What If It Were Your Mother?

What health care would you ask for?

by Richard D. Lamm

Let me answer for myself, up front, one of the most commonly asked questions in health care. What health care would you deny if it were your mother? My answer is the almost universal answer: Deny her nothing, I want her to have everything! Of course, we all would do everything to save a loved one.

But you cannot build a health care system, or any public system, a mother at a time. This is an unfair and unrealistic standard to hold public policy to. I would also want to locate a police station near my mother's home, and I would wish to double her Social Security check, and I want a flood light in her backyard, and an emergency response system in every room. And I would hope not to pay for any of it. But applied to all of our mothers, that road leads to national bankruptcy.

My wife had breast cancer with substantial lymph node involvement. I was frantic and did whatever it took to get her the best treatment. Thankfully, she recovered, but having a loved one with a critical health problem must be one of Dante's versions of hell. I would have spent any amount of money to buy even a marginal increase in survivability. But we all have mothers, and most of us have spouses and children: Can we all maximize their health on pooled money?

The "mother's test" is a good yardstick for your own money but not a sustainable yardstick for a health however heart felt. Every health plan must look dispassionately and intelligently at what is and what is not to be funded. They must set rules and parameters that apply to all their members equally: Mothers cannot be exempted. If some medical procedure is futile, or inappropriate, or has only a slight chance of succeeding, those procedures can legally and morally be excluded from coverage for all the membership. We can neither give mothers a different standard of care, nor can we bring up the standard of care for all subscribers to the "what if it were your mother" standard.

We are all free to provide our mothers extra safety, income, housing, clothes, but we cannot use either a health plan or government money to do so. When we pool funds, as we do with taxpayer monies or health premiums, we have to set and live by rational distribution rules. No commonly collected pool of funds (taxes or premiums) can maximize all beneficial care to all stakeholders. This is a reality that must be understood by both citizens and doctors.

American doctors were trained in a culture that maximizes everything in health care. As Hafdan Mahler, former head of the World Health Organization, noted: "Everywhere, it appears, health workers consider that the 'best' health care is one where everything known to medicine is applied to every individuals by the highest trained medical scientist in the most specialized institutions."

It goes without saying that this is an unsustainable yardstick. The price of doing something with commonly collected funds is always that we cannot do everything. The price of joint action is limits.

Both Medicare and health plans owe a duty to their policyholders, including our mothers, but not only our mothers. We cannot pay limited premiums and limited taxes and receive unlimited care. We cannot make our fondest hopes and dreams the common denominator

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for demands on common resources. We are entitled to our equitable share and no more.

The good news about modern health care is that we can expect a lot, the bad news is that we cannot expect everything.

But as one commentator said so well: "The central problem of American politics (is) the inability of the electorate to deal with the hard reality we all had to learn as small children: that some of something usually means less of something else.…Our refusal to acknowledge that trade-offs are necessary … makes intelligent debate about … trade-offs impossible."

If you seek universal health care you must fight a two-front war. You must persuade the selfish and uncaring that we all have certain duties to our neighbors and you must show the altruists that some limits must be set if we are to have a financially sound system. The price of compassionate coverage is restriction of benefits. Strange but true.

I was told by a wise person when I was 19 that "maturity is a recognition of our limitations." A mature nation must recognize that no health plan and no nation can meet the mother test. •

Death: Right or Duty?

'Ethical' medicine vs unethical health care policy

by Richard D. Lamm

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Too often, the limits of our language are the limits of our thinking. "If thought corrupts language, language can also corrupt thought," warned George Orwell. How we label something too often controls how we think about it. We get particular concepts in our head and they are hard to change. They govern how we think and how we act. "Disease" and "death" used to be considered as "God's will," and it took hundreds of years and no small number of martyrs to get that corrected. It was very hard to develop modern medicine when so many subjects were thought of as outside of human control. Similarly, the number of children a woman had was thought to be "God's will," and that has made the development of contraception controversial to this day. Human control over any part of human destiny is usually opposed vigorously. Humankind has the tendency to confuse the familiar with the necessary.

