
HOSPICE NEWS NETWORK

What the Media Said about End-of-Life Care This Week

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PALLIATIVE CARE PROGRAMS REVIVE HOUSE CALLS

How long has it been since your doctor visited you at home? In a recent article in *The New York Times*, **Jim Wilson highlights the growing revitalization of a once-common but now practically unknown medical practice: the house call.** “A relic from the medical past - the house call - is returning to favor as part of some hospitals’ palliative care programs, which are sending teams of physicians, nurses, social workers, chaplains and other workers to patients’ homes after they are discharged.” **Through this greater personal follow up in the homes of patients, these programs aim both to provide higher-quality treatment and to reduce overall costs.**

Wilson highlights the story of one man in San Francisco, in his late 60s, who says that this return to house calls enabled him to avoid returning to the hospital following a seven-week stay after a heart attack that he suffered in 2012. Following his discharge, palliative care specialists from the University of California in San Francisco visited him in his home and helped monitor his physical and emotional state. Health care workers helped him begin moving his life back towards normal, assisting with everything from household chores to organizing his medication. **As a result of this hands-on care, he says, he was able to avoid the much less pleasant, much more expensive alternative: another trip to the hospital.**

Because home care is generally less expensive than in-patient hospital stays, Medicare and Medicaid have been working for more than a decade to encourage hospitals to switch to less-expensive options. “Recently, under the Affordable Care Act, Medicare has begun to penalize hospitals when, under certain conditions, patients are readmitted within 30 days after discharge.” Helpfully, some insurers, including Medicare, cover house calls by medical personnel who specialize in advance care. **With growing incentives to reduce return visits to the hospital, however, many medical institutions are taking steps to finance this type of palliative care themselves, even in the absence of insurer coverage.**

Even aside from the comfort and quality of care that patients receive from in-home palliative treatment, the benefits to hospitals themselves are at least as profound. “A 2007 study by Dr. Richard Brumley and colleagues found that palliative care patients who received in-home, interdisciplinary care were less likely to visit the emergency room or be admitted to the hospital than those receiving more-standard home care, resulting in lower costs.” With both additional penalties for return hospital visits and increased aid for outpatient care under the Affordable Care Act, palliative care teams are increasingly working with a patient’s regular doctors and specialists “to provide an added layer of support for people living with serious illness,” offering practical help to enable patients to stay in their homes.

These palliative efforts can and do often go hand-in-hand with efforts to treat and cure patients. The home-based, palliative care approach is not limited to terminally ill patients, and there is an increasingly understood distinction being made between palliative care and hospice. “There are a lot of people, including my mother, who don’t fit the criteria for hospice,” says Cameron Egan, and yet are greatly benefiting from in-home palliative care. (*The New York Times*, 4/20, www.nytimes.com/2014/04/20/business/house-calls-are-making-a-comeback.html)

SERIOUS ILLNESS? THOSE ARE FIGHTING WORDS

Are you a fighter who refuses to give up? When you die, will you have lost the battle with disease? **In a recent article published in *The New York Times*, Paula Span explores the use of language in end-of-life care, asking whether the language of “fighting,” “battles,” and “never giving up,” contribute to misframing American’s understanding of death and dying.** Span examines the very different culture of speaking about death and dying in the United Kingdom, and questions whether the language of patients, caregivers and physicians can positively or negatively shape the end-of-life care landscape.

“People working in health care health care [at the University of Lancaster] have been discussing military imagery for a decade,” says Elena Semino, head of the linguistics department. **“There’s a lot of awareness that battle metaphors can be very harmful to patients,” and British doctors and other health care professionals are increasingly advised not to use such metaphors with patients.**

Instead, the tendency among British public health professionals is to describe the end of life using the metaphor of “journey,” speaking about “pathways” and “steps,” rather than fights and weapons. “A 130-page report from the British government on cancer treatment, published a few years ago, was almost devoid of fighting words, for instance. Though it occasionally talked about ‘tackling’ some aspect of cancer, it was more likely to talk about ‘progress.’” **In American reports and media, on the other hand, war language is much more common. Span reports, “On websites for [US] cancer organizations... like Susan G. Komen and the American Cancer Society... I found frequent references to battles.”**

