Again, benzodiazepines and second- and third-generation antipsychotics should be in the tool kit of the advanced consultant, but for front-line clinicians not well versed with the psychiatric aspects of palliative medicine, they should not be on the list.

The antipsychotic example also brings up the issue of cost and distributive justice. When medications appear to have equal efficacy and safety, cost should be taken into account (Simon et al., 2005). The Medicare Hospice benefit, which is the payer for over 80% of hospice care in the United States, is a capitative system; all therapies and durable medical equipment needs, as well as all clinical care except physician services (i.e., nursing, social work, bereavement, chaplaincy) related to the hospice diagnosis are paid for by hospices out of the per diem rate received from Medicare (Medicare and Medicaid Services, 2008; National Hospice and Palliative Care Organization, 2007). This amounts to much to care for with very little resources. Cost savings for equal net benefit allows hospices to provide more care to more people.

Agitation and insomnia are challenging *symptoms* in this population. As with depression, most antidepressants do not offer anxiety relief fast enough. Benzodiazepines are burdened with adverse effects, as discussed above, and the benzodiazepine receptor

agonists are not likely any better in this population of patients (Hirst & Sloan, 2002). Nonpharmacological interventions are typically the first line of therapy in patients with advanced life-threatening illnesses (and should also be used with depression and delirium). Supportive and/or group psychotherapy, Dignity Therapy, spiritual counseling, and alternative medical approaches such as progressive muscle relaxation, massage therapy, guided imagery, hypnosis, meditation, acupuncture, or aromatherapy can be particularly useful tools to decrease anxiety and address insomnia (Spiegel et al., 1981; Greenstein & Breitbart, 2000; Payne & Massie, 2000; Classen et al., 2001; Goodwin et al., 2001; Breitbart, 2002; Breitbart et al., 2004; Chochinov et al., 2005; Standish et al., 2008). If psychopharmacology is needed, medications not typically used for anxiety or insomnia, such as beta-blockers, mood-stabilizers, gabapentin, and Trazodone (Schatzberg et al., 2003) have varying levels of evidence for efficacy and safety. Benzodiazepines should not be used as first-line agents; they should only play a very limited role for anxiety management in this patient population and should not appear on a short list of psychopharmacological interventions for front-line clinicians. Interestingly, there is evidence for the use of these same interventions for agitation associated with dementia (Schatzberg et al., 2003; Martinon-Torres et al., 2004; Levenson, 2005; Inouye et al., 2006; Schneider et al., 2006).

Dosing for breakthrough symptoms should take into account the pharmacokinetics of the medications being used. If a medication is not affecting a symptom by the time it has reached maximal concentration in the blood, it is not likely to be effective beyond that point. Either an additional dose, an increased dose, or another medication needs to be chosen. For example, when treating agitation, antipsychotics should be dosed subcutaneously every 30 min or orally every 60 min until the agitation is under control or the maximum dose of the medication in a 24-h period has been reached (Emanuel et al., 2005).

Lastly, the article by Barnhorst *et al.* (2008) suggests a formulary that will give more autonomy to nurses at the point of care. Nurses are the lifeblood of hospice care, and it is a field that has largely grown up around nursing care. However, nurses working in hospice and palliative care are often put in a difficult position where, outside of specialty units, they are the front-line clinicians. As such, hospice nurses find themselves trying to care for a patient where the general practitioner or primary care physician responsible has inadequate experience, knowledge, or skills in palliative medicine. This can put nurses in the awkward position of trying to diagnose or recommend treatment. Although nurses in the field

should be expected to report what they see, that is, signs and symptoms, it is the physician's responsibility to formulate a differential diagnosis and order pharmacological interventions. Hospice care was founded on good interdisciplinary care, meaning the disciplines need to work together in a synergistic fashion within their scopes of practice to provide the best care possible for a patient. Therefore, guidelines such as Barnhorst et al. propose should be given to nurses and others as a tool to use in collaboration with a responsible physician, not as a "cookbook" for nurses or the palliative medicine naive to use in independent practice. Although hospice nurses and physicians with little palliative care experience can be savvy about formulating diagnoses and suggesting interventions in this population, unless they have advanced practice training, it is unfair to expect clinicians to work outside their scope of practice or comfort. It would likely leave these clinicians feeling unsupported, breed ineffective interdisciplinary care, and lead to suboptimal treatment for patients.

Now that I have wagged my finger, I would like to also tip my hat (Colbert, 2008). My first and best psychiatric consult-liaison education was as a visiting subintern on a team led by Dr. Bourgeois. I am grateful to have been (and continue to be) educated by him. I hope this letter reflects the generativity of his efforts.

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