Science finally overcame (mostly) such concepts, however

sincerely held. Medicine has developed ever more inventive (and expensive) things we can do to the body as it ages and approaches death. Now, language limits us in a different way. Today, we have so changed the concept of death that we talk about the "right to die" almost as if death were an option. "Right to die" is a useful term in some contexts, but it has completely reversed the concept of death from "God's will" to a matter within our individual control. Too many Americans think themselves "entitled" to all healthcare no matter how marginal, and will spend unlimited insurance or government money on long- shot attempts to delay death. We have gone from superstition to hubris.

"Money desperately needed elsewhere in society is being spent on marginal and low benefit medicine..."

This has its own trap. Death is not an option. Shakespeare said it so well, "We all owe God a death." Humanity has a hard time putting death in perspective. Over the history of humankind, we have been alternatively paralyzed or dismissive. Both concepts of death are wrong and cause substantial harm. We are not helpless in the face of death – there are a myriad of things we can do to postpone death. Likewise, death is not an option. Thinking of death as a "right" to be exercised misallocates tens of billions of dollars a year. America spends 30 percent of its health dollar on the sickest 1 percent of the population, 55 percent on the sickest 5 percent. This "concentration of expenditures" is far above spending patterns in all other developed countries. Insulated against the costs and petrified by the results, a culture that considers death the enemy spends more and more on less and less.

We do not have a "right to die." Human beings are mortal. Death is neither a right nor an option. Yet, there is a public policy tragedy in our misconception. Money desperately needed elsewhere in society is being spent on marginal and low benefit medicine throughout the system, but particularly on the dying process. No other society would take a 90-year-old with congestive heart disease or terminal cancer out of a nursing home and put him into an intensive care unit. My wife and I were recently at the bedside of a 93-year-old man with three fatal diseases (metastatic cancer of the prostrate, end-stage kidney failure, and he had just been brought into the intensive care unit with a serious stroke). Massive resources were being poured into this gentleman, while blocks away people were going without primary care and kids were going without vaccinations.

Ten percent of U.S. hospital beds are ICU beds, while the rest of the developed world uses 3 percent of their hospital beds as ICU beds. What do we get for our extra intensive care beds? Expensive deaths. There is no evidence we save more critically ill people than other societies. We have failed to develop policies that rationally limit the use of intensive care beds to those who truly benefit. An ICU bed was designed for a realistic salvage attempt, not end-stage care.

Proust observed, "The real voyage of discovery lies not in seeking new lands, but in seeing with new eyes." So also, we must see with new eyes. Everything we do in healthcare prevents us from doing something else. We live in a new world of tradeoffs, but without either the ethical standards or yardsticks to decide those tradeoffs.

I would suggest the sum total of all "ethical" medicine, as now defined, is unethical health policy. The hubris in thinking that medicine can deliver to an aging society all the "beneficial" medicine its inventiveness has developed is misplaced. We are spending too much money on the last generation at the expense of the next generation. As one author observes:

> *Modern men and women of medicine now have the capability to spend unlimited resources in heroic and sometimes vain attempts to extend life … Such changes pose a serious dilemma to society. A dilemma so new that neither our social, legal and religious institutions, nor our healthcare providers or consumers have developed a*

satisfactory means of coping.[1]

It is imperative we begin this dialogue. My generation's bodies are developing ailments and chronic conditions faster than our economy can fund the treatments. We have run smack into the "law of diminishing returns." Modern medicine has presented us with a Faustian bargain: our aging bodies can bankrupt our children and grandchildren. Healthcare is important, but it cannot trump every other societal need. We could begin this dialogue by thinking clearly about death and its costs. •

NOTE

1. Graig LA. *Health of Nations: An International Perspective on U.S. Reform.* Wyatt Co. 1991.