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Health care reform: What is costly overuse, what is humane?

Katherine Dowling Schlaerth

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President Obama has impressed me once again with his multifaceted talents.

Citing his grandmother's hip-replacement surgery as a personalized experience, he has made his case to deny aggressive and costly end-of-life care, and his concepts have been embodied in HR3200, "America's Affordable Health Choices Act of 2009," rocketing its way through Congress.

All of us would agree that putting a dying person through painful and useless procedures not only costs a lot, but also interferes with normal developmental tasks of the end of life, such as putting one's financial and spiritual house in order and saying goodbye to loved ones. To quote President Obama, we must correctly inform families who might otherwise approve of "additional tests or additional drugs that the evidence shows (are) not necessarily going to improve care."

My problem, as a physician who has practiced medicine for decades, is that I just can't predict with certainty what is end-of-life care, nor can I determine for another individual the meaning of "quality of life."

I recall cases like that of the nonagenarian WWII veteran, comatose for days with multiple organ failure, who with the help of a loving family and dedicated ICU nurses walked out of the hospital, brain intact, to live a few more years.

I've seen "terminal" cancer patients kept alive long enough to hold a new grandbaby, and a 2-year-old's cancer-ridden body sustained for the weeks it took for his heartbroken parents to finally come to peace with his passing.

This current legislation, however, seeks to prevent such costly overuse of health resources through a program of "advance care planning consultation," wherein those on Medicare, or their families, could meet with a "practitioner of advance care planning" every five years, or sooner if illness supervened. Such an adviser need not be a physician, either.

This specialist would discuss care issues such as "the individual's desire regarding transfer to a hospital ... the use of antibiotics and the use of artificially administered nutrition and hydration."

The discussion may, in fact, be triggered if "there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease."

I would be loath to talk a person on dialysis or in a wheelchair from a stroke into forgoing antibiotics for a pneumonia that may itself be treatable.

HR3200 has created tiers of administrators, who do not necessarily have medical experience. They will attempt to facilitate your end-of-life care, probably with the assistance of the electronic medical records each medical facility will shortly be required to use.

These and other provisions of the health choices act frankly scare me. As a physician, I took an oath long ago to put my patient's interests above all else, but provisions in the bill have a quality of coerciveness that make me wonder if I can fulfill my oath. Certainly they bear

deeper inspection than possible during the brief monthlong look-see President Obama wants lawmakers to give this 1,000-page bill before passage.

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The following article appeared in the **Washington Post**

Undue Influence

The House Bill Skews End-of-Life Counsel

By Charles Lane
Saturday, August 8, 2009

About a third of Americans have living wills or advance-care directives expressing their wishes for end-of-life treatment. When seniors who don't have them arrive in a hospital terminally ill and incapacitated, families and medical workers wrestle with uncertainty -- while life-prolonging machinery runs, often at Medicare's expense. This has consequences for families and for the federal budget.

Enter Section 1233 of the health-care bill drafted in the Democratic-led House, which would pay doctors to give Medicare patients end-of-life counseling every five years -- or sooner if the patient gets a terminal diagnosis.

On the far right, this is being portrayed as a plan to force everyone over 65 to sign his or her own death warrant. That's rubbish. Federal law already bars Medicare from paying for services "the purpose of which is to cause, or assist in causing," suicide, euthanasia or mercy killing. Nothing in Section 1233 would change that.

Still, I was not reassured to read in an Aug. 1 Post article that "Democratic strategists" are "hesitant to give extra attention to the issue by refuting the inaccuracies, but they worry that it will further agitate already-skeptical seniors."

If Section 1233 is innocuous, why would "strategists" want to tip-toe around the subject?

Perhaps because, at least as I read it, Section 1233 is not totally innocuous.

Until now, federal law has encouraged end-of-life planning -- gently. In 1990, Congress required health-care institutions (not individual doctors) to give new patients written notice of their rights to make living wills, advance directives and the like -- but also required them to treat patients regardless of whether they have such documents.

The 1997 ban on assisted-suicide support specifically allowed doctors to honor advance directives. And last year, Congress told doctors to offer a brief chat on end-of-life documents to consenting patients during their initial "Welcome to Medicare" physical exam. That mandate took effect this year.

