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Corn- Ending End-of-Life Phobia- A prescription for Enlightened Health Care Reform.

Written from the perspective of an oncologist. Addresses "the last collective phobia of the Western World".

1) Where do end of life issues fit into health care reform?
    a. "patients perceive their vulnerability when such discussions are initiated (end of life)… may fear that the physicians who broach the topic are striving to cut costs and compromise services"
    b. "death panel" controversy (Palin's facebook page)→ Section 1233 of House Bill vaguely defined federal end of life counseling- would permit Medicare coverage for an end-of-life consult once every 5 years. (Rep Earl Blumenauer D-OR) explained clause was to "reimburse doctors for having thoughtful conversation to prepare pts and families for delicate, complex, and emotionally demanding decisions surrounding end-of-life".
        i. This language scared people (rationing health services, killing off the elderly/sickest). Also some worried such counseling might put subtle pressure on pts to make decisions not on sound medical bases but in order to conserve costs. The bill does not define "palliative care" or "end of life services". Where is the euthanasia line drawn?
        ii. Section 2707 of Senate HELP (Health, Ed, Labor, Pensions) bill (intro July 15, 2009) requires that insurers develop and implement reimbursement structure for making payments to healthcare proveders that includes incentives for use of evidence based medicine and best clinical practices. This provision creates the possibility that health care coverage determinations could be based on pt's health, age, quality of life. Concerns that the resulting structure could become a means of advocating for the least expensive rx at the expense/respect for life. If cost is the primary driver for health care- the elderly, sick, disabled may have far fewer options
            1. Ammendents offered to address this concern (all were defeated):
                a. Amendment to prevent the denial of end of life care and prohibit rationing on the basis of pt age, disability, medical dependency, or quality of life
                b. Amendment to ensure that taxpayers were not forced to fund assisted suicide
                c. Amendment that would have prevented private halth insurers from being prohibited from covering rx
                d. Amendement that would have ensured all individuals have access to essential health benefits
                e. Amendment that would have required certification that participating plans do not have a pattern of practice or denying

coverage based on their age, expected length of life, and disability

2) To include pts in discussion of death, need to respect “personal autonomy, sanctity of life, and climate of balance”- by balance, need tactful exchanges of all specialists and patient advocates involved including patients, families, chaplains, etc without questioning “hidden agendas”
3) Will hospice services be expanded?
    a. In the US- distinction is made between general palliative care and hospice (delivers palliative care at end of life); similar philosophy, however different payment system and location of services. Palliative services are paid by philanthropy, fee-for service mech, direct hospital support, other private groups, while hospice is paid for as a Medicare benefit. Some hospice benefits are offered by Medicaid and most private insurers.
        i. Under Medicare Hospice Benefit (MHB) a pt signs off their Medicare Part A (hospital payment) and enrolls in MHB with direct care provided by a medicare certified hospice agency. Under MHB the hospice agency is responsible for the plan of care and may not bill the pt for services. All costs related to the terminal illness are paid from a per diem rate ($126/day) that the hospice agency receives from Medicare- includes all drugs, nursing, social service, chaplain visits, and other services. Pts may elect to withdraw from MHB and enroll back in Part A, then may later re-enroll in hospice.
    b. In UK and other countries- no distinction between hospice/palliative care- in addition to specialized hospices, non-hospice based palliative care teams provide care to those with life-limiting illness at any stage of disease (Imagine if everyone on disability qualified for these services?)
    c. Canada’s Guide to Palliative Care (good comparison to US- near identical health care system until 1960s)
        i. Specific to this argument cancer rate mortality, detection (except breast? US has greater detection of asx cancers- does it affect mortality?), incidence nearly identical; Other studies argue colorectal, and stomach cancer has higher incidence in Canada. One study based on data from 1978-86 found similar survival rates across all cancers compared between the 2 countries. Another study (data 1993-97) found lower survival rates among Canadians. Cancer survival mores strongly correlates with class in US according to another study.
        ii. Have a model guide to hospice palliate care- norms and principles of practice (118 pg) put out by Canadian Hospice Palliate Care Association
            1. Movement of hospice palliative care beganin 1970s
4) Should expensive therapies that only slightly prolong life be reimbursable?
5) Can our profession evolve nuanced strategies for resolving questions of medical futility?
6) Can we find creative ways for restoring dignity to the dying process? (purple butterflies)
7) Should national guidelines be created for physician assisted suicide?

Doyle- Suck it up America

Article ran in Pittsburg paper

Summary: "We have become a nation of whining hypochondriacs, and the only way to fix a broken health care system is for all of us to get a grip."

"What is being debated in Washington…is health-care insurance reform (not health reform)

- 2007 Consumer Reports- health care system with 24% of general population underinsured (skeleton insurance) and 16% with no insurance (totals 40% of American population); it's okay that we are focusing on health insurance reform
- Is health care a universal/human right?

"Health care costs too much in our country because we deliver too much health care. We deliver too much because we demand too much"

- WHO 2009 stats- US spends a greater portion of GDP (16%) on health care than any other UN member except East Timor (158th in human development index, second lowest in Asia). However actual use of health care services by most measures is below the median among developed countries.
- While defensive medicine, over-ordering tests/proceedures, these things factor in- Some say factors influencing cost: absence of price controls, intellectual property rights (making generics unavailable for years)
- Price inflation has been a major contributor to rise of health care costs from 1947 to 1987 (1990 Fuchs) US health care costs rose 2.5% per year faster than growth of overall economy. 2/3 of this growth rate due to health care prices rising more rapidly than prices in overall economy, 1/3 due to increase of quantities of health care relative to increases of goods and services (the over-delivery of health care Boyle mentions)

Creative means to educate population about "Emergency medicine"- "we should worry about smoking, drug abuse, obesity, cars and basic hygiene. If you go by pharmaceutical advertisement budgets, our most critical health needs are to have sex and fall asleep."

- When working with a cold, flu or headache, I often feel I am like one of those cute animal signs in amusement parks that say "you must be taller than me to ride this ride" only mine should read "you must be sicker than me to come to our emergency dept"
- Scott- charge everyone $5 who is not in extremis/obtunded, if it is deemed you have an emergency, you get your $5 back
- Ideas for adding pt education (heart disease, STIs, prenatal care, how to talk to you physician, etc)
    - can we do videos since every room has a tv?
    - Word search/crosswords in waiting room or in private rooms
    - Pamphlets given to everyone as they triage
    - Perceived wait times have been shown to be decreased