

INTRODUCTION: MY BOSS

“Nearly all men die of their remedies and not of their illnesses.”
Moliere, *Le Malade Imaginaire*, 1673

Recently I gave an educational talk to a group of nurses and aides at a nursing home and assisted-living facility about the dangers of hospitalizing the frail elderly who live in long-term care. I am a certified medical director (CMD), which means that I took courses and other extensive training to acquire a title that I can tack on after my MD. But most significantly, through my training and subsequent conferences I learned how to be a medical director of long-term care facilities, mastering the regulatory minutiae and Medicare rules that impact much of geriatric medicine in the twenty-first century. I currently direct several assisted-living facilities, retirement communities, and a nursing home. When I talk to the nursing staff, I usually focus on a pragmatic arena of health care that will alter the way they care for their aged patients.

In this talk I distributed a handout elucidating the many pitfalls that elderly people may encounter in a hospital, highlighting the lack of efficacy and inherent dangers of hospital care in many circumstances. In fact, as I hammered multiple times in my talk, treating them in the facility itself is typically more humane and beneficial. The talk went over particularly well, as the nurses and aides understood the futility of hospitalization from their ample experience and enjoyed discussing the topic.

However later that night I received notice that one of the nurses who attended the talk sent a ninety-eight-year-old demented woman from the assisted-living facility to the hospital for confusion and weakness. At the hospital the woman became more confused and had to be sedated. She had needles shoved into her arm and was tossed in a head scan, something that must have been frightening to her. She also was exposed to harmful medicines, to dangerous infections, to a high likelihood of treatment mistakes, and to a medical system that pushes the most aggressive of care on elderly people despite a paucity of evidence to support that approach. As is common, they found a urine infection (something fairly ubiquitous in the elderly, to which much illness is ascribed) and they sent her back, not admitting her to the hospital where she may have been tied down and exposed to even more deleterious trauma.

I was somewhat irritated that within hours of hearing my talk on hospitalization, a nurse still insisted on sending this confused patient to the hospital for a fairly common medical issue, when I believed that the patient would have been better off staying put and having more gentle care and observation in familiar surroundings. But I understood all the many forces that conspired to force her to do something that likely she did not think was clinically necessary or even prudent, something we will discuss extensively in this book.

I saw the patient a few days later. She was in a room with other demented residents, sitting in a chair, smiling, and clapping her hands. Some of the nursing aides were leading them

in a sing-along. At that moment, freed from blood pressure cuffs, blood sticks, x-ray machines, nursing home regulatory rules, and handfuls of medicine, my patient was receiving perfect geriatric care. She was socializing, exercising, and using her brain. She was under no stress. She was not exposed to the sting of modern medicine. The dichotomy between her experience at the hospital and what I witnessed now was striking to me. Now she was in the hands of people who knew her and were making her life enjoyable, instead of at the mercy of people who dug into her elderly body trying to find problems and fix them. The former scenario is the very epitome of good geriatric care, the latter is a geriatrician's nightmare. The former is also cheap and humane, while the latter is horribly expensive, tearing our Medicare system to shreds while decimating its unknowing victims. Unfortunately, it is the latter that is becoming the norm in the geriatric wilderness that I inhabit. And the most tragic part is that Medicare itself is financing and encouraging the very aggressive care that is its own dagger.

With this book I hope to demonstrate how our health care system is failing our oldest and frailest Americans, and how that failure is inextricably tied to Medicare's philosophy and payment structure. An idea has blossomed within our medical thinking that equates aggressive, specialized care with good care, even for patients very advanced in years. That lore has taken root in how Medicare treats its seniors, and prompts our financially strapped national insurance to thrust a large amount of its budget into futile efforts to keep people alive at the end of their lives with the full gamut of technologically advanced medical services. But very little evidence exists to support the utility of what many people label as "thorough" care in the elderly. For those of us who practice medicine every day, we in fact know otherwise.

