

# Medicare Says Doctors Should Get Paid To Discuss End-Of-Life Issues

By Kristian Foden-Vencil, Oregon Public Broadcasting and Stephanie O'Neill, Southern California Public Radio August 18, 2015

Remember the so-called death panels?

When Congress debated the Affordable Care Act in 2009, the legislation originally included a provision that would have allowed Medicare to reimburse doctors when they meet with patients to talk about end-of-life care.

But then Sarah Palin argued that such payments would lead to care being withheld from the elderly and disabled. Her comment ignited a firestorm among conservatives and helped fuel the opposition to the legislation.

Her assertions greatly distressed Dr. Pamelyn Close, a palliative care specialist in Los Angeles.

“It did terrible damage to the concept of having this conversation,” she said.

Amid the ensuing political uproar, Congress deleted the provision. And the lack of payments and concerns about the controversy further discouraged doctors from initiating these talks, according to Close.

“We just are not having these conversations often enough and soon enough,” Close said.

“Loved ones who are trying to do always the right thing, end up being weighed with tremendous guilt and tremendous uncertainty without having had that conversation.”

When done right, according to Close, these counseling sessions often delve into end-of-life treatment options and legal documents, such as advance directives and living wills. The issues to be covered are complex and typically require a series of discussions.

Right now, Medicare only pays doctors for this sort of advanced care planning if it happens

during the first visit for new Medicare enrollees. But the government recently has again proposed that Medicare reimburse doctors for including these conversations in their practice, whenever they occur.

Already, some private insurance companies are starting to do just that.

Meanwhile, the Alliance Defending Freedom, a conservative Christian organization, has formally opposed Medicare’s proposal.

“By paying doctors for these conversations, what we’re doing is opening the door to directive counseling and coercion,” said Catherine Glenn Foster, an attorney with the group. Foster says her organization supports end-of-life counseling and planning, but not in a doctor’s office.

“A doctor is not really the person you’d want to be having it with – particularly not a general practitioner who would not be able to advise on the nuances of end-of-life care in the first place,” she says.

But patients seem to want these talks. A 2012 study by the California HealthCare Foundation found that 80 percent of Californians would like to have an end-of-life conversation with their physician, but fewer than one in 10 has done so.

Many doctors who initiate the discussions often do so on their own dime. More often, they don’t have them at all, said Dr. Daniel Stone, an internist with Cedars-Sinai Medical Center in Los Angeles.

“When a doctor has patients scheduled every 15 minutes {but sees them in 8 minutes}, it’s difficult to have a face-to-face conversation about values and goals related to the end of life, which is one of the most sensitive topics that you can possibly discuss with a patient,” Stone said.

Dr. Susan Tolle, an internist with the Center for Ethics in Health Care at the Oregon Health and Science University in Portland, says the informality with which such conversations are held now means that family members may not be included. Having the discussion as part of a formal doctor’s appointment can change that, she said.

“What it does is, it gives this really

important conversation dignity and standing,” she said.

In Oregon, doctors have been squeezing end-of-life discussions into regular medical appointments for decades, under less-than-ideal circumstances. Over the last five years a quarter of a million Oregonians filed their wishes with a state registry. They use what’s known as a POLST form, which stands for Physician Orders for Life Sustaining Treatment. A version of it has been adopted by some other states, including New York and West Virginia.

Jo Ann Farwell, a retired Portland social worker who was recently diagnosed with a brain tumor, completed the form after talking to her doctor.

“I had surgery and had a prognosis of four to six months to live,” she said, after she was diagnosed with a brain tumor.

She did it, she said, to make sure her last hours are as comfortable as possible.

“I wouldn’t want to be on tube-feeding,” she said. “I wouldn’t want to be resuscitated, or have mechanical ventilation, because that would probably prolong my dying, rather than giving me quality of life.”

In the 1990s, health care workers all over Oregon recognized that the wishes of patients weren’t being consistently followed. So the health care establishment worked with the state and with ethicists to prioritize end-of-life talks; the result was the POLST form.

Rep. Earl Blumenauer, a Democrat from Portland, has introduced the Medicare reimbursement legislation every session since 2009. Until now, he says, the federal government hasn’t placed any value on helping people prepare for death, and he finds that ironic.

“The Medicare program will pay for literally thousands of medical procedures, many of them very expensive and complex, even if the person is at the latest stage of life and it may not do any good,” Blumenauer says.

From a purely financial point of view, the change could save money. But Blumenauer says that’s not what’s driving him.

“I don’t care what people decide,” he says. “If they want to die in an ICU with tubes up their nose, that’s their choice. What we want is that people know what their choices are.”

Farwell, the brain tumor patient, well remembers when her sister was dying from cancer.

“She never talked about death or dying,” Farwell said, “never talked about what she wanted at the end. It was very, very difficult for me to try to plan and give her care.”

Farwell wants her sons to be in a better position when it comes to carrying out her wishes.

The federal government is now accepting public comment on the Medicare reimbursement proposal. It’s expected to make a decision in November.

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