

Bioethics Council Rejects Assisted Suicide Option

Report also recommends establishing a presidential commission on aging, dementia, and long-term care.

BY JOYCE FRIEDEN

Associate Editor, Practice Trends

WASHINGTON — Assisted suicide and euthanasia should not be considered for terminally ill patients, the President's Council on Bioethics suggests in a new report.

"If you say assisted suicide and euthanasia are not the way to fix these problems, you have reaffirmed the principles we affirmed in the last chapters of this report," said Gilbert C. Meilaender, Ph.D., council member and Phyllis and Richard Dusenberg Professor of Christian Ethics at Valparaiso (Ind.) University.

"We think that euthanasia and assisted suicide are out," agreed council member Paul McHugh, M.D., the Henry Phipps Professor of Psychiatry at Johns Hopkins University, Baltimore. "This is just an old idea that crops up again and again in society, and various people tried it, and it always fails."

The patients who are driven to consider assisted suicide "are the people who burn out in the process of care," said Dr. McHugh, who is also professor of mental health at the university's school of public health. "They burn out simply because doctors have been extending things too far for them, asking more than they can deliver. ... Never forget that inflicting extra care on people is to ultimately burn them [out]."

Dr. McHugh said he also favored giving family caregivers tax benefits to help them financially. He added that he wished there were more role models to persuade people to think of elder care as a career. "We

don't have any Florence Nightingales, any Mother Teresas to tell people this is a wonderful life."

Council member Alfonso Gómez-Lobo, D. Phil., lauded the report but said there was more work to do on the subject. "We have to think more about the way of making a distinction between ordinary and extraordinary means," said the Ryan Professor of Metaphysics and Moral Philosophy at Georgetown University, Washington. "It is important to affirm, on the one hand, the goodness of life. On the other hand, it's not an absolute good. It's frail and fragile, and there are moments in which we just have to open ourselves to the fact that we have to let go."

The report also recommended establishing a presidential commission on aging, dementia, and long-term care.

"Someone might say the last thing America needs is another commission, but this commission is really set up to be unique, understanding death not as a problem to be solved but an experience to be faced," said council member Peter Lawler, Ph.D., chairman and the Dana Professor of Government at Berry College, Mount Berry, Ga. "We as a people aren't particularly equipped to think of death as an experience to be faced. But if a commission can accomplish that, it would be quite a commission. And I'm all for that."

At the meeting, the commission heard from Robert Friedlander, Ph.D., director of the Center for an Aging Society at Georgetown. Dr. Friedlander told the council that although most of the caregiving for elderly patients is provided at home—of-

ten by family members—three-quarters of the money spent on caregiving is spent at institutions. This is partly because institutional long-term care is a mandated benefit under Medicaid, whereas home- and community-based care is not.

But "there have been tremendous efforts on the part of states to move care out of the nursing home," especially since states think care is cheaper outside of institutions, he said. "This rebalancing has meant that in the period from 1991 to 2001, the expenditures in home and community-based care in Medicaid have more than tripled, from \$6.2 billion to \$22.2 billion."

There also has been movement toward changing the financing of long-term care. "The past 6-8 years, most of the focus has been on tax credits for caregivers and more public incentives for the purchase of long-term care insurance," Dr. Friedlander explained.

More fundamental changes need to be made to the long-term care financing system than are currently in place, Dr. Friedlander said. "I think without structural changes, it is likely to be harder for caregivers in the future."

Further, things will only get worse as baby boomers live longer, and there are fewer children to support and care for them. "I would call these the best of times. I think when we get to the real crisis, these are going to look like the good old days."

Greg Sachs, M.D., chief of the section of geriatrics at the University of Chicago, said that when it came to caring for dementia patients, he was "less worried about the advancing number of people and smaller numbers of caregivers ... and much more worried about the propensity to overtreat, to not provide good end-of-life care, and in fact, to have

a healthcare system that is particularly ill-suited for the ongoing care of people with dementia."

Current financial incentives don't encourage the idea of letting dementia patients die peacefully at a nursing home, Dr. Sachs said. "When the [nursing home] patient has pneumonia and is getting close to dying, the nursing home has to provide more care ... but they are not reimbursed more. Depending on where they are and if the patient is on Medicaid, if they send the patient to the hospital they can actually be paid a 'bed-hold,' and they are actually making money while the patient is in the hospital, rather than losing money from having to provide additional care."