I am an internist, and the focus of my practice has been on geriatrics, caring for the old. I love the idea of Medicare. I studied it as a history student at Brown University, and I have been immersed in it for the past twenty-five years. During my professional life I have read the debates in Congress and among the intellectual elites about its future, have listened to the politicians and academic giants dissect its flaws, have studied Medicare's own solutions to its woes, and read how the lay press perceives its impending collapse and how it may be saved. But more significantly, every day I live under the shadow of its rules, regulations, and reimbursement. I know Medicare better than anyone, because it is my perpetual companion; it is my boss. So as I listen to the people in ivory towers talk about Medicare on the pages of the *Washington Post* or the sound waves of NPR, as I hear CMS representatives and geriatric academic leaders talk with wonder about the new innovations that are around the corner, I just cringe, wondering what they are seeing that seems so different to me. True, I am just a doctor, and not one with any more titles and credentials than caring for patients affords me. But I do understand Medicare. I know why it is failing, and how it can be saved. And it comes down to acknowledging what really is Medicare's philosophy and how that thinking has led Medicare down a precarious path.

Because I am a geriatric physician, Medicare controls a huge part of my life. It pays the bills and sets the rules of my practice. I cannot charge more or less than it dictates to me, I must write notes as it instructs, and even my interactions with families and patients are controlled by

its regulations. Medicare is truly my boss. And Medicare is not without its bosses. The consumers of health care—my patients—hold Medicare’s reins, because Medicare ultimately rewards those who utilize its resources the most, and neglects those who age with dignity and comfort. Many can, and do, exhaust the system’s finances with an interminable search for eternal life. Some believe a false credo that more is better, fueled in their misconception by doctors, the press, drug companies, and the very zeitgeist of the American way of life. Others are pushed to be aggressive by Medicare’s rules. Hovering over everything is the politics of perception: when Medicare curtails any service, people on both sides of the political aisle cry foul, insinuating that any restriction in Medicare’s quest to do everything for everyone is akin to letting our elderly die. It is difficult to reform Medicare under such a toxic cloud.

There is a national obsession with illness in our county. Americans think they are sick and perpetually search for cure and resolution,ⁱ especially as they age. Their quest for medical answers to the ravages of aging fills them with a heavy dose of stress, merely exacerbating their own decline and dragging the health care delivery system down with them.^{ii iii} The public—from patients and their families to doctors and experts and politicians and journalists—perceive that more is better in regards to caring for the elderly. And they believe that with enough perseverance, our health care delivery system is capable of virtually anything, even reversing the ravages of aging. Those are Medicare’s bosses, and Medicare rewards them by financing their plunge into a sea of aggressive care. It is because of all these bosses that Medicare is about to lose its wheels.

This book is essentially about the very old. One could argue that the youngest and most vibrant Medicare recipients, many of whom still work and engage in vigorous activity, may benefit from aggressive care. There are many who dispute this claim, but I will not try to address that debate in my book. Most of my subjects are the oldest and sickest of our Medicare patients, many who have dementia, many who live in assisted-living facilities and nursing homes, and who often utilize excessive Medicare resources without deriving any benefit from their “thorough” care. To what would actually help the very old—compassionate care delivered in their own homes—Medicare turns its blind eye, reluctant to assist those who seek dignity and comfort in their quest to stay healthy and active in their later years without being shoved into the claws of medical excess.

A century or so ago American medicine evolved from a field dominated by charlatans who dispensed potions and false promises to a distinguished profession led by well-trained practitioners versed in the science of medical care. (See Paul Starr’s *The Social Transformation of American Medicine* for an excellent discussion of the history of health care in America.) Unfortunately, as medical science advanced, so too did the perception that science and technology could cure everything. More machines, drugs, procedures, and tests sprouted across our medical landscape, and a lore grew that all illness, even the illness of age itself, would fall prey to the ingenuity of American medicine. People no longer had to get sick and die. By utilizing all of our brilliant resources, by assaulting disease at its roots, we could halt the aging

process and begin a trek toward immortality. None of that proved to be true, but the public started to believe it. More specialists emerged, promising more narrowly focused care. More scans, more drugs, and bigger and more sophisticated hospitals all sprouted across the landscape, growing from an errant belief. And into this landscape stepped Medicare, the most expansive leap into health care delivery ever enacted by the US government.

