

CONTEXTFLORIDA

Karen Cyphers: Talking about death saves heartache, money

“Throw my brain in a hurricane, and the blind can have my eyes, the deaf can take both of my ears, if they don’t mind the size.” – John Prine in “Please Don’t Bury Me”

Nearly 90 percent of Americans say they would refuse aggressive medical treatment if it left them in an incompetent condition, and 70 percent would prefer to die at home. Yet only 25 percent of Americans die at home and more than 70 percent in hospitals.

Why? Most people don’t talk about what they want for their death, and most don’t have an advance directive. More problematic is that among those who have written down their wants, less than a third of physicians treating those patients are aware of that fact.

What does this mean for patient care? Is there a difference for patients and their families who have made plans and shared them with the appropriate people?

In study after study, yes.

There are two aspects to end-of-life planning that really matter: humanity and cost, and as it turns out the two are aligned.

Patients who engage in end-of-life discussions report less fear and anxiety and feel they have more influence over their medical care. And interestingly, patient and caregiver satisfaction at the time of death is inversely related to how much is spent on last-minute care.

Health care costs are generally lower among patients who engage in end-of-life discussions. They have less resuscitation, ventilator use, and ICU stay... all with *no difference in survival time*.

For good reason, the default response to a patient crisis is to resuscitate and extend life using any possible means. During these times, families are often left making decisions that are challenging even when wishes *are* known, and gut-wrenching when they are not.

There is no placing a dollar amount on human life, and I would never suggest that sparing costs is anywhere near as important as fulfilling the wishes of patients, whether these wishes are to be kept alive, given only comfort care, or otherwise.

But it turns out that in most cases, wish-fulfillment and cost-savings go hand in hand.

One large study found that advance directives were associated with an average of \$5,585 lower Medicare spending in regions such as Florida that have high end-of-life expenditures. Directives are also associated with lower rates of in-hospital death and higher rates of hospice care.

So, what would happen if the percentage of Floridians with advance directives increased from 30 to 60 percent? Based data of Floridians who died in 2011 of chronic illnesses, spending could be reduced by \$77 million to \$192 million simply by asking people to formally express their end-of-life wishes.

Too often, those discussions happen in hospital emergency rooms or on ambulance gurneys. They are not ideal environments for making tough decisions.

Dr. Ken Brummel-Smith, Professor and Chair of Geriatrics at the Florida State University College of Medicine, is on a mission to enhance physician-patient communications.

“Unfortunately, many health care providers view an advance care planning discussion as ‘getting the patient to sign the forms,’ much like the early misunderstanding of the informed consent process,” he said. “Advance care planning is fundamentally about finding out what the patient’s goals, values and wishes are. The forms come after that.”

One such form, the Physician Orders for Life-Sustaining Treatment (POLST), was created with the intent that physician orders would be transferable across health care settings. POLST forms are actual orders written by a physician and signed by the patient instructing other health care providers to implement patient wishes. POLST is the gas pedal to the Advance Directive’s green light.

The POLST form has not yet been approved in Florida, but efforts are under way . A number of Florida cities are planning pilot projects using POLST, a strategy used in other states. Dr. Brummel-Smith and Florida State’s Center for Innovative Collaboration in Medicine and Law are also working to educate policymakers on its merits.

If it is tough to talk about death with family members, it is downright thorny to do so relative to public policy. People immediately think “death panels” or worse. But quite the contrary, encouraging end-of-life conversations are the best safeguard for ensuring your own desires are known and met.

For my dad who has Alzheimer’s, his desire is for “comfort care only” when and if he is no longer cognitive. For me, with two young kids and a lot of hope in what science will bring during my lifetime, I’d want my life extended via all possible interventions.

Dollars are secondary to humanity; and dollars saved by fulfilling people’s preferences, even better.