Peering Over the Ether Screen:
The Elephant in the Room

By Karen S. Sibert, M.D., Associate Editor

One of my partners recently sent out a call for an extra pair of hands to help out in the operating room—and with good cause. The patient on the OR table was a woman in her 60s whose massive stroke had left her hemiplegic, aphasic and unable to swallow. She weighed well over 400 pounds. Attempts to place a percutaneous endoscopic feeding tube had failed due to her size, and she was now scheduled for open gastrostomy tube placement under general anesthesia.

Even with two experienced anesthesiologists working on the patient, getting vascular access and an endotracheal tube in place wasn’t easy. She was anemic for reasons that weren’t fully worked up, and her blood pressure was alarmingly labile. At the end of the procedure, the patient could not be extubated, so she went to the ICU. As it turned out, she never left. The family could not agree on any reduction in the level of life support, and after a stormy five-week stay, she finally expired. The cost must have reached hundreds of thousands of dollars—resources drained away to sustain a patient who had no hope whatsoever of meaningful recovery.

This is really the elephant in the room in all the endless talk about health care costs in America, and it’s a subject that few policy makers will discuss in public: the amount of money that we spend fruitlessly on nonbeneficial end-of-life care. I am not talking about comfort measures, hospice care, palliative medicine, or any of the other valuable support functions that ease the process of dying. I’m talking about using the full technical and pharmacologic armamentarium available in our hospitals, and depleting the finite economic resources available for health care, in order to treat people who cannot be restored to any reasonable level of health, function, or quality of life.

In anesthesia, we see this problem every day. As consultants, we aren’t involved in the decision-making process, but we are the ones responsible for getting desperately ill patients through a variety of diagnostic and therapeutic procedures. There are days when not a single patient I look after is likely to survive six months, or in some cases, ever to leave the hospital.

Some procedures are palliative and are justified on humanitarian grounds alone—for example, talc pleurodesis for recurrent malignant pleural effusion, or pinning a painful hip fracture. Others are more questionable. How many lung biopsies on ventilated ICU patients ever lead to a diagnosis that changes the treatment plan and improves the outcome?
I bet that most anesthesiologists at some point have asked themselves the question, when faced with a terminally ill patient, “Why are we doing this?” Sometimes the answer is that the family is pushing to have “everything” done—out of loyalty, guilt, or an inability to face the inevitable. Sometimes it seems that the primary doctor is casting about to find something else to offer as a treatment, whether or not there is much likely benefit. Sometimes a deadening inertia takes over, and it involves more effort to stop doing things than it does to continue. (No one enjoys conferring with the hospital’s ethics committee.) Once everyone has agreed to schedule a procedure, the anesthesiologist hesitates to put any roadblocks in the way. Raising any objection will only upset the family. And, let’s be honest: in a fee-for-service system, cancelling the case will deprive both the surgeon and the anesthesiologist of income.

Lately there has been more public discussion about the millions of dollars we are spending on patients in the last months of life. Dr. Atul Gawande published a thoughtful article titled “Letting Go” in the August 2, 2010, issue of The New Yorker magazine. It focuses most on the experiences of relatively young cancer patients, and the difficulty of balancing quality of life and heroic treatment. Anesthesiologists have a different perspective. Many of our aging patients suffer from chronic problems that compound to the point where meaningful recovery is improbable. At what point does it become unreasonable to pursue further aggressive, costly treatment? Should intensive care units continue to evolve into premortem holding wards?

One of the saddest facts about the health care reform bill is that an important provision was deleted in the final negotiations: one that would have allowed Medicare to compensate doctors for time spent with patients and families to plan for end-of-life care. In the public hysteria over “death panels,” this provision was dropped. Certainly in managed care or “accountable care” systems, we must guard against an unethical incentive to reduce services or cancel cases just to save money. However, time-consuming counseling is critical so that patients and families can truly understand their options. This should occur with the patient and/or family well before the patient comes to the operating room. The fallback position inevitably is to “do everything,” wasting millions if not billions of dollars in the process.

A few months ago, I was scheduled to give anesthesia to a 99-year-old man for a cardioversion. He had come into the hospital with an exacerbation of congestive heart failure and now was feeling much better since his medications had been optimized. In fact, he was ready to go home. Although he already had a pacemaker, the cardioversion had been proposed because his underlying rhythm was atrial fibrillation, and it might slightly improve his cardiac output.
The patient was alert and delightful, but he weighed only 110 pounds and looked as fragile as a bird. He might do fine with a cardioversion, but the slightest complication (let alone CPR) almost certainly would be the end of him. For the first time in my more than twenty years in anesthesia, I pulled the brakes. I took the patient’s daughter into the hallway and said that if he were my father, I would put him in the car and take him home to enjoy the high holidays with his family. The daughter looked startled but relieved. The cardiologist had no objection, and said that cardioversion probably wouldn’t help much anyway. The patient and his daughter left. I was actually quite shaken up after the fact, hoping that I had done the right thing.

If anesthesiologists never speak up, are we doing our job as physicians? Or are we ignoring the elephant in the room, and furthering the uncontrolled consumption of medical care in the last weeks of life? There is only so much money available to pay for health care services. Our nation needs for physicians to make sure that we use our resources wisely and ethically, for care that brings true benefit.

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