President Truman first attempted to create a comprehensive, inclusive health care system that ultimately was drowned by a perception, despised in America, that his reform would lead to rationing of care,^{iv} a fate that destroyed President Clinton's attempted reform efforts and emasculated President Obama's ACA, all for similar reasons. When President Johnson pushed through Medicare in 1965, he too met vigorous opposition from medical and community groups that feared a loss of autonomy for patients and doctors and envisioned that Medicare would spark a socialized medical system that would decimate America's medical excellence and lead to rationing. The AMA (American Medical Association) especially fought to stop Medicare's enactment,^{v vi vii viii ix} something I researched as part of my senior thesis at Brown University. I pored through AMA journals, in which physicians and medical experts predicted doom if Medicare became reality, and I read contemporary articles in newspapers and magazines that mirrored much of the debate that we are hearing now regarding health care reform and its potential to destroy quality through rationing. The AMA actually proposed its own more private insurance plan for the elderly called Eldercare even as it threatened to boycott Medicare and not participate. When it finally did agree to endorse Medicare, the AMA had forced enough concessions from the government, especially with regard to keeping hospitals strong and independent, that it actually gained financially from the plan's enactment.^{x xi xii xiii} It is not ironic, then, that the AMA is one of many medical organizations now fighting to keep Medicare intact and largely unchanged, despite its initial opposition to the plan. Doctors and hospitals thrive in Medicare, as Medicare finances the most advanced and aggressive medical care for all elderly Americans. At Medicare's birth such a philosophy seemed both sound and affordable. But the medical profession, and the population it serves, has changed dramatically since 1965.

When Medicare was envisioned, there were far fewer elderly in America requiring health care. The population over age 65, before Medicare started caring for them, accounted for about 8 percent of the population, or twelve million people. By 2009 the elderly represented 12.8 percent of the population, tripling to thirty-five million people. By 2050 the elderly are expected to be 20 percent of the US population, exploding to 88.5 million people. Of the elderly, the very old are proportionately growing faster than any other group. Those over eighty are projected to be the most populous age group by 2050, representing 7.4 percent of the population, or 32.5 million people.^{xiv} Medicare must now serve more and older people than its framers anticipated.

The number of Medicare recipients with diseases of dementia, such as Alzheimer's disease, has also ballooned since the insurance's inception. At the time Medicare was scripted, Alzheimer's was not even identified as a medical condition, and the cost of dementia care was minimal. But as that reality has changed, the cost of such care has accelerated rapidly. Currently

five million Americans are diagnosed as having Alzheimer's, and that number is expected to reach seven million by 2025. The cost of caring for those people is estimated at \$203 billion, over half of which is paid by Medicare. That number is expected to reach \$1.2 trillion by 2050.^{xv} Health care costs for US residents with dementia are triple the cost of other nondemented elderly, approximately \$33,000 per recipient per year versus \$10,000 for those without dementia.^{xvi} Currently sixty-one million Americans care for their ill or disabled family members, many of whom have dementia, spending an average of eighteen hours a week doing so. A quarter of the baby boom generation provides care for an aging parent.^{xvii} Because Medicare pays so little to help care for demented people in their homes, often families have to resort to hospitalizing their loved ones out of desperation, something that escalates Medicare costs needlessly. Medicare's framers never considered the consequences of dementia and other debilitating diseases of aging on its model of care.

In addition to the sheer numbers and illnesses of its clients, Medicare's expenses are impacted by changes in health care delivery since 1965. We are now a medical society dominated by specialists, high-priced tests and procedures, and very expensive hospitals. Compared to 1965, Medicare patients now have at their disposal massive amounts of medical technology that society has embraced as being the most thorough means of assaulting illness and disability. In addition, because the AMA persuaded Medicare to focus on and finance hospital care above all else, every American over age sixty-five has access to Medicare A, which pays for hospitalization. The hospital is free for all elderly Americans after a single deductible (approximately \$1,000), a cost that is usually paid by their secondary insurance. The hospital remains the center of care for the elderly, the place where older Americans must flock when they are too sick to stay at home, when they seek Medicare's payment for round-the-clock nursing and rehabilitation services, and when they want Medicare to pay for certain invasive treatments such as IV fluids and antibiotics. Under Medicare's current payment structure, the frail elderly are pushed into the hospital even when they would prefer to stay at home, despite the peril and price tag that such a journey entails.

Medicare B covers most other services, including doctor's visits, tests, procedures, and physical therapy. Americans have to pay a small premium to enroll in Medicare B, and well over 90 percent of Americans have done this. After charging patients a nominal deductible (approximately \$150), Medicare B will pay for 80 percent of all services. The vast majority of Americans purchase secondary insurance that will pay the 20 percent of cost that Medicare does not cover. Thus, most elderly Americans, after paying their annual premiums and deductible, will get all medical services without charge. Medicare B will not pay for meaningful health care in the home, for home health aides, or for medicines. Often when they get too ill patients will need to use Medicare A, and that typically requires a stay in the hospital. In its current rendition, Medicare puts no limits on expensive tests and specialty visits, encourages hospitalization for those most ill, and does not contribute to more palliative care in the home.

