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The Case for Killing Granny

Rethinking end-of-life care.

By **Evan Thomas** | NEWSWEEK
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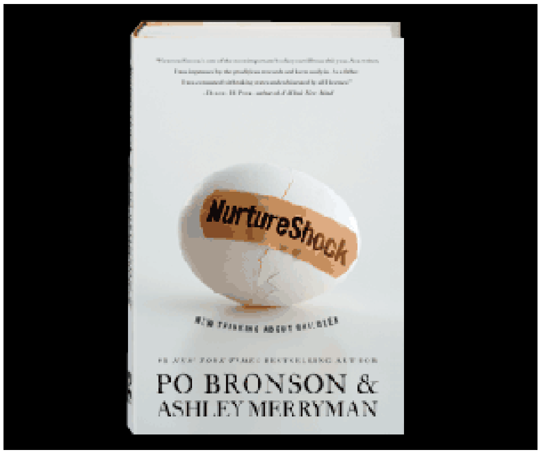
My mother wanted to die, but the doctors wouldn't let her. At least that's the way it seemed to me as I stood by her bed in an intensive-care unit at a hospital in Hilton Head, S.C., five years ago. My mother was 79, a longtime smoker who was dying of emphysema. She knew that her quality of life was increasingly tethered to an oxygen tank, that she was losing her ability to get about, and that she was slowly drowning. The doctors at her bedside were recommending various tests and procedures to keep her alive, but my mother, with a certain firmness I recognized, said no. She seemed puzzled and a bit frustrated that she had to be so insistent on her own demise.

The hospital at my mother's assisted-living facility was sustained by Medicare, which pays by the procedure. I don't think the doctors were trying to be greedy by pushing more treatments on my mother. That's just the way the system works. The doctors were responding to the expectations of almost all patients. As a doctor friend of mine puts it, "Americans want the best, they want the latest, and they want it now." We expect doctors to make heroic efforts—especially to save our lives and the lives of our loved ones.

The idea that we might ration health care to seniors (or anyone else) is political anathema. Politicians do not dare breathe the R word, lest they be accused—however wrongly—of trying to pull the plug on Grandma. But the need to spend less money on the elderly at the end of life is the elephant in the room in the health-reform debate. Everyone sees it but no one wants to talk about it. At a more basic level, Americans are afraid not just of dying, but of talking and thinking about death. Until Americans learn to contemplate death as more than a scientific challenge to be overcome, our health-care system will remain unfixable.



Compared with other Western countries, the United States has more health care—but, generally speaking, not better health care. There is no way we can get control of costs, which have grown by nearly 50 percent in the past decade, without finding a way to stop overtreating patients. In his address to Congress, President Obama spoke airily about reducing inefficiency, but he slid past the hard choices that will have to be made to stop health care from devouring ever-larger slices of the economy and tax dollar. A significant portion of the savings will have to come from the money we spend on seniors at the end of life because, as Willie Sutton explained about why he robbed banks, that's where the money is.

As President Obama said, most of the uncontrolled growth in federal spending and the deficit comes from Medicare; nothing else comes close. Almost a third of the money spent by Medicare—about $66.8 billion a year—goes to chronically ill patients in the last two years of life. This might seem obvious—of course the costs come at the end, when patients are the sickest. But that can't explain what researchers at Dartmouth have discovered: Medicare spends twice as much on similar patients in some parts of the country as in others. The average cost of a Medicare patient in Miami is $16,351; the average in Honolulu is $5,311. In the Bronx, N.Y., it's $12,543. In Fargo, N.D., $5,738. The average Medicare patient undergoing end-of-life treatment spends 21.9 days in a Manhattan hospital. In Mason City, Iowa, he or she spends only 6.1 days.

Maybe it's unsurprising that treatment in rural towns costs less than in big cities, with all their high prices, varied populations, and urban woes. But there are also significant disparities in towns that are otherwise very similar. How do you explain the fact, for instance, that in Boulder, Colo., the average cost of Medicare treatment is $9,103, whereas an hour away in Fort Collins, Colo., the cost is $6,448?

The answer, the Dartmouth researchers found, is that in some places doctors are just more likely to order more tests and procedures. More specialists are involved. There is very little reason for them *not* to order more tests and treatments. By training and inclination, doctors want to do all they can to cure ailments. And since Medicare pays by procedure, test, and hospital stay—though less and less each year as the cost squeeze tightens—there is an incentive to do more and more. To make a good living, doctors must see more patients, and order more tests.

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All this treatment does not necessarily buy better care. In fact, the Dartmouth studies have found worse outcomes in many states and cities where there is more health care. Why? Because just going into the hospital has risks—of infection, or error, or other unforeseen complications. Some studies estimate that Americans are overtreated by roughly 30 percent. "It's not about rationing care—that's always the bogeyman people use to block reform," says Dr. Elliott Fisher, a professor at Dartmouth Medical School. "The real problem is unnecessary and unwanted care."

