POINT

Healthcare Reform, Classicism, and How We Treat the Elderly:
The Politics of Epidemiology

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It wasn’t supposed to happen this way. The 1000-page House of Representatives healthcare reform bill, “America’s Affordable Health Choices Act,” was supposed to follow the new Congressional passage sequence: distribute it to all the usual suspects, read it on the cab ride to the hotel, and immediately sign it into law. So when Congressional members on both sides of the aisle started boring into the draft of the bill and came back with concern over language that only suggested a troubling threat to seniors, political veterans were caught off guard. Since then, with protests ringing across the country at town hall meetings and every other conceivable venue, it has become clear that Americans want a healthcare system bent on healing.

The immediate concern was over the now infamous end-of-life counseling provision, Section 1233, which would have authorized Medicare to pay for a consultation between a patient and doctor or nurse about how much or how little medical care is desired in the event of incapacitation, informing patients about the benefits of hospice and palliative care. At first blush, there was nothing alarming here. Providers and payers have been wrestling to draw the line between aggressive care for the terminally ill and the pointless, wasteful use of costly drugs that do little to improve or extend life in terminally ill patients. But there is an existing context for this language and the net effect of other provisions in the House bill that are intended to ration care, which would lead to the same result: an early and cost-effective death, hospice-oriented care for the elderly and the rationing of care, is government embracing a regressive healthcare system? Is government’s healthcare vision one of reduced access to care for the elderly and infirm, coupled with reduced development of new life-saving drugs because payer coverage strategies are skewed against coverage of branded medications, the profits of which are needed for innovation? If this is the picture, would the affluent consent to the terms that a regressive healthcare system proffers to the public at large? Would the wealthy accept a government mandate that says “it is your turn to die”? Be it death counseling or rationing, the end goal is the same: death is good for the bottom line.

Before concluding that this cannot happen here, consider that fiercely pragmatic civilization, ancient Rome, which relied on the widespread use of death to achieve practical ends. Her brutal exaltation of the state over the individual was evident in its mass executions—Julius Caesar had his troops execute 50,000 Celtic soldiers.
It's preposterous that they adopt the same strategy. Disease is not invincible armys by an unshakable resolve to win. Their approach was simple: the enemy was out to annihilate America, and surrender was not an option. As politicians set out to assist the healthcare system, it is imperative that they adopt the same strategy. Disease is not something to run from, but to address head on. Ultimate solutions for solving the entire picture do not constitute reform, just utopianism. In a recent appearance on Charlie Rose, Mayo Clinic CEO and President Denis Cortese advised we undertake healthcare reform one chunk at a time, not all at once. He also faulted the bill for its emphasis on cost-containment instead of balancing this with quality; combine them and you have value, not just cost-savings, he warned.

The ultimate abdication from quality of care is the restriction of access to care for the oldest and sickest, the facilitation of death via dehydration, starvation, avoidance of cardiac resuscitation or ventilator usage, or simply rationing care. The concern over the aforementioned consultations in the healthcare reform bill stems from apprehension over realpolitik, where cost trumps quality and politics trumps cost. Is the bill the first stage of a strategy to entice seniors to sign boiler-plate forms amounting to do not resuscitate (DNR)? If so, it is placing American healthcare on the slippery slope to icy utilitarianism. If not, then the language must clearly forbid it.

The American spirit of can-do that the Marines showed at Belleau Wood and Iwo Jima in World War II is the proper approach to American healthcare system reform. But first, government must stop trying to dominate the triangle of sectors (clinical, business, regulatory) and instead support the clinical and business systems. Periodically, each of these 3 sectors regards itself as the one with the answers and seeks hegemony over the system, when it is balance of power that is needed. Enlightened government is measured not by its power over citizens, but its protection of their liberty.

Government healthcare policy must avoid domination of the healthcare process and policies that encourage, and eventually mandate, terminally ill patients to die quickly and inexpensively. The language of the healthcare bill must be crafted to pursue healing, not dying. It must keep the emerging American healthcare system true to our positive core values—life, liberty, and pursuit of happiness—not QALYs. To be progressive and effective, the American healthcare system must embrace prevention, intervention, and innovation. Conspicuous by its absence is any fourth point called DNR. Instead of planning for an ultimate retreat from healthcare for seniors, policymakers should embrace strategies that encourage development of new drugs and devices that save lives and money spent when illness drives patients into nursing homes and hospitals. A society not committed to taking care of its elderly is essentially indecent and on its way out. We are better than that. We can and
Mr. Henry’s thoughtful comments raise serious concerns about the future of healthcare for the elderly. However, it is necessary to voice a response to some of these points.

I completely agree that we cannot allow ourselves to support a medical system that has the potential to abandon the elderly in time of need. We must be able to provide the necessary care for those individuals. However, I fully support efforts to have meaningful conversations with patients about their wishes at the end of their lives. Death is inevitable for all of us. Many patients (my wife and I are 2 of them) have strong beliefs that when faced with some terminal illnesses, we would prefer to have minimal treatment, be kept comfortable, and, hopefully, spend our final days in relative dignity rather than submit to futile and possibly uncomfortable treatment.

Case in point: A close family member has advanced Alzheimer’s disease. This person has not known anyone in the family for more than 2 years. In essence, the “death of the person” we knew and loved has already occurred, and we have already gone through many of the grieving stages over that loss. Death for her would be a blessing, and although we have ensured that she receives good care, we do not intend to take action to prolong her physical existence if a life-threatening event happens.

In our current healthcare environment, meaningful discussions between patients and their physicians about end-of-life care rarely occur. These discussions are difficult, and in a busy medical practice, it is often easier to avoid such difficult conversations with patients. However, an important aspect of care for patients with an end-stage illness is to discuss the level of care and intervention that such patients may want. Once that level of care is understood, the system must be poised to act according to those needs and wishes. On the one hand, if an elderly patient wants aggressive life-sustaining care, the system must be there to provide that care. On the other hand, if the patient wants to be kept comfortable and have only palliative treatment, the system needs to be able to honor that request also.

This is a matter of choice. All too often, patients, their families, and the physicians who care for them are faced with decisions about treatment near the end of life, without that discussion having taken place. In such situations the physician, unaware of the patient’s choice and values, often must choose to act aggressively, because the wishes of that patient are not known. In my clinical career, I have witnessed too many situations where care provided to the elderly to prolong the inevitable end point has been simply futile. The system cannot afford, either morally or financially, to continue to function as it has in the past. We definitely need a system to allow choice, and the only way to do that is to have open and honest discussions about those end-of-life choices before the event happens.

I agree with your concluding statement, “We must continue to define our healthcare system as one befitting a free people, a system supportive of progress and the health of its citizens, a system confident in the ability of science and physicians to find the cures needed to sustain our healthcare system.” Such a system must make care available to those who need it, yet it must respect the values of those patients who are faced with end-of-life treatment choices. By having discussions about these needs in advance of a crisis situation, we can accomplish both goals.

I invite all readers to comment on Mr. Henry’s interesting and thought-provoking points.