The newest incarnation of Medicare that was enacted in 2006, Medicare D, covers a large part of medication costs for those recipients who pay an annual fee. Already by 2010 the program was costing the federal government \$62 billion, or 12 percent of the entire Medicare budget.^{xviii} Congress made two crucial errors in enacting part D. First, it underestimated the cost of the program and how widely it would be used. Second, it explicitly forbade the government from negotiating with pharmaceutical companies to create a formulary of reasonably priced medicines, a strategy that other federal agencies such as the VA have employed to keep costs down. As a result, Medicare D recipients can choose the most expensive brand-name drugs with little restriction and with no competitive price reductions.^{xix} In our medical landscape cluttered by high-priced drugs that promise miraculous results to the elderly, Medicare D has become an albatross that strangles the entire Medicare system.

The result of Medicare's failure to adjust as the world has changed around it has taken a toll on the US economy, placing Medicare under the political microscope as one of the primary drivers of our budget deficit. While Medicare represented 2 percent of federal spending in 1970, it jumped to 15 percent by 2011,^{xx} due to the aging of our population and the increasing cost of medical care. Although over the past few years the rate of growth of Medicare has slowed, it is still growing and becoming more costly. The financial numbers are staggering. Medicare cost the government \$7.1 billion in 1970, \$35 billion in 1980, \$109.7 billion in 1990, \$219 billion in 2000, and \$550 billion in 2012.^{xxi} The cost of care escalates for the oldest of Medicare's recipients. In 2008 the per capita cost among Medicare recipients over eighty-five was nearly double the amount spent by younger people. (\$13,219 versus \$7,626). The cost of those who reported that they were in poor health was even higher, \$22,612. Many of these people are very old, demented, and live in institutions.^{xxii} Many of them are forced into the hospital and encouraged to undergo tests and procedures that are both costly and ineffective. No amount of money can fix their aging bodies, and much of the money thrust at them likely only causes more harm, as we will show. A recent *Washington Post* article highlighted that in the American medical system 1 percent of patients exhaust 21 percent of total health care costs, at a price of \$88,000/person/year.^{xxiii} Clearly the sickest Americans, many of whom are not likely to improve despite the money spent on their care are taxing our system, often for reasons instigated by Medicare itself.

Can thorough and aggressive medical care help prolong life and improve quality in our oldest patients? The very idea that an overutilization of health care leads to improved outcomes has been debunked repeatedly,^{xxiv xxv} something we will explore extensively in this book. We in the geriatric field know it innately; our very souls are watered by the knowledge that more is less, and that aggressive care can be deleterious care. When one studies the literature it becomes apparent that there is a paucity of data specifically relevant to our oldest patients, many of whom have multiple illnesses and are on a plethora of medicines.^{xxvi xxvii} So, often erroneously, we extrapolate data from younger patients, or we make assumptions that have been hammered into our heads, that all diseases should be eradicated, and that our society is blessed with an

abundance of life-saving treatments. In fact, as little as 15 percent of what doctors do is backed up by valid evidence.^{xxviii} And thus do we send our oldest and frailest patients on a journey that is costly to both them and to society with little evidence to back us up.

Many books and studies have explored the false notion that aggressive care leads to improved outcome in the elderly, and I have been lucky enough to be able to use them as resources. These include:

- Nortin Hadler, *The Last Well Person* and *Rethinking Aging*
- H. Gilbert Welch, *Overdiagnosed*
- Shannon Brownlee, *Overtreated*
- John Abramson, *Over-dosed America*
- Erik Rifkin, *The Illusion of Certainty*
- Robert Duggan, *Breaking the Iron Triangle*
- Ira Byock, *The Best Care Possible* and other books
- Multiple studies by Jack Wennberg and Elliott Fisher regarding their work with the Wennberg Institute at Dartmouth College

