Limiting End-of-Life Care by Patients and Physicians

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Most of the media attention on problems with the U.S. healthcare system has focused on the growing number of uninsured (forty million plus and counting), but there is also the problem of the continuing increase in the costs of delivering healthcare. Lack of access to care is a very different type of problem than that of determining how much care will, or should, be paid for. Though there are many factors driving the increased cost in the U.S., one of the most significant reasons is the routine use of aggressive, high-technology medical therapies instead of supportive care only at the end of life when it is unlikely that any medical intervention will significantly prolong life or improve the quality of the patient’s life. Indeed, the majority of Medicaid money is spent during the last sixty days of a beneficiary’s life, and thirty-one cents of every dollar spent on healthcare is spend on hospital care, much of this driven by demand from an aging population.

The question of whether society is better served by less costly, less aggressive medical care at life’s end has no simple answer. Societal values, as well as patient and health care provider personal preferences must be considered along with economic efficiency and health economics. Whether aggressive care or withdrawal of care is the primary management plan, both approaches force all parties concerned to at least confront the question of whether the care makes sense from an economic point of view. One way the two approaches differ is in how much autonomy patients have over the end-of-life decisions; another might be the degree to which evidence-based reasoning can be used to justify to continuance or discontinuance of treatment. Regardless of whether the ultimate decision to continue or discontinue end of life care is evidence-based, or should be based on clinical outcomes data even in the face of patient or physician pressure otherwise, there at least is some medical evidentiary basis which can be used to decide the likelihood of successful therapeutic intervention for some of the most common end of life care situations patients, their families, and caregivers face on a daily basis. Whether the medical evidence, and medical economics, are translated into a change in patient and physician behavior, remains to be seen, but may depend on what part of the U.S. one is living in. Two recent items in the news illustrate this.

Physician-Assisted End of Life Care: Data on the Futility of Some Interventions?

The medical profession has methodically accumulated substantive, prospective, evidence-based outcomes data for a wide range of common health care delivery scenarios involving life-threatening events and care. A recent article in the *Journal of the American Medical Association* drives this point home. Out-of-hospital cardiac arrest is “a

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devastating syndrome that has a dismal prognosis in many communities.

Patients who fail to meet certain criteria for out-of-hospital resuscitation have little or no chance of being resuscitated if brought to an emergency room, and bringing them there is a poor use of emergency room medical personnel and hospital resources. As harsh as it may sound, untold millions of dollars could be saved and already overburdened emergency rooms in this country could better utilize their limited resources if this medical reality were reflected in policy. This fact serves as a good starting point for an even more prevalent and greater problem for patients who are already hospitalized: resuscitation, intensive care, and aggressive medical treatment for patients who are terminally ill.

The medical data and the cost data for this growing sub-population of hospital patients are sobering, long-standing, and all point to the same conclusion. One of the most common examples of expensive and labor intensive medical care is aggressive, intensive care for terminally ill patients. Hard data has been available for years demonstrating that much medical routine intervention in the last several months, or minutes, of life for these patients is a waste of scarce financial and medical resources. A significant percentage of money spent during the last sixty days of the individual’s life is spent on aggressive medical care for incurable conditions. This data, and conclusions, are not just confined to patients with cancer. The same can be said for intensive medical care for patients with end-stage heart disease (an even larger group than cancer patients), and end-stage AIDS patients. Earlier placement in palliative care programs, including utilization of either hospice or home care services, would save money, medical resources, improve patient’s and family’s quality of life, and be just as much an exercise of their physician’s fiduciary responsibilities as would a futile, full-court press in a hospital.

Patient-Assisted End of Life Care

At one end of the spectrum is the scenario where patients and families insist, and physicians cooperate, with efforts to perform every aggressive effort at care that can possibly be done at the end of life even when such expensive, labor-intensive intervention has virtually no chance of success. At the other end of the spectrum of end-of-life care is the physician-assisted suicide movement. To some, physician-assisted suicide (or, as some prefer, patient-assisted suicide) is simply a logical extension of the hospice movement and other efforts to beat back the technological, interventionist medical juggernaut some patients are subject to at the end of life. There is some evidence that

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8 Id.
the legalization of physician-assisted death (deaths under the Oregon act are not classified as suicides\textsuperscript{11}) has been associated with substantial improvements in the utilization of palliative care services and less-invasive end-of-life care.\textsuperscript{12}

It has been 14 years since the state of Oregon became the first state to allow physician-assisted suicide.\textsuperscript{13} Efforts to pass similar physician-assisted suicide measures failed in Michigan in 1998 and in Maine in 2000. No other state has passed a similar law until this year, when voters in the state of Washington approved the Washington Death with Dignity Act.\textsuperscript{14} The new law in Washington is modeled closely after Oregon’s and allows a mentally competent, terminally-ill adult to obtain a prescription from a physician for a lethal dose of medication. Under the new Washington law, two independent physicians must conclude that the patient is mentally competent and has less than six months to live in order for a patient to obtain the prescriptions needed to end their life. As in Oregon, the physicians merely write for the medications; the medications themselves are self-administered orally by patients. The primary reason the 1997 effort to pass a physician-assisted suicide law in Washington failed in 1991 was because that proposed law allowed physicians to administer the lethal doses of drugs. The new law changed the role of physician from actively participating in the administration of lethal medications to a more passive role of allowing patients to obtain the prescriptions to exercise their option to self-medicate. Another reason the current Washington ballot initiative was successful might have been because of the strong backing from Governor Booth Gardner,\textsuperscript{15} a well-respected figure in the state with a widely publicized battle with end-stage Parkinson’s disease.

Though physician-assisted suicide laws have only been passed in the Pacific Northwest, there is no law on the books in other states to prevent patients from hoarding medications written for another purpose to accomplish the same goal, even though suicide remains illegal. One alternative, non-legislative route for access to doctor-assisted suicide is through state courts. Just this week Montana became the third state in the U.S. allowing doctor-assisted suicide when a state district judge ruled that the Montana state constitution’s protection of human dignity and individual privacy permitted competent, terminally-ill Montana residents to secure lethal-dose prescriptions from their physicians.\textsuperscript{16} Montana’s attorney general has already indicated that he will appeal the judge’s opinion.\textsuperscript{17}

\textsuperscript{12} Id.
\textsuperscript{13} OREGON DEATH WITH DIGNITY ACT (ORS 127.800-995) 1994.
\textsuperscript{14} WASHINGTON DEATH WITH DIGNITY ACT (INITIATIVE 1000) 2008.
\textsuperscript{17} Id.
The relative paucity of state laws passed approving physician-assisted suicide may indicate reluctance on the part of the citizens of many states to engage in one more battle in the culture wars. Perhaps there is a general unease with the subject itself in many parts of the U.S. or a desire to avoid another political confrontation with the Bush administration over whether states such as Oregon have a right to regulate the practice of medicine when that practice involves prescribing federally-controlled substances. This sentiment may persist even though in 2005 the United States Supreme Court rejected efforts by the Department of Justice to prevent physicians in Oregon from being able to write prescriptions for the drugs used in lethal doses by patients.

One thing is certain: examination of the data for the past ten years following the passage of Oregon’s law demonstrates no exodus of terminally ill patients moving to Oregon to end their lives at the hands of Oregon physicians, refuting one of the basic contentions of opponents of the law. To date, fewer than 350 people have taken advantage of Oregon’s physician-assisted suicide law. With the incoming administration of President-elect Obama, it is possible though by no means certain that a political shift to the left at the federal level may translate into efforts by more states outside the Pacific Northwest to pass laws similar to those already on the books in Oregon and Washington.


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