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# Eli's Hospice Insider

## Popular Press: New Yorker Article Fosters End-of-Life Discussions

**Aetna sees success with concurrent care experiment.**

As a hospice employee, you know how important discussions focused on terminal illness decisions are, but are you prepared to conduct them with your own family members? Even palliative care professionals have a hard time conducting these end-of-life conversations with their loved ones, according to an article in the Aug. 2 issue of the New Yorker magazine.

In "Letting Go," physician **Atul Gawande** with **Brigham and Women's Hospital** in Boston explores the process of grappling with a terminal diagnosis and broaching end-of-life decisions from a variety of angles: patient, family, physician, oncologist, and hospice nurse among them.

"Few people have this discussion and there is good reason for anyone to dread these discussions... Handled poorly, the conversations can cost a person's trust. Handled well, they can take real time," Gawande writes.

"A family meeting is a procedure, and it requires no less skill than performing an operation," says Dr. **Susan D. Block**, MD, chair of the department of psychosocial oncology and palliative care at the **Dana-Farber Cancer Institute** in Boston -- a pioneer in training physicians to navigate end-of-life issues in the article.

Yet Block almost missed having a vital conversation with her own father the night before he faced surgery to remove a mass from his spinal cord that had a 20 percent chance of leaving him quadriplegic. Returning to have the discussion with her father was difficult but proved invaluable when surgical complications arose. Block's approach was to tell her father "I need to understand how much you're willing to go through to have a shot at being alive and what level of being alive is tolerable to you." Her father's response that he was willing to stay alive as long as he could watch football on TV and eat chocolate ice cream surprised Block but helped her guide his health decisions.

**La Crosse Checklist Reduces Costs**

Gawande's lengthy article looks at several studies and initiatives along the way, including the case of La Crosse, Wisc. with its "unusually low end-of-life hospital costs. He traces this back to a 1991 initiative by medical leaders to encourage physicians and patients to discuss end-of-life wishes.

In La Crosse, all patients who enter a hospital, nursing home, or assisted-living facility must complete a multiple choice form that answers four main questions, Gawande writes:

1. Do you want to be resuscitated if your heart stops?

2. Do you want aggressive treatments such as intubation and mechanical ventilation?

3. Do you want antibiotics?

4. Do you want tube or intravenous feeding if you can't eat on your own?

By 1997, 85 percent of La Crosse residents who died had written advanced directives, Gawende reports. But more importantly, families have become comfortable with having end-of-life discussions early on, before they are clouded by crisis and fear.

**Aetna's Experiment Boosts Hospice Enrollment**

Gawande admits that "like many people, I had believed that hospice care hastens death because patients forego hospital treatments and are allowed high-dose narcotics to combat pain." But he points out that studies have shown this belief to be false and that with some diseases (such as pancreatic cancer) hospice patients may actually live a little longer than non-hospice patients.

The reluctance of patients to give up treatment of a terminal disease and to enter hospice care inspired a 2004 experiment by Aetna, Gawande says. A group of policy holders with a life expectancy of less than a year were given the opportunity to receive hospice services without giving up other treatments.

Participants in this "concurrent care" program were more likely to use hospice (70 percent, up from 26 percent), Gawande reports. But the more surprising find was that these patients were also more likely to forego medical treatments such as visits to the emergency room or ICU admissions. Medical costs for study participants dropped by almost 25 percent.

**Industry Responds to Gawande's Article**

Writing on the Pallimed blog (www.pallimed.com), **Christian Sinclair, MD, FAAHPM**, associate medical director with **Kansas City Hospice and Palliative Care,** recommended reading Gawande's piece and sharing it with hospice teams to foster discussion. It's "good to know how the public perceives this," he said.

Over at the Healthcare Economist (http://healthcare-economist.com), Gawande's article stirs up dissatisfaction with the direction health reform has taken, "In the debate surrounding health reform, many politicians hijacked the serious discussion of end-of-life decisions, and decisions to use non-invasive medical treatment were termed death panels. But end-of-life decisions merit further investigation. Not only can giving patients end-of-life treatment options lower cost, but it can also improve the patient remaining quality of life."

And the **Hospice Foundation of America** tips its cap at Gawande on the Hospice and Caregiving blog (http://blog.hospicefoundation.org/) saying, "Gawande does a good job of dispelling some of the misconceptions people have about hospice care and the article emphasizes some of the different ways we could approach the care of dying patients."

On the New Yorker's website at press time, Gawande's article was the publications "most emailed" article.

Note: Read Gawande's article here: http://www.newyorker.com/reporting/2010/08/02/100802fa_fact_gawande

And see the transcript from Gawande's Ask the Author live chat here:
http://www.newyorker.com/online/blogs/ask/2010/07/questions-for-gawande.html