But the crux of my argument flows from my own experience and that of my colleagues. While medical literature can help guide us to make sensible decisions, most of us who practice medicine every day have become skeptical as to the validity of what we read in journals. We know that many studies are financed by pharmaceutical companies and special interest groups, that the overly screened subjects accepted into such studies look nothing like the more complicated patients we see every day, and that the conclusions are subject to many interpretations. We also have seen studies touting the benefits of a drug or treatment, only to be completely reversed some years later. When I was a medical student it was considered standard of care to treat women with estrogen after menopause, and it was deemed to be dangerous to treat patients with failing hearts (congestive heart failure) with a class of drugs called beta blockers. Studies and literature supported such suppositions, academic physicians assured us of their validity, and clinical pathways enshrined such beliefs as gospel. Well, some years later, new studies emerged, and now it is bad practice to give women estrogen after menopause, or to deny patients with congestive heart failure beta blocker drugs. There are so many examples where science and dogma are thrown on their heads, leaving us doctors to ascertain reality for ourselves. Also, I have seen academics and physicians interpret a single study to argue opposite points, showing me that the literature is far less scientific and objective than we are led to believe. Finally, few large studies focus on the frail elderly among their subjects, and those are the people most vulnerable to the sting of aggressive care. Hence, my book, while citing the literature that is out there, relies on my own experience as a geriatric doctor to reach many of its conclusions.

What drives Medicare's continued advocacy of aggressive medical care despite its suffocating cost and lack of efficacy? And why are draconian measures not being taken to curb

that excess and to redefine geriatric medical care so that it can sensibly address the changing population that it serves?

At present we live in a specialized medical society where technology is king. Hospitals, certain doctors, and many institutions benefit from aggressive care. Drug companies too. By denying “thorough” care to the most frail of our elderly, many doctors and institutions would be financially hurt. Thus, a strong wall of opposition stands against the thrust of meaningful change.

My most frail patients, and their families, also often demand “thorough” care for many reasons. One is financial; as we will discuss, under Medicare’s rules it is often much less expensive for them to get aggressive medical treatment than to be conservative and compassionate, even if it costs Medicare substantially more and the outcomes of such care may be worse. But just as important, many of my oldest patients, and their families who ultimately make their decisions, believe in aggressive care. They have been inundated by the idea that more is better at any age, that numbers need to be fixed, that a cure is out there if only they pursue it. Even those who are skeptical are forced to live in a society where everyone else is telling them to be aggressive. When conservatives talk about death panels, and liberals declare that any restrictions on Medicare spending is akin to killing people, it is difficult for anyone to make rational decisions.

My own life as a doctor has demonstrated to me the futility of pursuing excessively thorough care for many elderly patients, while revealing to me the wall that Medicare has enacted preventing us from offering our patients a more sensible and economical alternative. My career started in a small town called Taunton, and that two-year experience opened my eyes wide to what is wrong with our current Medicare system. Taunton was a world unto itself. Small and isolated in the bog-filled serenity of southeastern Massachusetts, speckled with ethnic Portuguese who had been there for generations, Taunton housed a population of working-class families who rarely moved away or thought much beyond the confines of their town. When one of my patients occasionally relocated twenty miles away to the Portuguese enclaves of New Bedford or Fall River, their families mourned their abandonment. And although they lived a half hour away from the medical meccas of Boston and Providence, most of my patients refused to travel that far; they preferred little Morton Hospital with six beds in a room and their spattering of local doctors. They trusted us, they listened to us, they respected us, and they treated us with unfettered kindness.

In Taunton my patients understood the limits of medical intervention. They did not chase medical miracles or rely on the promises made by aggressive doctors, pharmaceuticals, and the press. Compared to the well-educated enclaves in which I practiced subsequently, my Taunton patients understood the aging process and based their decisions on common sense and dignity. These were the smartest group of patients with whom I have ever worked.

Often on my way home to East Providence I made home visits, where I was greeted with a hug and a smile, never a list of demands or piles of Internet articles. One day I stopped to see an elderly Portuguese woman with moderate dementia. She lived in a two-story colonial house that was older than she, cuddled upstairs in a small bedroom with a hospital bed and a large metal lifting mechanism (called a hoier lift) juxtaposed with some old upholstered furniture and a nightstand. Grandkids ran in and out, up and down; any number of them visited the house regularly. Some children lived in the house, many others lived nearby, all congregated here on the days I arrived.