Yet, the observation of British practitioners is that this way of framing death and dying is not helpful. **Warlike metaphors assume that there is an opponent to be defeated. It assumes a competition, with the goal being victory. In this context, death comes to mean defeat. Death can feel like a failure. The language of “journey,” on the other hand, doesn’t involve an enemy or a dynamic of winning and losing. Instead, “it suggests sojourners passing various milestones.”**

In a separate article, written for *Eldercare Resources East Valley*, Marjorie Fox suggests that sometimes saying “no” to the “fight” is the most sane and most life-giving thing an elderly person can do. The article explores the value of aggressive treatment in elderly patients, and suggests that age, prognosis and physical condition all need to be taken into account when contemplating surgery or other invasive procedures. **Within a fighting mindset, both patients and their children often push for more aggressive treatments than will be helpful.** “You

have families who say ‘but mom you’ve always been a fighter. You have to do this.’” Yet, sometimes the best answer is to release the metaphor of struggle altogether.

Span admits that the way we understand serious illness is contextual. It will depend on where we are in life and what our experience is. Age may be the most significant context of all. After all, it is one thing for an elderly person with multiple illnesses to talk about a “journey,” but it is quite another thing for a young person with potentially decades of life ahead to think in the same terms. **“Some people use fight metaphors in what can only be described as an empowering way,” according to Semino.** The language of fighting is infused with “pride and purpose.” This ambiguity suggests that while there may be preferred metaphors that health care workers are encouraged to employ, fight metaphors should not be censored. (*The New York Times*, 4/22, newoldage.blogs.nytimes.com/2014/04/22/fighting-words-are-rare-among-british-doctors/; *Eldercare Resources East Valley*, 4/22, www.eldercareresourceeastvalley.com/end-of-life-decisions-for-the-oldest-old/)

HOSPICE NOTES

*** NHPCO repeats its objections to MedPAC’s recommendation that hospice be “carved in” to Medicare Advantage.** “The National Hospice and Palliative Care Organization emphasizes its position that the MedPAC recommendation would provide less hospice choice for Medicare Advantage beneficiaries, and at a higher cost.” (*NHPCO*, 4/22, www.nhpco.org/press-room/press-releases/nhpco-stresses-position-hospice-carve-proposal)

*** Could a hospice model save American health care? James C. Salwitz thinks so.** Writing for *Kevin MD*, Salwitz argues that a “realistic and appropriate education” and a team-based approach can provide “rational, realistic and optimal choice [which] is often low tech, low cost and high benefit.” (*KevinMD*, 4/22, www.kevinmd.com/blog/2014/04/hospice-model-save-american-health-care.html)

*** In a letter to the editor of *The New York Times*, Carol Holguin extols the benefits of hospice care.** “Hospice and palliative care not only improve the care of the patient but also lessen the need for disruptive, expensive and futile treatment.” (*The New York Times*, 4/18, www.nytimes.com/2014/04/18/opinion/benefits-of-hospice-care.html?_r=0)

*** “Statistically, the average person who enters hospice care uses its services for about two weeks before death occurs,” writes Carla Barber for *The McPherson Sentinel*.** Having conversations early could lengthen the amount of time that we have to receive quality end-of-life care. (*McPherson Sentinel*, 4/18, www.mcphersonsentinel.com/article/20140418/NEWS/140419172/-1/opinion)

END OF LIFE NOTES

*** How has dying in America changed since 1960? In a detailed interactive infographic, *Bloomberg* looks at trends in death and dying in America throughout the last fifty years.** (*Bloomberg*, 4/17, www.bloomberg.com/dataview/2014-04-17/how-americans-die.html)

* **Physician's Orders for Life Sustaining Treatment is “not without controversy, and the criticism sounds much like the fear over death panels...”** reports **Jim Demaine, MD, for Kevin MD.** “The benefit of the POLST form is huge,” Demaine notes, and the use of the form often “goes beyond its initial intention.” “There is a tendency now to use (or even try to require) the use of the POLST form in retirement community facilities and nursing homes.” (*Kevin MD*, 4/21, www.kevinmd.com/blog/2014/04/polst-form-controversial.html)

