

A Quiet End to the 'Death Panels' Debate

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Photo



Credit Anna Parini

It seemed like a logical idea, the congressman told me, and not a particularly radical one.

American health care tends to encourage doctors to make money by ordering more tests and procedures rather than by having conversations with patients. But when those patients face decisions about what they want to happen, and not happen, as they near death, they need to talk over their options, not receive an additional [M.R.I.](#)



So in 2009, Representative Earl Blumenauer, then a seven-term Democrat from Oregon, introduced a provision into what would become the Affordable Care Act requiring that [Medicare](#) cover voluntary discussions with a physician about advance directives and end-of-life treatment preferences.

Geriatricians, palliative care doctors and [hospice](#) staffers all vividly remember what happened next: It was the Dec. 7, 1941, of advance-care planning.

Conservatives blasted the idea as the embodiment of evil, the precursor to government-sponsored [euthanasia](#). Sarah Palin [denounced the creation of “death panels.”](#)

None of that was remotely true, but the measure disappeared from the health care act nonetheless.

Medicare officials later tried to incorporate advance-care consultations into a package of regulations, then backed off again. “It was the height of the frenzy, and the administration got cold feet and yanked it,” Mr. Blumenauer said afterward.

Last month, however, this six-year struggle came to a quiet resolution. With hardly a ripple of dissent, Medicare [authorized payment for end-of-life discussions.](#)

Now health care professionals can punch in a code to bill Medicare for sitting down with patients to discuss end-of-life decisions. They’ll get paid \$86 for the first half-hour’s conversation in an office (in a hospital, it’s \$80), and \$75 for an additional 30 minutes. If you need to reopen the subject in a few months, or a few years, Medicare will pay again.

What changed this time around? “The [apprehension](#) and concern has slowly ebbed as public support got stronger,” Mr. Blumenauer said. “And some of the people making the most outrageous charges have gone on to make outrageous charges about other things.”

Public support does appear strong. The federal [Centers for Medicare and Medicaid Services](#) received hundreds of comments this fall on its proposed rule, a spokesman told me; the great majority felt the agency should pay doctors to confer with patients about the end of life.

“Almost universally, people say doctors should be talking to their patients about this,” said [Liz Hamel](#), who directs public opinion research for the [Kaiser Family Foundation](#). In a survey of 1,200 adults in September, more than 80 percent [said Medicare should cover doctor-patient discussions of end-of-life treatment](#). A similar majority thought private insurers should, too.

The poll also demonstrated how rarely these conversations take place. Fewer than one in five respondents reported actually having had such a discussion with a health care provider, including only about a third of those over age 75 and about a third of those with a debilitating disability or chronic medical condition.

Any emergency room physician or intensive care unit social worker can tell harrowing tales of frantically trying to locate a relative, a neighbor, a document — any clue to what an incapacitated older adult wants when she can’t speak for herself.

Medicare reimbursement, alas, will not magically solve that problem. A lot has to happen first.

Somehow patients must learn that they can have extended discussions about life and death decisions with a doctor if

they want to. In the Kaiser poll, about a third said they wouldn't want to talk to a doctor about the end of life.

(In fact, Kaiser polls from 2010 through 2014 repeatedly found that 30 percent to 40 percent of respondents [mistakenly believed that the health care law established "a government panel"](#) to make end-of-life decisions for Medicare beneficiaries. Death panels live, if only in the imagination.)

Somehow, too, doctors must learn how to broach and explore very tender subjects. The prospect makes them hesitant and anxious, said Dr. Diane Meier, who leads the [Center to Advance Palliative Care](#) at Mount Sinai Hospital in New York.

"The great majority of providers allowed to use these new codes have had no training in effective communication about what's most important to people with a serious illness," Dr. Meier said. "People are not born knowing how to have these conversations any more than they're born knowing how to do an [appendectomy](#)."

Before health care professionals can pose unnerving what-if questions, truly listen to people's answers, and help frame a plan, "communication skills need to be practiced and drilled and rehearsed," Dr. Meier added. "It's cognitively and emotionally difficult."

Moreover, even when patients, families and doctors manage to traverse this tough terrain, "sometimes people do all the right things, and they still get medical care on autopilot," Mr. Blumenauer said.

He and co-sponsors from both parties plan to introduce legislation next year to train providers in end-of-life discussions, find effective ways to store and access advance-care directives, and measure how well the whole apparatus works. "We need to ensure that this expression of interests follows people, that it gets integrated into the records and ultimately that it's respected," he said.

A tall order. For every hospital social worker lamenting that patients haven't discussed how they want to be cared for when they're extremely ill and the medical options are running out, there are patients or family members arguing that they knew and expressed exactly what they wanted — and were overridden.

Crucial documents are left in drawers or safes. People make decisions, then change their minds. Health care proxies, appointed to make decisions for people who can't speak for themselves, don't always know that they've been selected to play that role. It's [a messy business](#).

Still, this modest move by Medicare could make a substantial difference. Far more important than the money — physicians aren't going to boost their income enormously by billing \$86 for a half-hour — is the message. "It's an important step to have the federal government place a value on the conversation about end of life," Mr. Blumenauer said.

We've been urged for years to have this conversation. Campaigns like [The Conversation Project](#), [Prepare](#) and [Five Wishes](#) try to help people tackle it.

But for our doctors, "there was little incentive, no kick in the butt to move it forward," Dr. Meier said. "Now there is."