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By Barbara Coombs Lee and Kim Callinan

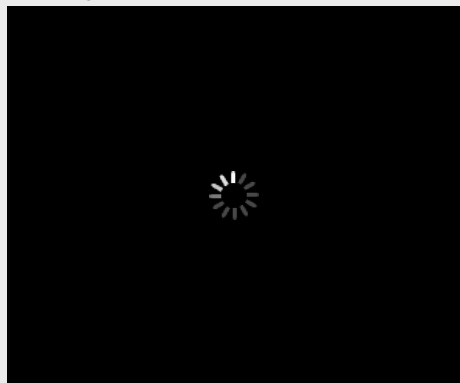
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During a **CNN presidential town hall** on Feb. 3, an 81-year-old man from Concord, New Hampshire, with phase IV colon cancer, Jim Kinhan, asked **Hillary Clinton** what she could do to “help advance the respectful conversation that is needed around this personal choice that people may make, as we age and deal with health issues or be the caregivers of those people, to help enhance and -- their end of life with dignity.”

Jim Kinhan is not alone.

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Our society is in the midst of a profound shift in attitudes toward end-of-life healthcare. We are increasingly aware that too many suffer needlessly in their dying. Too many endure tests and treatments that increase suffering but do nothing to extend life. Too many carry memories of the pain, confusion and agony of a dying loved one.

Every day, 10,000 people turn 65. The proportion of the population reaching age 85 is 48 times larger than a century ago. Increased life expectancy brings challenges of advanced illnesses among the aged.

Our medical system focuses almost exclusively on extending life at any cost, often at the expense

of its quality. The Centers for Medicare and Medicaid Services reinforces this focus by reimbursing doctors generously for complicated tests, ICU stays and medical device implantations, but not for conversations and comfort care.

People who do not communicate their values and priorities as illnesses advance often pay dearly for this failure. Lacking clear guidance on how an individual weighs the quality of life against its absolute duration, physicians often assume the latter, so they propose agonizing tests and treatments that steal life's joys as they prolong the dying process.

Most Americans want to die at home, peacefully and with loved ones close by. But nearly 40 percent die in a hospital, and almost 60 percent of these hospitalizations include an ICU admission.

As noted in the Jan. 19 issue of the Journal of American Medical Association, devoted entirely to end-of-life care:



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"ICU care in the United States at the end of life appears unwanted, expensive, and futile."

In other words, our healthcare system is failing to deliver what people need as they approach an inevitable and imminent death.

Polls shows people across the country increasingly expect candid information, more options and more personalized care at the end of life.

We've seen the power of storytellers like **Brittany Maynard**, a 29-year-old Californian who moved to Oregon to utilize its death-with-dignity law to end her unbearable suffering from terminal brain cancer. Her story led to a **5-fold increase in bills to authorize medical aid in dying** as an option for terminally ill, mentally competent adults. Last fall's historic signing of the End of Life Option Act in California quadrupled the number of Americans with the option of medical aid in dying --- to nearly one in six.

But medical aid in dying is only one part of the story of a shifting paradigm. Authorized medical aid in dying fosters frank conversations about the crucial balance between the quality of life and its absolute quantity. It empowers patients to die on their own terms and that is a potent beginning for many types of reform. Empowered patients ask more and better questions. They weigh treatment decisions carefully and they understand how an ICU admission, with its cascade of tests and treatments, impacts the end-of-life experience.

People need greater access to information and options as the end of life approaches. And they want our national and state policy makers to address this need.

Compassion & Choices has federal policy solutions to achieve this transformation. They build on the Institute of Medicine's landmark study, **Dying in America**, released in late 2014. Below are three of our 18 policy reforms.

1. Allow people to continue to receive disease-specific treatments after they enter hospice care. A Medicare demonstration project called **Medicare Choices Model** is currently testing this concept with Medicare beneficiaries in 140 locations nationwide.
2. Establish consistent federal payment for palliative care consultations to ensure that treatment decisions align with patients' goals, priorities and values.
3. The Centers for Medicare and Medicaid Services should stop reimbursing providers for unwanted medical treatment.