Whenever I saw Mrs. A. she smiled and held my hands gently. She spit out a few words in Portuguese that her daughters translated for me, typically more niceties than anything of substance. I usually listened as she or her daughters expressed any concerns. We reviewed her medicines, stopping any we could. I took her blood pressure, and waved my stethoscope on her heart and lungs, a requisite action by any of us in the medical field. After my brief visit Mrs. A. thanked me profoundly, typically with a kiss on the cheek, after which her daughter pushed something on me, whether some homemade sweet bread or a box of candy. I always left elated, although part of my brain questioned the significance of the service I provided or why Medicare would pay me for doing so little.

One dreary and cold day in the New England winter I stopped by her house at the behest of one of her daughters. After our traditional greetings, I noticed that Mrs. A.'s eyes were yellow. She was scratching herself, something that proved to be her daughter's only concern. She still smiled, and the stomping and laughter of children had not faded one bit. I examined her. She had a large liver protruding down to her groin, and she was severely jaundiced. I was concerned.

I took her daughter aside. "Your mom has something serious going on," I told her. "She has jaundice. We may need to do some tests."

The daughter smiled. "My mother is eighty-five years old," she said. "If we could just give her something for her itching. She seems so uncomfortable."

"But it could be treatable," I went on. "Maybe it's a gallstone. Or a resectable cancer."

The daughter put her hands on my shoulder. "She is eighty-five," she repeated, with a smile that shined with absolute serenity and conviction. "I don't want to put her through all those tests. But I would like her not to be so uncomfortable, if that is even possible. You tell us what is best."

I nodded and gave her both an antihistamine for the itching and some Questran powder that worked particularly well for the jaundice itch (although very constipating, as I warned the daughter). The daughter stepped to another room for a moment, and returned with a bottle of wine in a weaved basket casing. "Take this," she said. "And thank you. My mother feels so much

better after your visits. And so does the whole family. Thank you so much.” It was if the daughter knew that this would be my final visit.

Mrs. A. died many months later, comfortable and surrounded by her family.

If only all of our country followed the sensible script of Mrs. A. and Taunton. She charged Medicare no more than the cost of a few of my visits and some rented medical supplies. Probably less than a thousand dollars. And all of this for the perfect ending to a stress-free aging process.

Contrast that to a child who chided me for not checking her eighty-plus-year-old dad’s PSA blood test, and when she did bring him to a urologist at a major academic medical center to perform that test, and it showed that he had prostate cancer, she graced me with several instructional notes about how his new squadron of doctors were actually doing something for her dad, rather than neglecting him as I did. After a multitude of tests, biopsies, scans, treatments, and visits to the most brilliant minds at the mecca of medical science, as my once carefree patient became consumed by a cauldron of stress, he finally did die, of a heart attack, not anything to do with his PSA. To which his child said: “At least I know that they were thorough in their treatment of my dad and we did all we could to get him well.” She would have had it no other way. Tens of thousands of dollars later, dollars paid by Medicare, her father died of stress, likely precipitated by the very misguided pursuit that Medicare financed.

In any given week I may encounter a patient or family member who demands unreasonable tests, treatments, hospitalizations, specialist visits, and impossible answers for the ravages of aging in patients little different than Mrs. A. And instead of loving kindness and an acceptance of aging, they conjure incessant stress for themselves, their loved ones, and me and my staff by trying to achieve the impossible. On any given day I will encounter many more patients and families who prefer to live the life of Mrs. A., to be kept comfortable, to be on fewer medicines and have fewer tests, but who are pushed reluctantly in the direction of aggressive care by a medical system, a society, and an insurance that enables and encourages excess.

Whenever I hear about proposals to ameliorate our society’s excessive consumption of medical care, I find that many reformers ascribe blame to doctors who both profit from and relish a health care system that is fueled by excess. They concoct ingenious theories that contend that by tying physician salary to performance and not to fee-for-service, somehow patients will no longer be allowed to abuse services. But in my career I have seen it from a different angle. Many primary care doctors do their best to stop older patients from pursuing aggressive care, only to be met by a system that not only pays for that care but encourages it. In fact, we as primary care physicians have no capacity to slow the overuse of resources. Medicare encourages patients and families to be aggressive, and it pays specialists and hospitals generously to be aggressive; we often just get in the way.

