America's End-Of-Life Care is Mixed Bag, Study Says

By Gil Ross — January 20, 2016

A recent report in *JAMA* by a large study group shows mixed results when it comes to end-of-life care in the United States.

*The National End of Life Care Intelligence Network* based in London, England, assessed trends in dealing with terminal cancer in the last year of life in seven wealthy nations: Canada, the United Kingdom, Norway, the Netherlands, Belgium, Germany and the U.S.

Parameters studied included time spent in hospital, ICU admissions, palliative care and expenditures. Surprisingly, America came out better than we would have expected in several of these categories but worse in others.

Drs. Ezekiel J. Emanuel and Justin E. Bekelman, two of the co-authors of the study, entitled [1] "Comparison of Site of Death, Health Care Utilization, and Hospital Expenditures for Patients Dying With Cancer in 7 Developed Countries," recently published an op-ed in the *New York Times* discussing their work. That piece [2] is intriguingly entitled, "Is It Better to Die in America?"

Dr. Emanuel was amongst the original health care advisers to the new Obama administration during the creation of the Affordable Care Act.

The study's goals were to compare site of death, health care utilization, and hospital expenditures employed via a retrospective cohort study using administrative and registry data from the seven countries, from 2010. Subjects whose data were evaluated were decedents older than 65 years who died with cancer.

Some of the results are surprising, given the widespread belief that most of our healthcare dollars are wasted on terminal care.
Among patients older than 65 years who died with cancer, end-of-life care was more hospital-centric in Belgium, Canada, England, Germany and Norway than in the Netherlands or the U.S.

That was not true, however, for ICU care at life's end: intensive care unit admissions were more than twice as common in the U.S. than in other countries. And hospital expenditures near the end of life were higher in America, Norway, and Canada, intermediate in Germany and Belgium, and lower in the Netherlands and England.

Also, and disturbingly, the U.S. had higher rates of chemotherapy use at the end of life, second only to Belgium.

In their op-ed, Drs. Emanuel and Bekelman posit some ideas to deal with those areas wherein we might all benefit from a more reasonable and realistic approach.

"...the next step needs to be empowering patients to make realistic choices that are consistent with their hopes for how they want to live near the end of life and where they want to die," they wrote. "This means having candid conversations about when chemotherapy or I.C.U. admissions are no longer helpful, and increasing palliative care, which has been shown to improve both the quality and length of life. This can best be achieved by making access to palliative care the default, instead of just an option, for all patients with advanced and incurable cancer."

They go on: "Our study also has implications for cost control. It shows that end-of-life care is not the main contributor to higher health care costs in the United States; some countries with considerably lower overall costs still spend more on end-of-life care..."

And, like Pandora, an upbeat conclusion: "...there is a reason for hope. While the process has been slow, the United States has improved care at the end of life. In the mid-1980s, more than 70 percent of American patients who died with cancer did so in the hospital. We have cut that number by over two-thirds. And the use of chemotherapy near the end of life, while still high, is also lower than in the past. Interestingly, the trends we observed suggest improvement in what the United States does well, but also some worsening in using the I.C.U. more. But we can and should do better. We should start by providing universal access to the highest-quality palliative care as the default for all Americans near the end of life."

What we need is a more proactive approach to discussing end-of-life goals for all of us, not just those whose end is in sight. Clear-headed decisions involving loved ones prior to death's door staring us in the face, when issues are likely to be clouded. Health Care Proxies, Living Wills, and especially discussion clearly starting preferences need to be done sooner rather than later, and when the time comes, those wishes need to be enforced stringently sometimes against the wishes of over-zealous relatives and even liability-conscious hospital staffs.