

The New York Times - January 23, 2007

PERSONAL HEALTH

A Humorist Illuminates the Blessings of Hospice

By **JANE E. BRODY**

As the self-described “man who would not die,” the humor columnist [Art Buchwald](#) was a strange bedfellow with the hospice movement. But in the months between the end of his extended hospice stay and his death from kidney failure on Wednesday at age 81, Mr. Buchwald was a living testimonial to the benefits of hospice care.

What he hoped to do, he wrote in his recently published book, “Too Soon to Say Goodbye” (Random House, 2006), was make “hospice” a household word. “Unless they’ve had some experience with it, the hospice is still a mystery to most people,” he wrote. “Because hospice deals with death, people tend not to talk about it.”

Early last year, Mr. Buchwald wrote, after his kidneys failed, after he lost half a leg and after doctors told him he would have to be on dialysis for the rest of his life, he decided “enough already.” So he moved from a critical care bed to a comfortable room in a lovely hospice in Washington, D.C., to await his death, which his doctor expected would come in a few weeks.

But Mr. Buchwald managed to charm the Angel of Death. He did not die. Instead, his kidneys rebounded while he entertained a steady stream of visits from the rich and famous and ordinary in his hospice living room. And while his doctors said his kidneys would surely crash again soon, they did not. Finally, after five months of having “a swell time — the best time of my life,” Mr. Buchwald checked himself out of hospice to resume an ordinary life of a famous old funny man.

He continued to write his column and he worked on his book, in which he provided a first-hand account of the advantages of hospice.

“The hospice gives a person the opportunity to die with dignity,” he wrote. “It provides care, help, and as much comfort as possible.”

And not just for the person who is dying. As Mr. Buchwald described his experience, “When the patient enters the hospice, an entire team sets to work to meet the family’s needs — a doctor, a team of nurses, a case manager, a social worker, a chaplain, a nursing assistant, a bereavement coordinator, and of course, the volunteers,” who give nurses more time to spend with patients by answering phones, screening calls and running errands.

An Underused Service

Hospice services, in institutional settings or at home, benefit only about one person in three who dies in this country. “There are still over one million Americans who die each year without receiving hospice or hospice-type services that would have benefited them and their families,” according to a report, “Access to Hospice Care,” produced in 2003 by the Hastings Center.

And for most who do get hospice care, the benefit is short-lived, with the average patient receiving care for less than three weeks, 1 person in 3 for the last week of life, and 1 person in 10 for the last day of life.

With time in hospice so short, staff members often lack the opportunity to provide optimum care for a dying patient's physical and emotional needs. It can take days or weeks to determine the best way to control a patient's pain, to help a patient tie up life's loose ends and to fulfill a patient's spiritual and emotional needs.

The most common report from families after a loved one's death is regret that hospice had not been called in sooner. In a study of 275 patients, families that benefited from hospice thought three months would have been optimal and that less than three weeks was too short.

There are several reasons that more patients do not go into hospice care earlier. One is the Medicare-dictated requirement that patients entering hospice forgo life-prolonging treatment for their disease and waive coverage that would pay for such treatment. Some patients or their families refuse to stop therapy for a fatal disease, even when it is obviously not helping.

Only comfort care is covered through the hospice benefit, and patients sometimes have to fight for therapies to control distressing symptoms, like blood or platelet transfusions, that may coincidentally prolong their lives.

Medicare also requires that the doctor referring someone for hospice care must certify that the patient is expected to die within six months. Doctors — as was the case with Mr. Buchwald — are notoriously poor at predicting life expectancy unless patients are within days or hours of death. And for most life-threatening chronic diseases — congestive heart failure, kidney failure — it is impossible to predict longevity with the precision that Medicare requires.

Some doctors fear allegations of fraud if patients they refer to hospice do not die within six months, and so are afraid to make an early referral even when patients are ready to end life-prolonging treatments. And, as the Hastings report noted, "Fearing denial of reimbursement and ensuing financial difficulties, some hospice programs are denying access to those whose condition is not worsening or who might stay for so long that they would bring regulatory scrutiny upon the hospice agency."

Finally, there are simply not enough hospice centers and services available to meet the needs of dying patients throughout the country. Most hospices operate on a shoestring, supported by donations as well as reimbursements from Medicare and private insurers. Insurers rarely cover the full costs of operating a well-run hospice service. Yet good hospice care costs far less than treatment of dying patients in hospital intensive care units, which insurance does cover.

Understanding End-of-Life Care

The philosophy of hospice is to neither hasten nor postpone death. As Dr. Matt Kestenbaum, the medical director of Mr. Buchwald's hospice, put it: "We're not here to pull the plug. We let nature take its course, and we give patients all the things they need to be comfortable."

Dying “naturally” in hospice does not preclude treatment for common complications like blood clots, urinary tract or respiratory infections or painful bone metastases from advanced [cancer](#). Hospice expenses are automatically covered by Medicare. Most employer-based and private insurers provide hospice coverage as well.

Choosing hospice care does not mean patients lose the services of their personal doctors. Nor are they penalized if, like Mr. Buchwald, they leave hospice care because their condition improves or they want a therapy the hospice does not provide. They can return to regular insurance benefits, and should the need arise later, they can reinstate hospice benefits.

One concern of doctors is that patients will lose hope if they go into hospice. But the goal should be to refocus hope on what might be realistically achieved in the time remaining. A patient who enters hospice sooner rather than later can have the opportunity to spend quality time with family and friends, settle unfinished business and find closure to strained relationships.

For those who wish to obtain hospice care at home, it is essential to have a caregiver — usually a spouse or other family member, or a partner or friend — who is willing and able to take primary responsibility for the patient, assisted by the hospice team. For patients who need nursing home care, there are many hospices that have contracts with local nursing homes.

Ideally, patients or families should research hospice options well in advance of needing them. Check the Web site for the National Hospice and Palliative Care Organization, www.nhpco.org, and click on Find a Provider. Or call (703) 837-1500. The Web site provides a list of questions to ask when seeking hospice services.