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Volume 17, Issue 12 December 16, 2025

Current Evidence of Randomized Clinical Trials on Hospice-Eligible Patients with Agitation and Dementia

Wang O, Calev N, Mintzer J, et al

Agitation is one of the most distressing behavioral symptoms among hospice-eligible patients with dementia. It compromises patient comfort, increases caregiver burden, and undermines the quality of end-of-life care. Although pharmacologic treatments are frequently used, evidence guiding their safe and effective use in this population remains limited. **Objective**: To identify and synthesize existing randomized controlled trials (RCTs) that evaluated interventions for agitation in hospice-eligible patients with dementia, and to assess the quality and relevance of current evidence. **Methods**: A narrative review was conducted using systematic search strategies to identify RCTs published between 1990 and 2024 across 8 databases. Studies were included if they (1) focused on hospice-eligible patients with dementia, (2) targeted agitation as a major outcome, and (3) used an RCT design. Studies lacking eligibility criteria, non-RCTs, and non-English articles were excluded. **Results**: Of 44 articles screened, only 3 met the inclusion criteria: 2 studies tested nonpharmacological interventions (Namaste and Balancing Arousal Controls Excesses) and 1 tested a pharmacological intervention (sertraline). Results from the nonpharmacological interventions were mixed, and the pharmacologic trial showed no difference between treatment and placebo. Common limitations included small sample sizes, lack of racial and gender diversity, and absence of home-based hospice settings. **Significance of results**: There is a critical gap in high-quality and generalizable evidence to guide agitation management at the end of life for patients with dementia. Addressing this gap is essential to improving not only symptom control but also to preserving dignity and reducing caregiver distress in hospice care. Future trials must include diverse populations, incorporate home-based hospice settings, and rigorously evaluate both pharmacologic and nonpharmacologic interventions to support compassionate, patient-centered care.This review highlights urgent gaps in research and care delivery, underscoring the need for inclusive and scalable intervention designs to address agitation at the end of life. Palliat Support Care 2025;23:e209
Full text is freely available at https://pubmed.ncbi.nlm.nih.gov/41305862/

Society of Critical Care Medicine Clinical Practice Guidelines on Adult End-of-Life Care in the ICU

Marshall M, Davis D, Fogelman P, et al

Evidence-based practice has evolved significantly since the release of the 2008 Society of Critical Care Medicine (SCCM) End-of-Life (EOL) Consensus Statement. The purpose of this 2025 guideline is to identify and disseminate evidence-based recommendations grounded in current research to better understand how to deliver appropriate and effective adult EOL care in the ICU. A multidisciplinary team approach to EOL care in the ICU is crucial with the aging of the U.S. population, due, in part, to increasing life expectancy and the burdens associated with chronic disease. Research indicates at least 20% of ICU patients currently have goals that are not medically attainable or their treatment plan does not align with their achievable goals (1,2). Thus, it is paramount that we better understand how to assist with decision-making, mitigate conflict about treatment goals, address suffering, and enhance capacity for EOL care in the ICU. This includes detailed knowledge of how EOL care fits into the delivery of high-quality ICU care. These guidelines represent new knowledge and address previously unconsidered issues such as identifying and educating substitute decision makers on their roles, education, and training in primary palliative care for all ICU team members, protocolized approaches to withdrawing life-sustaining-treatment, and interventions to educate and assist patients, surrogates, and non-ICU treatment teams with decision-making before ICU care is needed.. Crit Care Med. 2025;53(12):e2734-e2746
Full text is freely available at https://pubmed.ncbi.nlm.nih.gov/41342842/

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Physician Perception of Trust and Communication with Asian Patients with Serious Illness and Their Families in the United States

Huan C, Yeh I, Troiani F, Tjia J

Asians in the United States receive less palliative care and enter hospice less than Whites, disproportionately receive more invasive mechanical ventilation, and report less involvement in decision-making with physicians than they would like. Despite the growing literature addressing serious illness in diverse patient populations, communication with Asians is understudied. This study aimed to explore U.S. physician perceptions of clinical interactions with Asian patients with serious illness and barriers and facilitators to physician-patient communication. **Methods**: This is an exploratory qualitative descriptive study using semistructured interviews with U.S. physicians who cared for Asian patients with serious illness. We used an inductive content analysis approach to identify themes related to facilitators and barriers to communication between Asian patients, their families, and physicians. **Results**: We conducted 10 physician interviews between February and April 2024. Of participants, 50% were White and 50% were Asian, the majority were male, and 50% specialized in palliative care. Three major themes arose: (1) trust cannot be assumed; (2) understanding and honoring the role of family are key; and (3) honoring the patient's preferences for communication can build trust. **Conclusion**: This study is a step in illustrating how a cross-cultural approach to communication needs to align physicians, patients, and families on the process of communication and shared decision-making and not only on the goals for care. Moving toward a cultural adaptive approach can empower clinicians to engage in a trust-building process of inquiry, observation, and understanding of how sociocultural factors impact patient preferences for health care. Palliat Med Rep. 2025;6(1):542-553

Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12670691/

End-of-Life Care for Older Adults With Dementia by Race and Ethnicity and Physicians' Role

Oyeyemi D, Ikesu R, Saliba D, et al

Evidence is limited regarding whether end-of-life care for individuals with dementia varies by race and ethnicity, and whether observed variations can be explained by differences in the physicians providing their care. **Objective**: To evaluate end-of-life care among individuals with dementia across racial and ethnic groups, and to investigate whether care variations are explained by differences in treating physicians. **Design, setting, and participants**: This cohort study used national, population-based claims data from a 20% random sample of Medicare fee-for-service beneficiaries aged 66 years or older with a diagnosis of dementia who died between 2016 and 2019. Data were analyzed from January 2024 to June 2025. **Main outcomes and measures**: Emergency department, hospital, and intensive care unit use, mechanical ventilation or cardiopulmonary resuscitation, and feeding tube placement in last 30 days of life; death in acute care hospital; hospice use and palliative care counseling in last 180 days of life; and any billed advance care planning before death. **Results**: Among 259,945 decedents with dementia (mean age, 85.8 years; 60.4% female), 8.3% were non-Hispanic Black, 4.4% were Hispanic, and 87.3% were non-Hispanic White. Compared with non-Hispanic White decedents, non-Hispanic Black decedents were more likely to receive emergency department (difference, 5.7 percentage points [pp]), hospital (difference, 4.0 pp), intensive care unit (difference, 4.3 pp), mechanical ventilation or cardiopulmonary resuscitation (difference, 3.8 pp), and feeding tube placement (difference, 1.8 pp) care, as well as die in a hospital (difference, 3.5 pp). Non-Hispanic Black decedents were less likely to use hospice (difference, -6.1 pp) and more likely to receive palliative care counseling (difference, 3.2 pp) and billed advance care planning (difference, 1.8 pp) than non-Hispanic White decedents. Similar patterns were observed among Hispanic decedents. Variations in end-of-life care remained qualitatively unchanged when comparing decedents treated by the same physician. **Conclusions and relevance**: Findings from this cohort study suggest that non-Hispanic Black and Hispanic decedents with dementia received more intensive end-of-life care despite higher rates of billed advance care planning and palliative care counseling than non-Hispanic White decedents. Observed racial and ethnic variations were not explained by differences in the physicians treating them. JAMA Health Forum. 2025;6(11):e254235

Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12619101/

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Allowing Natural Death in End-Of-Life Decision-Making

Erickson J, Cantrell M, Greenle M

There are currently 2 primary terms used in end-of-life (EOL) discussions when people do not desire life-saving measures: Do Not Resuscitate (DNR) and Allow Natural Death (AND). As a newer term, less is known about how AND influences EOL decision-making. This article reviews the extant empirical literature regarding the use of AND in EOL decision-making. ProQuest PsycINFO, CINAHL, and PubMed were searched through March 2024 for empirical studies on AND in the English language. Eight publications dated 2008–2018 were reviewed and synthesized. Overall, individuals' decisions regarding EOL scenarios are influenced using AND. However, AND does not carry consistent meaning among healthcare providers or individuals, most of whom were surrogate decision-makers. Further research regarding how healthcare providers, surrogate decision-makers, patients, and healthy adults perceive the terms AND is indicated to better understand whether and how AND can be used to improve communication in EOL decision-making. Geriatr Nurs. 2025;66(C):103625

Ophthalmology Considerations in End-of-Life Care

Shloush M, Eleff A, Eleff E

Ophthalmologic interventions can significantly impact quality of life, even in the context of end-of-life care. This paper explores the ethical and clinical considerations for ophthalmologic treatments in hospice care, with a focus on cataract surgery, age-related macular degeneration (ARMD) therapy, retinal detachment (RD) repair, glaucoma, painful blind eye (PBE) management, benign and surface ocular tumors, and corneal or anterior segment diseases. A review of published literature and clinical precedent was conducted to assess the benefits, risks, and practical limitations of ophthalmologic procedures in hospice patients, with an emphasis on quality of life. Cataract surgery has been shown to be cost-effective in hospice settings, offering significant improvements in vision and overall quality of life. Treatment for ARMD, though requiring ongoing injections, can provide benefits within weeks and help sustain visual function. RD repair, while more complex, can substantially restore vision when appropriately managed. Palliative glaucoma interventions, including individualized target intraocular pressures and laser therapy, can minimize treatment burden while maintaining comfort. PBEs may be managed with retrobulbar chlorpromazine or alcohol injections, and enucleation or evisceration may be considered when pain persists. Benign or surface ocular tumors and corneal or anterior segment diseases can often be addressed with conservative, comfort-focused measures to reduce symptoms and preserve quality of life. Ophthalmologic procedures should be considered viable options in end-of-life care when clinically indicated, with careful ethical review. Restoration of vision contributes meaningfully to the quality of life and deserves thoughtful inclusion in care planning. Cureus 2025;17(10):e94396

