End-Of-Life Decisions Often A Mystery

Matt Sedensky, AP

Lillian Landry always said she wasn't afraid to die. So when death came, the 99-year-old was lying peacefully in a hospice with no needles or tubes. Her final days saw her closest friend at her side and included occasional shots of her favorite whiskey.

Landry is an exception. Unlike most Americans, she made her end-of-life decisions years ago, with no heroic measures to save her and even instructions on the bar where mourners should gather. The health overhaul bill that narrowly passed the House on Saturday includes a provision to nudge more people to confront such choices and it would pay for end-of-life counseling for Medicare patients.

Supporters say counseling would give patients more control and free families from tortuous decisions. Critics have warned it could lead to government “death panels.” What few on either side note is that counseling could lead more people to choose less intensive care when they're dying, and ultimately trim government-funded health bills.

Hospice care has grown from about 25,000 patients in 1982, when Congress approved coverage under Medicare, to 1.45 million people in 2008. People on Medicare account for the vast majority of U.S. deaths, and care in the last year of life accounts for roughly a quarter of Medicare's budget. So increased use of hospice could mean sizable savings for the government, particularly if patients enter it sooner.

“It’s significantly underutilized. People are referred very late,” said Dr. Richard Payne, a Duke University professor who heads the school's Institute on Care at the End of Life. “Our culture just doesn't tolerate talking about death and dying. And the minute you even start talking about having conversations with a doctor, it's immediately pejoratively labeled as ‘You're trying to kill me.’”

That perception is precisely what got affixed to the counseling measure in the House bill. Even though the legislation specifies counseling wouldn't force patients to limit efforts to keep them alive, and even with the support of the American Medical Association, AARP and others, suspicion has lingered.

Dr. Jim Small, a Denver pathologist who belongs to the Christian Medical and Dental Associations, said he feared the provision would be twisted into something more intrusive if bureaucrats lay out the details. “It's incredible micromanagement,” Small said. “End-of-life discussions are part of normal, good patient care, but there's no reason for it to be in the bill.”

Dr. Joel Policzer is medical director for VITAS Innovative Hospice Care, which runs

the hospice wing at Florida Medical Center where Landry spent her final days. Often, Policzer says, a dying elderly patient may have wanted less invasive care. But it doesn't happen. “It doesn't happen because people are never asked. If they were, people would tell you they want to die at home in bed, surrounded by their family, their friends and their pets,” he said.

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