

N.Y. Palliative Care Law May Not Change Practice

BY ALICIA AULT

A new law requiring New York physicians to discuss palliative care and end-of-life options with terminally ill patients is well intentioned, but may not do much to change clinical practice or institutional culture, according to some observers in the state.

The New York Palliative Care Information Act was signed into law by Gov. David Paterson (D) in August. Perhaps as a sign that palliative care is being embraced more readily and becoming better understood, it took just 14 months from the bill's introduction in the state Senate (S. 4498 and A. 7617) to its signing.

Even so, "whether or not it will change behavior is a bit of a black box," said Dr. Bradley Flansbaum, director of hospitalist services at Lenox Hill Hospital in New York. "It's a nice thought, but I don't know how they're going to put it into effect."

Under the law, physicians and nurse practitioners are required to provide a patient who has less than 6 months to live with information and counseling on palliative care and end-of-life options, including, "the range of options appropriate to the patient, the prognosis, risks and benefits of the various options, and the patient's legal rights to comprehensive pain and symptom management at the end of life."

The physician or nurse practitioner can refer the patient to another provider who is willing to meet the legal statute or who is "professionally qualified" to offer the services.

There is no reimbursement offered for the required services.

Because it is an amendment to the state's public health law, violations of the new law could result in penalties or fines. It's not clear how it will be enforced or what might trigger the penalties; the health depart-

ment has until the law's effective date (February 2011) to devise regulations, said David Leven, executive director of Compassion and Choices of New York.

That advocacy group helped devise the proposal and then shepherded it through the legislature, said Mr. Leven. California has a similar statute, but is not as strong because it does not put the onus on physicians, he said.

The organization sought the legislation because even with increased training on end-of-life issues, too few physicians are having conversations with their dying patients, Mr. Leven said. That means patients' wishes aren't being respected, to the detriment of both patients and the practice of medicine.

The organization also hoped that the law would be a catalyst to improving end-of-life education in medical school and at the professional level, he said.

Dr. Wendy Edwards, director of the palliative medicine program at Lenox Hill, said that education would be a key component, but there appeared to be no such formal requirements in the law. About 15 years ago, she was part of a group that attempted to get a bill passed to mandate the teaching of palliative care in medical schools, but it did not get anywhere.

She said she wasn't sure that the new law was the way to increase attention to palliative care, but that it had likely come about as a result of frustration and impatience on the part of palliative specialists.

The law will be positive, however, she said. Palliative care won't just be the standard of care, but will be the law, which gives some backing to hospitals that seek to implement and strengthen their quality of care, and end-of-life care in particular.

But it still will not make it easier for physicians who do not have experience in palliative care, Dr. Edwards said. "It's a very hard discussion to have; it's not some-

thing doctors are trained to do."

A recent study in non-small cell lung cancer patients found that those who were given palliative care at the time of diagnosis had a better quality of life than did those in standard care (N. Engl. J. Med. 2010;363:733-42). This study may do more to advance the field than does the New York law, Dr. Edwards noted.

Although the Hospice and Palliative Care Association of New York State supported the law, the Medical Society of the State of New York did not. The medical society, which represents 25,000 physicians, opposed the law because of concerns that it would interfere with the way each and every doctor navigates through end-of-life situations with each individual patient, said Elizabeth C. Dears, the society's senior vice president for legislative and regulatory affairs.

Mandating that information be given on palliative care "may undermine the patient's belief and conviction in prevailing against their disease and undercut the confidence in their treating physician," said Ms. Dears.

The medical society also said that physicians are not licensed to provide legal advice in areas such as pain or symptom management, and that they may not know what they are supposed to be communicating to patients under certain provisions, while still being subject to penalties.

Although the medical society might object to requiring any such talk, both Dr. Flansbaum and Dr. Edwards said that, realistically, the law should be requiring palliative care to be offered sooner in the disease process and to a broader group of patients, such as those who have chronic life-limiting conditions such as heart failure.