Full text is freely available at https://pmc.ncbi.nlm.nih.gov/articles/PMC12604606/

Pain Management in the Older Adult with Opioid Use Disorder

Ellis R, Rodin R

Increasing prevalence of addiction poses challenges to pain management in older adults, a population already facing high rates of chronic pain and medical and psychosocial complexity. Little guidance exists on the management of pain in older adults with opioid misuse and opioid use disorder, in whom heightened pain sensitivity, comorbid mental health disorders, and potential harms from prescribed analgesic medications complicate treatment. This article will explore diagnostic and treatment strategies for older adults with opioid misuse and opioid use disorder, with special attention to the use of buprenorphine and methadone for comorbid pain and addiction. Clin Geriatr Med. 2026;41(1):175-189

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Goal-Concordant Care in People With Amyotrophic Lateral Sclerosis Receiving Palliative Care

Bonares M, Shapiro J, Vijayanathan V, et al

Although it is known where people with amyotrophic lateral sclerosis (ALS) are dying, less is known about whether they are dying where they want to. **Objectives** To determine the rate of dying in a preferred place and factors associated with doing so in people with ALS receiving clinic-based specialist palliative care. **Methods** Retrospective cohort study of people with ALS receiving clinic-based specialist palliative care in Toronto, Canada between July 2022 and February 2024. Association between preferred and actual place of death was determined using a $\chi 2$ test. Factors associated with dying in a preferred place were determined using a multivariable binary logistic regression analysis. **Results** In 367 individuals, at time of consultation, median age was 67 years; 60.8% had a Palliative Performance Scale score between 50% and 60%, and 43.3% had noninvasive ventilation. Mortality rate up to February 2024 was 41.7%. About 85.4% stated a preference to die at home, 8.7% in hospital, and 5.9% in a hospice facility, whereas 54.9% died at home, 34% in hospital, and 11.1% in a hospice facility. Of those with known preferred and actual place of death, 70.1% died in a preferred place ($\chi 2 = 36.2$; $P < 0.001$). Dying in a preferred place was associated with increasing age (odds ratio [OR] = 1.1; 95% confidence interval [CI] = 1.0–1.1) and having noninvasive ventilation (OR = 2.5; 95% CI = 1.0–6.2). **Conclusion** Younger age and not having noninvasive ventilation at the time of consultation may suggest a higher risk of goal-discordant end-of-life care and the need to engage in early future planning when these factors are identified. J Pain Symptom Manage. 2025;70(6):679-690

Opportunities to Improve End-of-Life Care in Assisted Living: Results From a National Survey of Administrators

Belanger E, Rosendaal N, Rogers M, et al

Assisted living is a common place of care for dying residents, with extensive variation in residents' outcomes such as hospice enrollment. This research aimed to gather national evidence about end-of-life care processes in assisted living. **Design**: A national survey of administrators was conducted in 2021-2023, using a random sample proportional to the number of large assisted living communities (≥25 beds) across licenses and states. **Setting and participants**: Administrators at eligible assisted living communities across the United States as listed in public state registries. **Methods**: Standard measures from existing surveys of residential care were used or adapted from other long-term care settings after cognitive testing, including staffing and admission/retention policies, end-of-life care processes such as protocols for dying and deceased residents, and quality of hospice collaboration. Nonresponse adjusted sampling weights provide nationally representative estimates. **Results**: Among 4796 eligible assisted living communities invited, 2084 administrators completed the survey from all 48 targeted states, a response rate of 43.4%. One in 5 (20.4%) administrators reported no residents dying in the past 12 months, and 15.3% of very large communities (≥100 beds) did not report decedents. Yet, among those caring for dying residents, less than one-third of administrators rated the quality of dying in their community as excellent. Among 1882 communities whose administrators reported collaborating with hospice, 32.0% also responded that hospice always assessed a resident within 24 hours of referral. **Conclusions and implications**: This national study of administrators highlights important opportunities to improve end-of-life care both as part of assisted living care processes for dying residents and through collaboration with hospice. These novel survey measures will help determine how end-of-life care processes vary along state regulations and shape residents' outcomes. J Am Med Dir Assoc 2025;27(1):105981
Full text is freely available at https://pubmed.ncbi.nlm.nih.gov/41232924/

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