



Bernard (Bud) Hammes, Gunderson Lutheran Medical Center (LaCrosse, WI)

Civic Caucus, 8301 Creekside Circle #920, Bloomington, MN 55437

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Present : Verne Johnson (chair), Marianne Curry, Paul Gilje, Sallie Kemper, Dan Loritz, Tim McDonald (phone), Wayne Popham (phone), Fred Zimmerman

Summary of meeting: Bud Hammes, medical ethicist at Gundersen Lutheran Medical Center in La Crosse, Wisconsin, discusses a program he started to encourage individuals to make decisions about their future care before they become ill. He describes the motivations for the effort and its impact: less stress on families, greater peace in the final years of life, and substantial savings in forgone cost of care. He discusses the politics and pragmatics of starting and running the program.

A. Welcome and introductions - Bud Hammes received his Ph.D. in philosophy from the University of Notre Dame. He has taught at the University of Gonzaga in Spokane, Washington, and at the University of Wisconsin-La Crosse.

Since 1984, he has served as the Director of Medical Humanities and as Director of the Respecting Choices Program for Gundersen Lutheran Medical Foundation and Gundersen Lutheran Medical Center in La Crosse, Wisconsin. In this position he provides educational programs for medical students, nursing students and physician assistant students. He also provides in-service training and workshops for the medical staff, nursing staff, social workers, and the pastoral care department. He chairs both the Institutional Review Board and the Ethics Committee.

B. Discussion

There are two major health systems in the La Crosse area, Hammes pointed out: Gundersen Lutheran and Franciscan Healthcare, which is part of the Mayo Clinic Health System. They are both integrated systems in that they contain all health care services under one administrative staff-from outpatient care to tertiary care in the hospital. So the two La Crosse health systems compete with each other, yet they also cooperate when it comes to doing something beneficial for the entire community. One such opportunity to cooperate has centered on the movement to improve advance care planning which has an impact on care at the end of life.

It is not right to make life or death decisions without knowing one's wishes.

Hammes outlined his interest in advanced care planning as it developed over the course of his career.

"I started here at Gundersen in 1984," Hammes said, "and my initial role was one educating young doctors. In that work I was closely involved in observing the doctors taking care of patients, particularly in the hospital. I was able to observe the process of care and the kinds of ethical questions that physicians face in the hospital setting."

He began doing ethics consultations for the physicians and started to see some troubling patterns. "We'd have patients in the hospital, many of whom had been in before, who were so ill that they were unable to make decisions about their own care."

He found the physicians coming upon situations where they were not sure whether a patient would live if physicians intervened. "And it wasn't always clear if patients would be 'in a good place' if we did intervene and kept them alive. I had to consult with families about the ethics of the medical decisions they faced. All too often the family didn't know what the patient would want-and I was stuck over and over again in this same situation with families facing the same difficult decisions."

"Here we were making potentially a life-or-death decision for someone when we had no notion of what they'd want us to do under the particular circumstances of their present condition."

A new approach to a common problem is developed.

This wasn't an occasional occurrence, Hammes added, but rather a highly common problem-one he found to exist around the world.

"I went to our ethics committee and said that this not only appears to be a widespread problem, but it is also preventable." He received support from the ethics committee to start a trial program addressing the issue.

He began working with patients that were in end-stage kidney failure and on dialysis.

"It was my experience that even when people filled out documents specifying guidelines for care, the mere completion of the documents did not necessarily help. Just because you had filled out the forms didn't mean that you had discussed your preferences with your family or that you had made an informed decision that would coincide with the family's values and goals."

Hammes wanted to have a discussion with patients and families to assure that they understood what a patient's future might look like if possible complications occurred following treatment.

The staff at the hospital had various concerns: Who would direct these conversations, who would participate, when would you do it, what issues would you talk about, and what would be recorded so that decisions or preferences would be documented?

It is a fallacy that more care extends life.

"We're in the midst of drafting a book on end-of-life health care in collaboration with the Center for Health Care Transformation, which was started by Newt Gingrich. One common fallacy in this area is that more care extends life. With a fuller understanding of the range of patient choices better outcomes can result. Hospice care and palliative treatment rather than continued acute-care, can, in fact, help people live longer and with a significantly better quality of life."

People are willing and interested to discuss end of life care.

As a result of their trial project Gundersen Lutheran found that people were quite willing to talk about future health care decisions including end-of-life care. With their initial kidney failure population some patients that began to have complications determined that if there was not a reasonable likelihood of getting better, they did not want to continue treatment.

"Against a rather high degree of skepticism we showed that could happen."

In the early 1990's the presidents of Gundersen and Franciscan began meeting regularly to see how they could collaborate on the health of the community. In 1991, the executives of all the major health organizations decided to take the pilot program with renal failure patients and begin offering it to all of the La Crosse community. Hammes was appointed the chairman of the community task force and led the initiative that has since become Respecting Choices.

Patient and family satisfaction increases with Respecting Choices.

"The task was to develop a process that would help patients effectively plan for end-of-life care. The success of this kind of planning was demonstrated in one of the most exhaustive studies on the topic published last year in the British Medical Journal. What this study showed is the people doing end-of-life planning in advance of critical illness are far more satisfied with their care than those that don't. It makes people feel as if they're part of the medical care team and that they're really listened to. It starts to make patient care much more patient-centered."

Another positive outcome of advance care planning affects the family, Hammes said. As the end of life approaches and as families deal with the difficult questions that often arise, those families that have worked out a plan ahead of time fare much better after the death of their loved one. The study showed that there was a lower incidence of stress and depression among those that did advance planning.

