

End-of-Life Care Needs Concrete Reforms, Not Sweeping Rhetoric

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How to obtain proper end-of-life care and die with dignity is a conversation topic that most patients and their doctors would prefer to postpone as long as possible. It is also a politically fraught issue, because any discussion of curbing expenditures on pricey treatments, even in hopeless cases, conjures up images of cold-hearted bean-counters — so-called death panels making unilateral decisions about when a patient's time is up. But treating high-intensity hospital care as the norm during the final stage of life isn't just hugely expensive; it also conflicts with what the overwhelming majority of patients actually wants. This is not a new problem, but ingrained practices within the health system always seem to frustrate all attempts at reform.

Recently, the Institute of Medicine released a 500-page report with recommendations for improving end-of-life care and honoring individual preference for those who wish to avoid full-scale hospitalization to extend their lives. Some recommendations are sweeping. For instance, the report seeks "a more pronounced shift away from fee-for-service medicine, which promotes an emphasis on medical interventions in part by reimbursing doctors based on procedures rather than for talking with patients." This conclusion is entirely warranted, and the Affordable Care Act may nudge insurers and providers in a more economical direction. Yet a change contingent upon uprooting the entire payment model of much of the health care system will take time and will likely meet stiff resistance from politically powerful interests.

For that reason, it's vital to identify more immediate reforms that will foster concrete changes in end-of-life care. Another policy change that would both help patients and curb costs, the report states, is to redesign Medicare, Medicaid, and other health care delivery programs so

that they provide financial incentives for services — such as home health care — that decrease the need for emergency and acute care services near the end of life. Changing Medicare's reimbursement structure, though, requires enacting new legislation.

Likewise, the report urges providing doctors a clear financial incentive for end-of-life counseling, which would be the starting point toward aligning medical care with patients' needs and wishes. The Centers for Medicare and Medicaid Services, in fact, could start reimbursing doctors for having end-of-life discussions very soon.

The report also encourages states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) program, in which a set of portable medical orders and forms document a patient's wishes for care towards the end of life, addressing issues such as cardiopulmonary resuscitation and artificially administered nutrition. Massachusetts began improving its end-of-life care system a couple of years ago, and launched a similar clinical program called MOLST. This was in response to a panel convened by the state in 2011 that reviewed issues surrounding end-of-life care here in the Commonwealth and nationally. A survey conducted earlier this year to evaluate MOLST implementation statewide found that about three-quarters of the health care providers surveyed had begun to use the form. That's encouraging, but how quickly this changes the course of end-of-life medical care remains to be seen.

The status quo on this issue is disappointing, most of all because of what it does to patients. People in their final days are shuffled from one medical setting to another, poked and prodded, and only belatedly moved to hospice. Ultimately, giving patients and their families more leverage to seek a more peaceful approach may provide the best hope of changing the system.