No one should suffer needlessly at the end of life. Our policy solutions are designed to minimize suffering and maximize comfort at the end of life.

Coombs Lee was an ER and ICU nurse and physician assistant for 25 years. Currently, she is an attorney and President of **Compassion & Choices**, the nation's largest end-of-life choice advocacy organization. **Callinan** is chief program officer for Compassion & Choices. She holds a Master's degree in public policy from Georgetown University, a graduate certificate in public health from the University of South Florida and a Bachelor's degree in government from Oberlin College.

TAGS: Hillary Clinton



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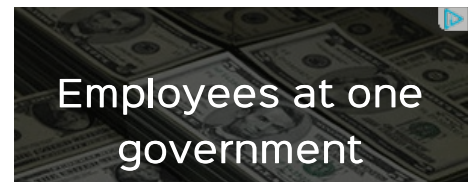


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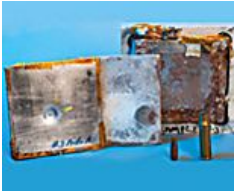
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notsoweaklyreader · 2 months ago

A more honest term for the "right to die" movement is the "DUTY to die" movement. What Obama's BFF and healthcare guru, Ezekiel Emanuel wants is to kill off seniors. He has stated publicly, IN PRINT, in The Atlantic and the NY Times, that people over 75 are in his mind a subhuman species and a waste of resources. And he has an agenda for them, created from his values. He advocates pushing seniors with serious health issues into "palliative care", which is another term for death row. In fact, a large number of people with serious health problems are not in pain, because there are strong pain killers out there. What the "palliative care" movement says is they will only make strong pain available if the patient agrees to decline procedures or meds that might improve their condition and prolong their lives. In other words, pain meds would only be available to you if you agree to let these ageist modern day Nazis kill you once you become inconvenient for others. So much for valuing each human being and each life!

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Bradley Williams · 2 months ago

We do need to read and digest the language of the Oregon model laws/bills before we expound on our positions. They are riddled with loopholes that work together to eviscerate the flaunted safeguards. For example how many times have you nodded your head when the proponents declared that the lethal dose must be self-administered? Well, read the language of the law/bill and you will find that there is no means provided to insure that marketing point. For example "self-administrate" was mentioned 6 times in the 20 page Colorado HB 16-1054 and yet there was no means provided to confirm that the lethal dose was forced on not.

In fact what is provided in all the bills/laws is that there may be no investigations allowed after the death. This is a red flag to repair our public safety net.

According to their own records in OR and WA a dangerous public policy that is being established is a low bar of "medical standard of care" is poisoning for people that "fear" the loss of autonomy.

We are all at risk of abuse by these poorly composed laws/bills.

PS: What other activities in the US prohibit investigations?

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Dingbat-cat · 2 months ago

Statistics have shown that a great proportion of our healthcare dollars (in the US) are spent for the last few months of life, often for care or procedures that do little to promote the comfort of the dying. Based on my experiences (I am in healthcare), the push to extend or continue life "at all costs" is not being pushed by the doctors/hospitals so much as by the family, who cannot let go without feeling guilty that they didn't do enough. We in the western world are uncomfortable with the idea of death and dying. We don't want to believe that death is an inevitable part of life; we do want to believe that we should never stop fighting for that last breath. To not go quietly into the dark. But there is a difference between the "good fight" and the "good death". As a result, we have extended the length of our lives without improving the quality if that life. To start, we need honest discussions with our loved ones about what we do and do not want, what our life is "worth" (in terms of quality, not cost). Then that discussion should be extended to our physician(s), so that everyone is on the same page.

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fivefoottwo · 2 months ago

There's quite a difference in dying of cancer and dying of some other medical conditions. I've never known anyone who couldn't make the choice to die at home with cancer and be kept very comfortable during the process via Hospice.

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