"These findings didn't strike me as surprising," Hammes said, "because that is exactly the goal I had when I first got involved in this effort."

Respecting Choices saves money.

"One of the most well-known outcomes of this study I know you are particularly interested in," Hammes said. Most patients, when doing the planning, identify areas where they would like to limit care. Usually this means they prefer not to return to the hospital for acute care when that additional care will either increase their suffering or have no positive effect on their condition. Under these conditions, they would rather remain in their home.

"Because of the way health care operates today, and with many once-fatal illnesses no longer untreatable as in the past, most of us will die of longer-term chronic illness," Hammes said. "And most of us will want to be able to say, 'the next treatment is not worth it.' Many are choosing to do just that."

This lets the care providers know when to stop-and lets the patient direct when the care should stop. At present Hammes said health care professionals often don't know when that point is, so patients are put through misery that they may not have wanted and spend money they may not have to spend.

"This improves quality of care, quality of life, and overall cost, and benefits the family in lessening the stress of an already difficult emotional time," Hammes said.

The program is now part of a pilot Medicare project for treating people in the final two years of life. This pilot provides a nurse care coordinator who can hasten access to staff to help facilitate end-of-life decision-making. Advocates believe the program has the potential to save thousands of dollars per year on individual health care costs. It saves this money NOT by denying care to patients, but rather by allowing patients to make informed decisions about their own care and treatment.

The current health care system does not offer incentives for this kind of activity.

What is your incentive to run this program, a participant asked-doesn't it just decrease the volume of your services and hence your income?

That's a good question, Hammes observed-and a common one. He recalled the speeches he makes to medical groups. Physicians always seem to respond well to the tenets of the program. Yet, "At some point someone from the financial side will say, 'Let me get this straight: you want us to train people, have professionals spend time that doesn't get reimbursed, and decrease our volume? Where's the business plan in this?'"

That reaction is a bit tongue-in-cheek, he said, because many of these patients are on Medicare, which is a capitated funding source and many are high-utilization patients for whom you will not be fully reimbursed. So with those patients there is indeed an economic incentive to avoid expensive, unnecessary or unwanted services whenever it is also in the patients' best interest to do so.

A similar program in Minnesota is underway.

Following a meeting he had with Minnesota care providers, Hammes said he and his colleagues have been working with Twin Cities Medical Society in Minnesota to bring a similar end-of-life planning program into our state. He has been working closely with that group's Honoring Choices Minnesota program (<http://tinyurl.com/3vbtasl>), a metro area effort to promote end-of-life discussions and help health care organizations facilitate in-house advance planning for end-of-life care. The Citizens League is a partner in Honoring Choices Minnesota.

The program needs to ensure that physicians follow patients' wishes.

A member observed that it had been her experience that if a doctor disagrees with a patient's health care directive he or she does not always adhere to them. There appears to be a fundamental dichotomy between the culture of physicians focused, sometimes obsessively, on saving lives and a more humane approach allowing someone to choose to move gracefully from life to death.

"These plans necessarily matter a lot to everyone involved," Hammes emphasized. The Gundersen program has a mechanism that requires any doctor who might disagree with a patient's choice to have a consult with the ethics committee. "They go to that committee before altering the plan for care. We got a couple of these ethics consults each month at the beginning. Now it's uncommon for physicians to override a patient's clear preference."

The La Crosse hospitals have peer review as well, as most hospitals do, and if there is a death the committee looks to the directives of the patient and determines whether they were followed. If they see that the wishes of the patients were not followed, then the physician must be held accountable.

"We've really come to the point that this respect for patients' end-of-life decisions is an integral part of our organization's shared values."

Using non-physicians is key to facilitating the discussions.

A participant asked: Does the system provide enough information to the patients about risks and aftereffects? Contingencies seem often not to be discussed.

"I agree," Hammes replied, "and that's one of the reasons why in the Respecting Choices approach we use non-physicians to facilitate the discussions. A doctor once said that 'we haven't been trained in this-we've only been trained to say 'if you don't do this, you're going to die.'" This approach of talking about other potential outcomes is not always compatible with physician training, which is so very focused on extending life. Physicians often also don't have the 60-90 minutes to have these complicated conversations. Training non-physicians who work closely with the patient's physicians is a great solution because the patient gets the assistance he or she needs to make the decisions, including access to the physician when specific medical issues arise.

Begin the politics locally for end-of-life planning.

A member asked Hammes how he is engaging the politics of end-of-life planning-particularly in light of the debates that led up to changes to the federal health care law and all the talk of "death panels".

"This has definitely become a third rail for politicians, a topic that is in many cases 'untouchable,'" Hammes replied. "In recent years I have had many politicians say they support it but don't want to publicly endorse it. I believe that on a local level these issues can be discussed more openly because of the trust relationships that exist among people within a community. Recently Honoring Choices Minnesota held a meeting at an Evangelical congregation, and the pastors attending supported the program. So there appears to be widespread interest across ideological lines. But the community conversation must begin with trust and keep focused on how we can improve our health system to take better care of the sickest patients/people."

C. Closing

To close, Hammes said that to implement this kind of program it is important to start in the local community. "During the uproar of death panels, a bi-partisan group of locals announced that they were having a 'death panel party'-they realized that they had not laid out their end-of-life plans, so came to the party dressed as their favorite historic figures and together straightened out all their health care directives and powers-of-attorney. It helps to look on this as an opportunity to do something positive. It is not about rationing care; it is about honoring choices."

"We really need to change our language in this business. We need to talk about the quality of living even in the last days of our life. That would help people cope so much more effectively with this life-to-death cycle that we all are part of."

Thanks to Hammes for a good overview of this important issue.