In addition, the physician, instead of being paid at a lower rate and doing less frequent visits, "hospitalizes the patient and makes more money by seeing the patient on a daily basis and gets reimbursed at a higher rate," he continued. And the hospital makes money because pneumonia is a disease for which the payment often exceeds the cost of care.

"All the financial incentives are aligned for this patient to be transferred to the hospital rather than being cared for in the nursing home and being allowed to die peacefully," he said.

The September meeting was the last one at which Leon Kass, M.D., a fellow at the American Enterprise Institute, would serve as council chairman. The new chairman is Edmund Pellegrino, M.D., professor emeritus of medicine and medical ethics at Georgetown. ■

The council's report, "Taking Care: Ethical Caregiving in Our Aging Society," can be found online at www.bioethics.gov/reports/taking_care/index.html.

MedPAC Efficiency Study to Assess Quality of Medical Care

BY JENNIFER LUBELL

Associate Editor, Practice Trends

WASHINGTON — Researchers with the Medicare Payment Advisory Commission are measuring the quality of care delivered by physicians as part of an overall analysis of physician resource use.

"We hope to look at variation in quality performance, to do this across conditions, regions, and to some extent across specialties," Karen Milgate, a research director for the MedPAC, said at a recent commission meeting. "We also hope to identify any gaps in quality measurement development that we can."

The ongoing research supports the commission's long-term goal of identifying more "efficient" providers, as a tool to encourage greater efficiency in care.

Variation in resource use may include cost of a service, types of services provided, or types of specialists that patients see, Ms. Milgate said in an interview. It could also mean variation in resource use across regions.

Using preliminary computer models, MedPAC researchers found variation in the cost of certain conditions.

For example, treatment of end-stage renal disease is fairly well defined, as the patient either requires long-term dialysis or a kidney transplant to stay alive. For that reason, average versus median costs for end-stage renal disease episodes don't vary that much, said MedPAC researcher Niall Brennan.

Significantly more variation in cost was seen in the care of hypertension, diabetes, and heart failure.

In areas where there is tremendous variation in resource use, "we might want to [see] if there are any guidelines in those areas that would better help us understand appropriate resource use levels," Ms. Milgate said.

MedPAC could identify conditions with variation in resource use where there might also be high variation in quality, Ms. Milgate said. Those might become priority areas for coordination of care.

Researchers are hoping to address questions such as "how do you attribute the

care of a particular beneficiary to a specific physician?" she said. The minimum number of cases needed to get a reliable measurement, and who you actually compare a physician's performance with, are other considerations, Ms. Milgate said. "What other physicians see similar patients to that physician?"

Ms. Milgate clarified that these claims-based measures would not necessarily be used in a pay-for-performance system.

"That's a pretty easy decision because we don't have that information" yet, she said. Researchers are planning to base this analysis on currently available information: claims data.

More than 35 indicators on conditions important to Medicare will be used to measure quality, Ms. Milgate said. "Most of them are primarily what we've talked about before as process measures. For example, for beneficiaries with coronary artery disease, did they have an annual lipid profile?" Outcomes measures would

also be used. For example, for beneficiaries with diabetes, what proportion of them ended up in the hospital with short- or long-term complications that were related to their diabetic conditions, she said.

MedPAC earlier this year advised the Department of Health and Human Services to test different types of provider payment differentials, which would essentially offer monetary rewards—bonuses, for example—for meeting certain goals on health care quality.

MedPAC Chair Glenn M. Hackbarth, J.D., said he hoped that Congress was prepared to move ahead with pay-for-performance legislation. Several bills are pending to link relief from the sustainable growth rate formula to the implementation of a pay-for-performance system for physicians, he said.

"Obviously we support both ends of that bargain. We have argued that in order to assure access to quality of care, there does need to be some relief from the SGR. But at the same time, we think that it should be not just more money into the existing system, but one that consistently, in a more focused way, rewards good practice and quality of care." ■

Researchers plan to base this analysis on available information: claims data. More than 35 indicators on conditions important to Medicare will be used.