

Physicians who manage patients with refractory MAC-LD should have access to information on all potential treatment approaches, as this disease remains quite difficult to treat and is associated with poor outcomes and high mortality.⁵ Amikacin liposome inhalation suspension is currently the only FDA-approved pharmaceutical product with a specific indication in patients with MAC-LD and is an important therapeutic option for some patients with treatment-refractory disease. The CONVERT study, together with the phase 2 study mentioned in Shulha's review,^{1(p1574)} represents the largest body of evidence for antibiotic efficacy and safety in this rare and difficult-to-treat pulmonary disease.

Colin Swenson, MD

Division of Pulmonary, Allergy, Critical Care, and Sleep Medicine
Emory University
Atlanta, GA

Angelo Del Parigi, MD

Insmed Incorporated
Bridgewater, NJ

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In reply—Amikacin Liposome Inhalation Suspension as a Treatment Option for Refractory Nontuberculous Mycobacterial Lung Disease Caused by *Mycobacterium avium* Complex

We thank Swenson and Del Parigi¹ for their comments on our article.² The article originally submitted on September 6, 2018. This formulation of amikacin inhalation (Arikayce) received Food and Drug Administration approval on September 28, 2018. Although we agreed that liposomal amikacin is an important therapeutic option for refractory mycobacterium avium complex pulmonary disease, at the time of our original submission we had included timely information on pages 1574 to 1575. Unfortunately, we did not have the Food and Drug Administration—approved dosage of Arikayce at the time of submission nor did the reviewers request us to include this information in Table 2 upon editing.

Jennifer Shulha, PharmD

Mayo Clinic
Rochester, MN

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1. Swenson C, Del Parigi A. Amikacin liposome inhalation suspension as a treatment option for refractory nontuberculous mycobacterial lung disease caused by *Mycobacterium avium* complex. *Mayo Clin Proc.* 2020;95(1):201-202.

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FRIENDS: A Communication Guide for Advance Care Planning

To The Editor: We propose a user-friendly communication tool to guide and routinize Advance Care Planning (ACP) discussions with patients in any care setting. ACP empowers patients to communicate their preferences for medical care in case they become incapacitated. ACP decreases stress for surrogate decision makers,¹ reduces health care costs, and produces positive outcomes at both patient and systems levels.² However, a national survey³ found that almost half (46%) of physicians felt unsure of what to say and less than one third reported having any end-of-life conversation training. Now that Medicare requires its beneficiaries be offered ACP services routinely,⁴ it is critical for physicians to get comfortable having these discussions. We propose FRIENDS as a communication tool to train clinicians on ACP discussions.

1. Familiarize yourself with advance directives forms: An Advance Directive (AD) is the documentation of decisions generated from ACP discussions. Clinicians must educate themselves on different types of ADs, as laws and documentation required vary by state (Table).

2. Routinize the conversation: ACP discussions should be a routine part of the clinical encounter regardless of the patient's age or stage of illness. This normalizes the process for both the patient and clinician.

TABLE. FRIENDS Mnemonic Communication Guide for Discussing Advance Care Planning (ACP)

F amiliarize yourself with advance directives forms	Learn about the laws pertaining to the documentation of ACP in your state and how those laws are applied in your health system.
R outinize the conversation	ACP as a standard and routine part of your clinical practice will increase clinician and patient comfort with the conversation.
I ntroduce topic; I nquire about past experiences	"As part of the routine care of all of my patients, I like to take some time to discuss advance care planning and health care proxies. Are you familiar with a Health Care Proxy?"
E licit Preferences/Goals/Values; E xpect E motions; E xplore "tell me more"	"What is most important to you?" "What do you consider to be good quality of life?" "How do you find support when you are having difficulty in your life?" "Could you imagine a situation that would be a fate worse than death?" "Tell me more..." [...about what happened with your mother... about how your family came to that decision...about how that experience has affected your wishes for your own care]" Take care to avoid certain commonly used phrases that are open to misinterpretation such as "Do you want us to do everything?" Rarely will you encounter a patient who does not want "everything," as "everything" implies good care. How does each patient define "everything"? Does it mean all treatments necessary to prolong life, regardless of suffering, or does it mean maximal treatment of symptoms for comfort? Taking the time to clarify and explore patients' statements will prevent confusion in the future.
N ame a Health Care Proxy (or 2)	"Whom do you trust most in the world? Whom would you trust to be your voice in making medical decisions if you were ever in a situation in which you were unable to do so for yourself?" "Do you have someone who could serve as your HCP?"
D ocumentation	Clearly document ACP conversations in the medical records. Also, document the patient's proxy and wishes, and ensure documents will be easily accessible to the HCP and clinicians in case of an emergency. Encourage patients to take a picture or e-mail a copy of the HCP to themselves, so they have easy access if they so choose.
S ummarize (Closing the Conversation. Thank you for sharing)	"What do you plan to tell your [proxy, spouse, child] about what we discussed today?" "Thank you very much for sharing your wishes and values with me today. This conversation will ensure that we can continue to provide you with the best care possible."

Patients' wishes may change over time, necessitating ACP as an ongoing process.

3. Introduce topic; inquire about past experiences: Introducing ACP begins with exploring the patient's understanding of the topic (Table). Inquiring about previous experiences with family or friends who suffered serious illness may be a good way to transition to wishes regarding their own preferences.

4. Elicit and Explore Preferences/Goals/Values; Expect Emotions: When clinicians understand their patients' values, goals, and preferences, they are better positioned to make medical recommendations about interventions. If emotions run high, acknowledge the emotion, and

explore with the patient whether the conversation should continue or be revisited on a subsequent visit.

5. Name a Health Care Proxy (HCP): Designating an HCP is important. Patients should be encouraged to name both a primary HCP and an alternate, with the HCP present if possible. With cases in which the patient has nobody to appoint as HCP, it is critical for the clinician to document the patient's preferences in the medical record.

6. Documentation: Clinicians should document ACP conversations in 2 ways: Document details of the ACP conversation in the medical record, in a way that can be easily accessed, and document designation of an HCP with reliable

contact information and patient preferences on the legally appropriate forms. Copies of the HCP form need to be provided to the patient, the proxy, and kept on file.

7. Summarize: The clinician and patient should review what was discussed, using a "teach-back" strategy to verify the patient's understanding (Table). Expressing appreciation to the patient for sharing emotional information may strengthen the physician-patient relationship and facilitate future exploration.

FRIENDS is not a rigid checklist. It can be used to train clinicians through key steps and provide recommendations for conducting meaningful conversations. For those

interested in further training, we recommend looking for opportunities to attend interactive communication workshops and exploring online resources.⁵

Cynthia X. Pan, MD
Kieran Palumbo, BS
Brigit C. Palathra, MD

Division of Geriatrics and Palliative Care
 Medicine
 NewYork-Presbyterian
 Queens, New York

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