Lessons from End-of-Life Care in Oregon

TO THE EDITOR: Tolle and Teno (March 16 issue)1 address the glaring deficiencies in the delivery of end-of-life care in the United States. The considerable benefits that the Physician Orders for Life-Sustaining Treatment (POLST) Program in Oregon provided its patients and health care system were encouraging, but these findings must be viewed with skepticism since Oregon is predominantly white (87.6% of the population) and historically whites have been more accepting of end-of-life care than nonwhites.2-4 The authors address this concern by comparing Oregon with Washington, a neighboring state that has “comparable demographic features,” but Washington has twice as many blacks as Oregon and a considerably lower percentage of whites (80.3%).5 The authors then compare end-of-life outcomes in Oregon with those in the rest of the nation, which has an even lower percentage of whites (77.1%).5

As compared with whites, blacks and persons of other racial minority groups are more likely at the end of their lives to use intensive care and life-sustaining treatments and to die in the hospital and are less likely to receive comfort-directed care.2-4 It is for these reasons that we question whether the experience in Oregon can be extrapolated to the rest of the United States.

The authors reply: In the face of an aging population, we call for public policy and local efforts to embrace the complexity of improving care at the close of life. The POLST Program in Oregon is more than just a form. The replication of a multifaceted intervention must take into account the unique circumstances of a new geographic region. It is difficult to disentangle the reasons for the observed difference. However, lack of certainty should not stop efforts to improve care.

Even after adjustment for age, race, and sex, the differences shown in Figure 1 of our article persist; for example, persons dying in Oregon were less likely than those in the rest of the United States to use an intensive care unit in the last month of life (adjusted odds ratio, 0.56; 95% confidence interval, 0.54 to 0.59).

Attributing differences to race does not acknowledge recent advances. Interventions addressing health literacy to ensure authentic preferences,1 similar rates of POLST Program completion among racial groups,2 and a reduction between 2000 and 2014 in the incidence of feeding-tube use among blacks with advanced dementia3 provide evidence of continued efforts to ensure that care is consistent with a person’s informed preferences regardless of age, sex, or race.

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