

StarTribune Editorial

Our perspective

Hospice

A better way to end a life

Becky Pansch sits at the bedside of the dying schoolteacher. "So what shall we sing?" she asks. "Perhaps 'The Red River Valley' — did you sing that to your students?"

The frail woman grabs anxiously at her quilt, stares uncomprehendingly and talks a little nonsense. Pansch moves her folding piano closer to the woman's bed, and soon a silky voice fills the tiny bedroom: "From this valley they say you are going . . ."

The old woman's blue eyes lighten with recollection, with fascination. She relaxes, lies back with a smile. It is as though an angel has come to sing for her.

This is what Becky Pansch does for a living — carting her electronic piano from house to house, singing her heart out to dying strangers. She works for Fairview Home Care and Hospice, and she and her colleagues spend their days dropping in on dying people all over town. They offer up massage and music and medicine and consolation and company — and whatever else is necessary to make life's last days as full of grace as they can be.

What they're offering, really, is another way of dying — a way that's hard to come by in a hospital. There, dying can be painful and lonely and long. It is interpreted not as life's last act, but as a sign of failure. Death comes surging over the sandbags of medicine, snatching its gasping victims from the hands of their protectors.

That kind of calamitous death is uncommon in palliative-care programs. The nurses, home health aides, social workers, chaplains, therapists, physicians and volunteers of the hospice movement don't see death as a disaster. They believe that it's no more an enemy than birth, that resisting it can often be pointless and painful.

And they see something else that doctors sometimes can't: that healing need not end — must not end — when curing is impossible. Forsaking the medical establishment's reflexive attempts to delay death, they help patients find comfort and meaning in their last days. They reject the notion that life's end is invariably grim and grueling and silent. Quite the contrary: With suffering relieved, hospice workers say, it can be a time of great intimacy and discovery and even joy — for the dying and those who stay with them.

Dying is hard work in the best of times, and hospice workers insist no one should have to do it alone. As Sandol Stoddard, author of "The Hospice Movement," argues, "Dying, like birthing, is a process requiring assistance. It is an event that asks us to be present for one another with heart and mind . . ." In short, it's an experience that calls for a midwife.

This is a philosophy that transcends place. Thus it makes sense that the term "hospice" usually refers not to a building where people go to die, but to a way of caring for the dying. Hospice workers care for patients wherever they happen to be — and most of the time, they can be well comforted at home. When pain gets out of hand or family members can't cope, patients can spend short stints at inpatient facilities. Medicare picks up most hospice costs — as long as a doctor certifies that a patient is likely to die within six months.

You'd think that such a humane and sensible approach to end-of-life care would be popular. But though the nation has more than 2,500 hospice programs, only 15 percent of the 2.4 million Americans who die every

Learning to die

Rethinking one's care at life's end

year choose to use them.

Why so few? Much of the explanation lies in the American insistence on postponing death — an attitude obviously incompatible with the notion of welcoming it. Doctors who see a terminal diagnosis as an admission of failure aren't likely to refer patients to hospice care. Patients, too, tend to think of entering a hospice program as a sign of surrender, of giving in to death rather than milking every last drop out of life.

Dr. Ronald Cranford, an ethicist and neurologist at Hennepin County Medical Center, notes another subtle stifling force: "There's money to be made in treatment," he says, "but not much money in nontreatment. Dying is not lucrative; hospice is not lucrative. It takes a little time and effort to let patients die humanely, and doctors don't have the time. It's much easier to treat patients and move on."

And the hospice movement must brook the suspicion not just of the medical establishment, but of regulators as well. Eager to ferret out fraud and abuse in the Medicare system, the U.S. Department of Health and Human Services has recently mounted an effort to recover \$83 million in payments from a dozen hospices whose patients outlived the six-month benefit limit imposed by federal rules.

Predicting how long a terminally ill person will last has always been a chancy business. Even so, more than 90 percent of all hospice patients die within the six-month "deadline"; half die within 36 days of enrollment. Going after the few who don't die as quickly as expected is coldhearted and unnecessary.

It's also counterproductive, because it threatens to scare dying patients away from the one program most likely to help them. Some hospice programs are already blaming the new regulatory crusade for a downturn in referrals. One local inpatient hospice — Midwest Community Hospice in Minneapolis — has experienced such an enrollment drop lately that it's been forced to lay off staff.

There's no sense in pinching these pennies. Hospice care, after all, is far cheaper than conventional care for the dying. A study released last year found that Medicare saves \$1.52 for every dollar it spends on hospice.

But the real promise of the hospice philosophy has less to do with thriftiness than with liberation. As Hennepin County's Cranford argues, "People feel they're prisoners of medical technology, and they want an escape." Some Americans are seizing upon euthanasia as the surest exit. But most would shake off that idea if a hospice death were within reach.

Whenever they suffer — wherever they die — human beings deserve the calm and comfort of palliative care. That kind of compassionate treatment ought to be a preoccupation of medical education and of medical care. It should be a fixture in every hospital ward, in every health-insurance plan, in every government health-care policy.

Surely society has more to offer at the end of life than a ventilator or a visit with Dr. Kevorkian. Somehow, it must open the door to a third possibility: a good death.