"By the time you're invoking palliative care in terminal patients, you're behind the curve," said Dr. Flansbaum. ■



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Bill Targets Radiation Dose

Sen. Mike Enzi (R-Wyo.) and Sen. Tom Harkin (D-Iowa) have introduced a proposal to create minimum education and credentialing standards for people who deliver radiation therapy and imaging procedures to Medicare patients. The CARE (Consistency, Accuracy, Responsibility, and Excellence) in Medical Imaging and Radiation Therapy Act (S. 3737) would, however, grandfather in technicians and others who do not meet the bill's standards. "This bill will reduce the risk of medical errors associated with misdiagnosis or inappropriate exposure to medical radiation, and save millions of health care dollars by decreasing the number of examinations that must be repeated due to poor quality," said Sen. Harkin in a statement. The CARE act was introduced in the House (H.R. 3652) in September 2009 by Rep. John Barrow (D-Ga.).

Part D Premiums Edge Up

Medicare beneficiaries can expect their monthly Part D prescription drug premiums to rise next year, but only by about \$1, according to the Centers for Medicare and Medicaid Services. Officials at the agency estimated that the average monthly premium for standard Part D drug coverage will be \$30, about

\$1 more than in 2010. By shopping around, beneficiaries may be able to find plans with lower premiums than they are paying now, CMS Administrator Donald Berwick said during a press conference to announce the new rates. He and other officials said premium rates will remain relatively steady in 2011 because minor cost increases for the Part D plans have been offset by increased use of generic drugs. Also starting in 2011, Medicare beneficiaries will be eligible for 50% discounts if they spend enough on brand name prescriptions to reach the Part D coverage gap, or doughnut hole. "These very modest increases in premiums, along with the new discounts for brand name drugs that are made available through the Affordable Care Act, are going to make medications more affordable, more accessible to Medicare beneficiaries in 2011 and thereafter," Dr. Berwick said.

Teens' Headaches Related to Habits

Migraines and other headaches are more likely to affect teens who are overweight, smoke, and rarely exercise, according to the American Academy of Neurology's journal *Neurology*. Overweight teens were 40% more likely to have frequent headaches than were those without any of the three negative factors, teens who

smoked were 50% percent more likely to have them, and teens who exercised less than twice a week were 20% more likely. "The study is a vital step toward a better understanding of lifestyle factors and potential preventive measures that can be taken," said Dr. Andrew D. Hershey of the University of Cincinnati in an editorial accompanying the study. These factors have rarely been studied in teens, Dr. Hershey added. The findings were part of a study in Norway for which researchers interviewed 5,847 students ages 13-18.

Hispanic Mothers Need More Folic Acid

Since the establishment of intake guidelines for folic acid in the United States and mandatory fortification of some cereal grain products, fewer children have been born with neural tube defects (NTDs). But according to a report from the Centers for Disease Control and Prevention, opportunities for improvement remain, especially among Hispanics. In 1995-1996, approximately 4,000 U.S. pregnancies were affected by NTDs, but that number declined to 3,000 pregnancies in 1999-2000, the year after folic acid enrichment was mandated. National Birth Defects Prevention Network data from 2005 to 2007 show that Hispanic women are at significantly greater risk of having babies with neural tube defects than are white and black women (prevalence ratio, 1.21), according to the report in the CDC's *Morbidity and Mortality Weekly Report*. The CDC authors pointed out that corn tortillas and other prod-

ucts made from masa flour are not currently fortified with the folic acid.

Consumers Worry About Drug Influence

Almost 70% of Americans who take prescription drugs believe that drug makers have too much influence over doctors when it comes to those prescriptions, and 50% believe that doctors prescribe drugs even when a person's condition could be managed without medication. The data are the result of a Consumer Reports magazine poll. On the basis of the survey of more than 1,150 adults, the magazine asserted that 51% of Americans don't think their doctors consider patients' ability to pay for prescribed drugs and 47% think gifts from pharmaceutical companies influence doctors' drug choices. In the 20% of respondents who had asked for a drug that they had seen advertised, 59% of them said their doctors prescribed what they requested.

—Naseem S. Miller

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