



United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 111th CONGRESS, FIRST SESSION

Vol. 155

WASHINGTON, MONDAY, MARCH 30, 2009

No. 53

House of Representatives

The House met at 12:30 p.m. and was called to order by the Speaker pro tempore (Ms. JACKSON-LEE of Texas).

DESIGNATION OF SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
March 30, 2009.

I hereby appoint the Honorable SHELLA JACKSON-LEE to act as Speaker pro tempore on this day.

NANCY PELOSI,
Speaker of the House of Representatives.

MORNING-HOUR DEBATE

The SPEAKER pro tempore. Pursuant to the order of the House of January 6, 2009, the Chair will now recognize Members from lists submitted by the majority and minority leaders for morning-hour debate.

The Chair will alternate recognition between the parties, with each party limited to 30 minutes and each Member, other than the majority and minority leaders and the minority whip, limited to 5 minutes.

LIFE SUSTAINING TREATMENT PREFERENCES ACT

The SPEAKER pro tempore. The Chair recognizes the gentleman from Oregon (Mr. BLUMENAUER) for 5 minutes.

Mr. BLUMENAUER. Madam Speaker, as we approach health care reform, there is no area that is more vital for honest discussion and careful analysis than what happens at end of a patient's life. For most of us, we will get the majority of our lifetime health care in that last year. Indeed, for many it is just the last few months of life, we use the most doctor care, the most intervention in terms of medical proce-

dures, the most days in a hospital. This is clearly the time of greatest stress both for the patient and the family as they watch their loved one enter what is often a struggle in these last few months.

The evidence is that this is the hardest period to be able to make those critical decisions. We don't want to force spur-of-the-moment action for families when they are talking about things that have great consequence for the quality of life for not just a "patient" but a family member, the ability to extend the quality of life, and perhaps deal with recovery. This is also the worst time for people to go on autopilot check out, to have a default option where they just turn decisions over to whatever the local medical activity may be on that site without a thought and consequence to what the individual wishes of the patient and their family may be.

There is strong evidence that in many cases the very intensive activities—the tubes, the procedures, the operations, the ventilators—actually don't prolong life, and they certainly impact in a negative sense the quality of life, the way that the patient may be able to interact with their family and friends in those last few days and their mind-set and their pain level.

This research has sparked action from coast to coast. Many States have developed a new end-of-life care directive called Orders For Life Sustaining Treatment. They are being developed in over 30 States. They help the seriously ill patient identify their treatment preferences using clear, standardized language. It is written as actionable medical orders signed by a physician, and they help communicate patient preferences regarding the intensity of medical intervention, transfers to hospitals, use of antibiotics, artificially administered nutrition and resuscitation.

Members of my family and I have concluded that we don't want those ex-

traordinary measures as our default, and have signed instructions accordingly.

What we find, however, is that too many people don't have access to the counseling and activities for them to be able to make an informed decision. The irony is that the Medicare system will spend thousands and thousands of dollars on intense medical intervention, intense medical activities, but they won't spend a few dollars to pay a doctor to have a conversation with a patient and the family about what they can expect, what their choices are, and to be able to engage with the patient and the family to decide what they want to have happen.

I guess that we don't do it to save money; but the evidence suggests that when people actually have a choice, they choose things that not only improve their quality of life, but actually save money. Why don't we give individual patients and their families that choice under Medicare?

That's why I will be introducing the Life Sustaining Treatment Preferences Act which will provide coverage under Medicare for consultations regarding end-of-life treatment options. It is time for Medicare to be able to address the needs that will truly reflect the preferences, the wishes, and the quality-of-life choices for Medicare patients and their families. It is the humane, compassionate thing to do. It will help us allocate our health care resources more appropriately to treat what people want, and it will relieve the pressure on the health care system so the default isn't always the most intensive, expensive interventions that often deteriorate the quality of life in those final days.

I would urge my colleagues to look at this option and join me in making sure that we modernize Medicare to meet the needs of patients and their families in their final hours.

This symbol represents the time of day during the House proceedings, e.g., 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.



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