* **What factors encourage physicians to talk about withdrawal of life-sustaining treatments?** A new study says, “A doctor’s willingness to discuss withdrawal of life support depends on how sick the patient is, but not necessarily on what the patient’s values are in regards to functional recovery. Interestingly, it also depends on whether doctors are required to record the patient’s most likely 3-month functional outcome before deciding whether to discuss withdrawal of life support.” (*Geripal*, 4/24, www.geripal.org/2014/04/talking-about-withdrawal-of-life-sustaining-treatments.html)

* **Demand is increasing for paid caregivers. An article in *The Washington Times* highlights the growing need for caregivers for America’s rapidly aging population. Yet, this line of work can be a hard sell, since many caregivers currently earn barely more than the minimum wage.** (*The Washington Times*, 4/19, www.washingtontimes.com/news/2014/apr/19/demand-increasing-for-paid-caregivers/)

* **For people with dementia, aggression strongly signals pain for those in the advanced stages of cognitive decline.** According to researchers at the University of Florida, those studied with severe cognitive impairment have “significantly more frequent aggressive behaviors” when in pain. “This was not true of residents with less severe dementia.” (*McKnight’s*, 4/21, www.mcknights.com/aggression-strongly-signals-pain-only-when-dementia-reaches-advanced-stages-researchers-find/article/343359/)

PALLIATIVE CARE NOTES

* **“Palliative care is the home run of American Medicine,”** says **Dr. Tom Smith, director of palliative care at Johns Hopkins’ Sidney Kimmel Comprehensive Cancer Center in Baltimore.** Palliative care offers improved symptom management along with fewer hospital days and hospitalizations at the end of life. And, Smith says, “It is care that we can actually afford.” (*Gastroenterology & Endoscopy News*, 4/2014, www.gastroendoweb.com/ViewArticle.aspx?d=In+the+News&d_id=187&i=April+2014&i_id=1048&a_id=26315)

* **“Better care can also cost less,”** says **Froma Harrop.** “Palliative care is not the same as hospice services for the dying. It can include a cure. It can actually extend life by helping patients avoid medical treatments that would make them feel worse or expose them to unnecessary risks.” (*Marietta Daily Journal*, 4/22, mdjonline.com/view/full_story/24972465/article-Better-care-can-also-cost-less?instance=special%20coverage_right_column)

OTHER NOTES

* **“Pointing the finger at Zohydro is not going to resolve the tension that exists today between chronic pain and addiction,”** write Yngvild Olsen, MD, MPH, and Joshua M. Sharfstein, MD, for *The New England Journal of Medicine*. “All concerned about the treatment of chronic pain and all responding to the rise in overdose deaths need to come together to promote high-quality and effective prevention and treatment for both conditions.” (*NEJM*, 4/23 online, www.nejm.org/doi/full/10.1056/NEJMp1404181?query=TOC&)

* **What will it take to tackle the “opioid-overdose epidemic”? Authors writing for *The New England Journal of Medicine* explain that while the epidemic of opioid abuse and overdose is complex, expanding access to drugs for patient care and implementing prevention policies to curb inappropriate prescription are necessary.** Above all, the authors point to diligence, fact checking and caution on the part of prescribing physicians. (*NEJM*, 4/23 online, www.nejm.org/doi/full/10.1056/NEJMp1402780?query=TOC)

* **The FDA is seeking stronger warning labels for long-acting opioids.** According to a report in *Reuters*, the FDA “is requiring labels of all long-acting opioids to say they should be used strictly for patients in severe pain, a response to surging overdoses and deaths each year from the widely used pain medicines.” Up until now, the labels have indicated that the drugs are appropriate for patients with moderate and severe pain. (*Medscape*, 4/18, www.medscape.com/viewarticle/823855)

* **In an article for the Johns Hopkins Newsletter, Carissa Zukowski writes that physician-assisted suicide should be legalized.** “In appropriate times, physician-assisted suicide can serve as a solution, and should be a legal and viable option for Americans.” (*Newsletter*, 4/22, www.jhunewsletter.com/2014/04/22/physician-assisted-suicide-should-be-legalized-78485/)

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