



## Living Longer - Hospice and Palliative Care

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**There is a widely held belief in the medical profession and in the community that hospice and palliative care hasten death. Is this belief true?**

THE NATIONAL HOSPICE and Palliative Care Organization (NHPCO) reports that, based on surveys, the majority of Americans would prefer to die at home. In contrast to this preference, only 25 - 30 percent actually do so. Why this discrepancy?

Hospice is intended to help patients die at home with love and dignity. Many physicians say that they are reluctant to refer patients to hospice because they do not want the patient to lose hope or do not think the patient is "ready to die." There is a widely held belief in the medical profession and in the community that hospice and palliative care hasten death. Is this belief true?

A retrospective study in 2007 showed that enrollment in hospice extended life by 29 days compared to other more aggressive treatment.<sup>1</sup> The study reported longer lengths of survival in four of the six disease categories studied. The largest difference in survival was observed in congestive heart failure patients, where the mean survival period jumped from 321 days to 402 days. The mean survival period was also significantly longer for hospice patients with lung cancer, 39 days, and pancreatic cancer, 21 days.

More than 98 percent of Medicare decedents spend at least some time in the hospital the year before death and between 15 and 55 percent have at least one stay in the ICU in the last 6 months of life.<sup>2</sup> Is this the most appropriate care?

In this day of escalating health care costs, what is the best use of health care dollars at the end-of-life?

Another 2007 study highlighted that the use of hospice decreased Medicare expenditures during the last year of life by \$2,309 per hospice user.<sup>3</sup> The maximum cost reduction was for cancer patients who used hospice services for the last 58-103 days of life (about \$7,000). Unfortunately, NHPCO reports that the average length of stay in hospice is less than 60 days and the median length of stay is 26 days. Furthermore, approximately 30 percent of patients enrolled in hospice die in less than 7 days.

Beyond traditional hospice care, inpatient palliative care consultation leads to lower costs and decreased length of hospital stay.<sup>4</sup> At Sutter Medical Center in Sacramento, we have also shown improved patient and family satisfaction after interventions by the Palliative Care Service compared to those who do not receive the service.

Physicians may not refer to hospice and palliative care because they are afraid of taking away the patient's hope. The question arises then: what hope is offered by pursuing aggressive therapies that may in fact shorten life and increase suffering?

It is false hope. Hospice and palliative care offer real hope to patients and their families by providing:

- Pain and symptom management to minimize suffering at the end-of-life.
- Emotional support to help patients and families address their fears and worries so that life can be meaningful up to the end.
- Family and caregiver education and resources.
- Assistance with activities of daily living.
- Spiritual care to help patients and families explore the meaning and purpose of life and death.

Some physicians may be reluctant to refer because they are concerned about losing control of their patient, sometimes after very long relationships.

When a patient elects to receive hospice, he or she designates an "attending" physician. If this physician is not the hospice medical director, the attending physician's services continue to be covered by Medicare Part B, which pays for outpatient care. Thus, the attending physician (unless a hospice employee) bills for professional services in the usual manner, independent of the hospice benefit and the local hospice program. In addition, the attending physician, in consultation with the hospice medical director, continues to provide services to the patient.

Rather than being reluctant to refer patients to hospice and palliative care programs, physicians should partner with these services to provide the best care possible to patients facing a life limiting illness.

I challenge you to look at your own practice, your own beliefs, your own comfort with death, and your commitment to your patients.

How would you answer the question: Am I providing the most appropriate care?

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4. Ciemins EL et al. The economic and clinical impact of an inpatient palliative care consultation service: a multifaceted approach. *J Palliat Med* 2007; 10: 1347-1355

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