

'Do no harm': Patient-centered end-of-life care means happier patients who live longer

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(Medical Xpress)—New doctors take an oath to do no harm, but many physicians, in their zeal to prolong people's lives, often end up exposing patients to aggressive treatments that don't improve outcomes and that drive up health care costs.

Researchers from the UCLA Department of Urology have found that patient-centered end-of-life care—ensuring that a dying person's wishes are known and followed—results in happier, less [depressed patients](#) who are in less pain and survive longer. By eliminating aggressive measures that [patients](#) might not want, this type of care also helps to keep costs down for those with advanced cancers and other diseases that can't be effectively treated.

"We can improve care while reducing costs by making sure that everything we do is centered on what the patient wants and what his or her specific goals are, and then tailoring a treatment plan to ensure we provide the specific care he or she wants," said Dr. Jonathan Bergman, a Robert Wood Johnson Clinical Scholar at UCLA and co-author of a new perspective paper published March 20 in the peer-reviewed journal *JAMA Surgery*.

Medical care during the final stages of life is often poorly coordinated and fails to take into account a patient's preferences, the UCLA researchers say. It also consumes the lion's share of health care dollars. A 2004 study found that 30 percent of Medicare resources are expended on the 5 percent of beneficiaries who die each year, and one-third of the

costs in a patient's last year of life are amassed during the final month.

Yet research has shown that by instituting patient-centered care, costs in the last week of a patient's life can be reduced by up to 36 percent, and death, when it comes, is less likely to occur in an intensive care unit.

UCLA researchers are currently testing the patient-centered care model on [cancer patients](#) at the West Los Angeles Veterans Affairs Medical Center. One of the first things doctors do with these critically ill patients is determine their goals in a multidisciplinary environment, integrating a palliative care specialist at the outset. The physician and specialist see the patient on the same day to coordinate their care.

"Unfortunately, the opposite is usually what happens," Bergman said. "Patients come in with incurable diseases and there's no discussion of prognosis and goals of care. Then a lot of very [aggressive treatments](#) can occur, due to inertia—patients are placed in an [intensive care unit](#) with oxygen and feeding tubes, and that's not always in line with their goals."

Patients who want aggressive care should, of course, receive it, Bergman said. But the UCLA research team is discovering that many don't want such treatments and simply have not been queried about their needs and desires.

To change this, the perspective paper suggests that medical residents first be educated about patient-centered care. Physicians will be better prepared to practice in the 21st century and to maximize patient outcomes if they are guided toward appropriate care for their patients in life's final stages, Bergman said.

Second, changes should be considered to Medicare, which pays for the majority of care at the end of life. To date, meaningful policy discussions on this issue have proven elusive, Bergman notes, with talk

about "death panels" and the like causing policymakers to shy away from such decision-making.

"Given the disproportionate cost of care at the very end of life, the issue should be revisited," the perspective paper states. "Addressing goals of care, not to deny aggressive care to those who want it, but to ensure that we deliver aggressive care only to those who do, reduces costs and improves outcomes."

Lastly, the UCLA researchers suggest that hospital "scorecards" be changed to reflect this new [care model](#). The Joint Commission, which accredits hospitals, issues an annual report that ranks hospitals on quality and safety using evidence-based measures linked to patient outcomes. However, none of the 44 accountability measures or the six non-accountability measures in the report address end-of-life care or the assessment of patient preferences.

"Adding such measures to the report would improve practice, as well as inform patient-centered care by empowering individuals to make educated decisions," Bergman said. "Better care in life's final stages should and can be led by physicians, who have accepted the mission of skillfully—and thoughtfully—caring for patients at every step of life's journey."

Provided by University of California, Los Angeles

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