But how do you decide which treatments to cut out? How do you choose between the necessary and the unnecessary? There has been talk among experts and lawmakers of giving more power to a panel of government experts to decide—Britain has one, called the National Institute for Health and Clinical Excellence (known by the somewhat ironic acronym NICE). But no one wants the horror stories of denied care and long waits that are said to plague state-run national health-care systems. (The criticism is unfair: patients wait longer to see primary-care physicians in the United States than in Britain.) After the summer of angry town halls, no politician is going to get anywhere near something that could be called a "death panel."

There's no question that reining in the lawyers would help cut costs. Fearing medical-malpractice suits, doctors engage in defensive medicine, ordering procedures that may not be strictly necessary—but why take the risk? According to various studies, defensive medicine adds perhaps 2 percent to the overall bill—a not-insignificant number when more than $2 trillion is at stake. A number of states have managed to institute some kind of so-called tort reform, limiting the size of damage awards by juries in medical-malpractice cases. But the trial lawyers—big donors to the Democratic Party—have stopped Congress from even considering reforms. That's why it was significant that President Obama even raised the subject in his speech last week, even if he was vague about just what he'd do. (Best idea: create medical courts run by experts to rule on malpractice claims, with no punitive damages.)

But the biggest cost booster is the way doctors are paid under most insurance systems, including Medicare. It's called fee-for-service, and it means just that. So why not just put doctors on salary? Some medical groups that do, like the Mayo Clinic, have reduced costs while producing better results. Unfortunately, putting doctors on salary requires that they work for someone, and most American physicians are self-employed or work in small group practices. The alternative—paying them a flat rate for each patient they care for—turned out to be at least a partial bust. HMOs that paid doctors a flat fee in the 1990s faced a backlash as patients bridled at long waits and denied service.

Ever-rising health-care spending now consumes about 17 percent of the economy (versus about 10 percent in Europe). At the current rate of increase, it will devour a fifth of GDP by 2018. We cannot afford to sustain a productive economy with so much money going to health care. Over time, economic reality may force us to adopt a national health-care system like Britain's or Canada's. But before that day arrives, there are steps we can take to reduce costs without totally turning the system inside out.

One place to start is to consider the psychological aspect of health care. Most people are at least minor hypochondriacs (I know I am). They use doctors to make themselves feel better, even if the doctor is not doing much to physically heal what ails them. (In ancient times, doctors often made people sicker with quack cures like bleeding.) The desire to see a physician is often pronounced in assisted-living facilities. Old people, far from their families in our mobile, atomized society, depend on their doctors for care and reassurance. I noticed that in my mother's retirement home, the talk in the dining room was often about illness; people built their day around doctor's visits, partly, it seemed to me, to combat loneliness.

Physicians at Massachusetts General Hospital are experimenting with innovative approaches to care for their most ill patients without necessarily sending them to the doctor. Three years ago, Massachusetts enacted universal care—just as Congress and the Obama administration are attempting to do now. The state quickly found it could not afford to meet everyone's health-care demands, so it's scrambling for solutions. The Mass General program assigned nurses to the hospital's 2,600 sickest—and costliest—Medicare patients. These nurses provide basic care, making sure the patients take their medications and so forth, and act as gatekeepers—they decide if a visit to the doctor is really necessary. It's not a perfect system—people will still demand to see their doctors when it's unnecessary—but the Mass General program cut costs by 5 percent while providing the elderly what they want and need most: caring human contact.

Other initiatives ensure that the elderly get counseling about end-of-life issues. Although demagogued as a "death panel," a program in Wisconsin to get patients to talk to their doctors about how they want to deal with death was actually a resounding success. A study by the *Archives of Internal Medicine* shows that such conversations between doctors and patients can decrease costs by about 35 percent—while improving the quality of life at the end. Patients should be encouraged to draft living wills to make their end-of-life desires known. Unfortunately, such paper can be useless if there is a family member at the bedside demanding heroic measures. "A lot of the time guilt is playing a role," says Dr. David Torchiana, a surgeon and CEO of the Massachusetts General Physicians Organization. Doctors can feel guilty, too—about overtreating patients. Torchiana recalls his unease over operating to treat a severe heart infection in a woman with two forms of metastatic cancer who was already comatose. The family insisted.

Studies show that about 70 percent of people want to die at home—but that about half die in hospitals. There has been an important increase in hospice or palliative care—keeping patients with incurable diseases as comfortable as possible while they live out the remainder of their lives. Hospice services are generally intended for the terminally ill in the last six months of life, but as a practical matter, many people receive hospice care for only a few weeks.

Our medical system does everything it can to encourage hope. And American health care has been near miraculous—the envy of the world—in its capacity to develop new lifesaving and life-enhancing treatments. But death can be delayed only so long, and sometimes the wait is grim and degrading. The hospice ideal recognized that for many people, quiet and dignity—and loving care and good painkillers—are really what's called for.

That's what my mother wanted. After convincing the doctors that she meant it—that she really was ready to die—she was transferred from the ICU to a hospice, where, five days later, she passed away. In the ICU, as they removed all the monitors and pulled out all the tubes and wires, she made a fluttery motion with her hands. She seemed to be signaling goodbye to all that—I'm free to go in peace.

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