

NEW YORK POST

Stop telling us where to die

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March 17, 2011

Hospice care isn't only a beneficial service for dying patients. It's also a \$4.5 billion industry flexing its muscle in state capitals -- including Albany, where a state senator faces federal charges for taking hospice-industry bribes.

Since coming to America from Europe in 1974, the hospice movement has boomed -- and changed. Today, nearly half of US hospice agencies are for-profit -- and an astounding 42 percent of Americans who died last year were in hospice.

Despite this growth, the industry is pushing for laws that would lead to more patients using hospice care and for longer periods.

A New York law, enacted last August and in effect since February, compels doctors to offer information on hospice and other end-of-life options to every patient diagnosed with a fatal illness. Physicians who fail to offer the information risk fines of \$2,000 for the first offense, \$5,000 thereafter and up to a year in jail.

The Medical Society of the State of New York opposed the law, and many doctors are furious about it.

But on Monday, a state-appointed "Massachusetts Expert Panel on End-of-Life Care" proposed that the Bay State consider copying the New York law.

Four hospice-industry employees sit on the Massachusetts end-of-life panel, an obvious conflict of interest.

Helping terminally ill patients know their options is a best practice -- but the government shouldn't be dictating what is discussed between doctor and patient, especially not at the behest of an industry.

Physicians worry that some patients will break down at the mention of hospice care and lose the will to fight their disease. Yet the New York law allows no flexibility. On its Web site, the state health department offers this Q&A: "Discussing end of life may be too distressing for some patients and their caregivers. Is there a therapeutic exemption for such patients?"

The answer: "No. The law does not permit a therapeutic exemption from its requirements."

And: "In certain cultures, discussions about end-of-life are considered taboo. Is there a cultural exemption from the requirement?" Again, the answer is "No."

Massachusetts should not copy this draconian law. New York should repeal it.

But big dollars are at stake. Medicare spending on hospice soared 250 percent from 2000 to 2007, because twice as many patients chose it and began care sooner. Compelling doctors to discuss it with patients will add demand.

Hospitals also stand to gain: They're paid based on a patient's diagnosis, not per day, like a hotel. The shorter a patient's time in the hospital, the more money a hospital makes. Discharging a patient to hospice can be more profitable than allowing the patient to linger and leave in a body bag.

The hospice industry is depicting its product as a "right." "Ensuring the right to be cared for in our homes is America's last great civil-rights battle," the National Association for Home Care and Hospice, a trade group, claims.

Most people would like to die at home but in Massachusetts, only 24 percent do. The state panel calls that a "failure" and sees government coercion as the answer.

That's misguided. Sometimes a patient doesn't die at home because the doctor doesn't foresee that death is imminent. A 2006 Emory University study showed that doctors treat patients who are expected to die less intensively than patients who are expected to survive -- but often doctors can't predict who is in the last year of life.

In New York, the state health department tells doctors who are uncertain to consult "Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases." It's published by -- you guessed it -- the National Hospice Organization, an industry group.

The benefits of hospice care are obvious. We don't need industry lobbyists and politicians interfering. It's none of the government's business where and how we die.

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