Section 1233, however, addresses compassionate goals in disconcerting proximity to fiscal ones. Supporters protest that they're just trying to facilitate choice -- even if patients opt for expensive life-prolonging care. I think they protest too much: If it's all about obviating suffering, emotional or physical, what's it doing in a measure to "bend the curve" on health-care costs?

Though not mandatory, as some on the right have claimed, the consultations envisioned in Section 1233 aren't quite "purely voluntary," as Rep. Sander M. Levin (D-Mich.) asserts. To me, "purely voluntary" means "not unless the patient requests one." Section 1233, however, lets doctors initiate the chat and gives them an incentive -- money -- to do so. Indeed, that's an incentive to insist.

Patients may refuse without penalty, but many will bow to white-coated authority. Once they're in the meeting, the bill does permit "formulation" of a plug-pulling order right then and there. So when Rep. Earl Blumenauer (D-Ore.) denies that Section 1233 would "place senior citizens in situations where they feel pressured to sign end-of-life directives that they would not otherwise sign," I don't think he's being realistic.

What's more, Section 1233 dictates, at some length, the *content* of the consultation. The doctor "shall" discuss "advanced care planning, including key questions and considerations, important steps, and suggested people to talk to"; "an explanation of . . . living wills and durable powers of attorney, and their uses" (even though these are legal, not medical, instruments); and "a list of national and State-specific resources to assist consumers and their families." The doctor "shall" explain that Medicare pays for hospice care (hint, hint).

Admittedly, this script is vague and possibly unenforceable. What are "key questions"? Who belongs on "a list" of helpful "resources"? The Roman Catholic Church? Jack Kevorkian?

Ideally, the delicate decisions about how to manage life's end would be made in a setting that is neutral in both appearance and fact. Yes, it's good to have a doctor's perspective. But Section 1233 goes beyond facilitating doctor input to preferring it. Indeed, the measure would have an interested party -- the government -- recruit doctors to sell the elderly on living wills, hospice care and their associated providers, professions and organizations. You don't have to be a right-wing wacko to question that approach.

As it happens, I have a living will and a durable power of attorney for health care. I'm glad I do. I drew them up based on publicly available medical information, in consultation with my family and a lawyer. No authority figure got paid by federal bean-counters to influence me. I have a hunch I'm not the only one who would rather do it that way. *The writer is a member of the editorial page staff. His e-mail address is lanec@washpost.com.*

End of Life Counseling

There have been flawed criticisms of my reading of a section of H.R. 3200. The critics have hastily read page 425 of the HR 3200, rather than reading the full relevant text (425-443) or considering the reality of being a frail elderly patient. Here are four facts frequently overlooked:

1. The counseling includes not only living wills and durable powers of attorney, but specific methods to end life. On page 430, the bill prescribes counseling on whether or not to forego nutrition, hydration, and antibiotics, in states where such counseling is permitted.

2. There is an inherent conflict of interest in this counseling. Medicare funding is going to be cut 10% over the next decade ($500 billion in cuts) to pay for the health reform legislation, at the same time that Medicare enrollment is projected to increase 30%. More people to care for and fewer dollars will necessitate rationing. It is understandable that the government wants to curtail spending on end of life care. But the use of specific “patient decision aids” (p.443) discussed in the legislation such as scripts, videos, and brochures is problematic. If United Healthcare provided end of life counseling with a script prepared by the insurance company, there would be up uproar over the obvious conflict of interest.

3. The author of “Pants on Fire” should read on to pages 443 to see that patients will participate in “shared decision making.” Shared with whom? The government certified counselors. No where is it stated that the patient unilaterally has the final say. The bill merely says the patient’s views will be “incorporated” into the decision making.

4. The author ignores how unlikely it is that elderly patients will instruct a doctor or other authority figure who offers end of life counseling to stop the presentation

In summary, the Truth-O-Meter should turn its attention to the man with his pants on fire, the President, who makes the false statement daily that if you like your health insurance you can keep it. Pages 15-17 of H.R. 3200 make it clear that is untrue.