One of my good friends, a fellow geriatric physician, lamented to me the other day about a situation involving a patient of his, Mrs. L., far more ill than Mrs. A. She was old and demented, although independent just a few months ago until she was pummeled by a series of medical insults that left her weak and nursing home bound. She needed kidney dialysis and artificial food to keep her alive. My friend was appalled to learn that her family sought to pursue every option and treatment to maintain her life at all costs, even though several doctors had advised them otherwise. “She was living on her own just a few months ago,” her family members said. My friend spent hours of unreimbursed time talking to doctors, reviewing notes, and reasoning with her children. But they persevered. “She was living on her own just a few months ago.” They could not get past that fact. And the more my friend pushed to keep her comfortable, the more they resisted him. So they found a new doctor, one willing to perform dialysis on a woman who could no longer feed herself or talk, dialysis that is well reimbursed by Medicare. And they found a new nursing home willing to endorse their aggressive approach to care.

These were educated children. One was a nurse. But how little they understood the aging process, and how little they realized what older people really desire in their last months. Over 70 percent of elderly say they want to die at home, not in a hospital.^{xxx} But there is a very sharp divide between the more palliative approach that most elderly seek and how aggressively their families, doctors, and the system treats them.^{xxxi xxxii xxxiii} Many families are peering through a jaded lens. They love their mom so much that they just want to keep her alive and wish for a miracle, the miracle of reversing age and returning her to her healthy state when she lived alone. The illusion of turning back the clock with aggressive care is alluring but often deceptive. In the elderly, it only takes one illness to trigger a chain reaction in the body that decimates it. Healthy three months ago and dialysis dependent now does not mean a mere blip has occurred. It is rather one of the consequences of aging, the end stage of a process that was accelerating beneath the surface and then exploded to its tragic conclusion. But fantasy overtakes their thoughts. Medicare pays the bills. And their mom pays the price.

Many of my patients squander tens of thousands of Medicare dollars in their last months of life, clinging to a quixotic hope that cure is possible if you push hard enough and spend enough money. End-of-life expenses, in fact, are one of the primary drivers of medical costs for the elderly. Twenty-five percent of total Medicare expenses finance end-of-life care, care that accomplishes nothing but painfully prolonging the inevitable. Incredibly, with the full endorsement of Medicare, the health care profession tosses the gamut of its medical resources at problems that are not able to be fixed and merely lead to death.^{xxxiv xxxv xxxvi xxxvii xxxviii} While only a negligible amount of Medicare funds are spent on helping people like Mrs. A. stay comfortable in their home where they can receive appropriate medical care, Medicare spends a quarter of its entire budget trying to save people who are not savable.

Although a majority of elderly people want to die at home with comfort, only a fifth of them actually achieve that goal. Fifty percent die in a hospital, and 40 percent of those are in

intensive care units “where they will likely be sedated or have their arms tied down.” Few elderly elect to be treated with such flagrantly ineffective aggression in their final days and months, but many forces, including the harsh reality of Medicare, push them where they do not want to be. Another 30 percent of the elderly die in nursing homes, often explicitly against their wishes,^{xxxix} forced to bow to the financial realities of our current geriatric health care system.

Unless we curb the dangerous folly of aggressive care in our oldest residents, unless we realize that with age comes a decline that no amount of dollars will curtail, unless we stop financing a medical quest that leads to nothing more than the very death it is attempting to stop, then Medicare will not persevere. Few of the innovations concocted by CMS or the Medicare reformers confront that reality. Few of them are proposing feasible means of helping Mrs. A.’s experience to become the norm.

My book is about all the bosses out there—patients, families, doctors, hospitals, drug companies, facilities, lawyers, newspapers, laws and regulations, and the misplaced dogma so prevalent in our society that more is better. My twenty-five-year experience practicing geriatric medicine has taught me the value of life in its last years, and it has provided me with tocsins of what can go wrong once the illusion of excess obfuscates a clear view of the aging process. When I listen to the debates raging about Medicare among administrators, politicians, and intellectual giants, I realize that they just don’t get it. When I am forced to contend with the reforms that the ACA and CMS have tossed at me to curb costs, I realize that they just don’t get it. They can pontificate all they want, they can speculate and theorize and argue until they are red in the face, they can throw up graphs and charts and statistics, and blame the doctors for perpetrating waste, but they don’t get it. I have always said that if you throw fifty primary care physicians in a room, doctors of every ethnicity and political slant, and ask us to fix Medicare, we would be done well before lunch, although we would likely stay long enough to enjoy a nice lunch if someone else was paying. We would hand you a paper, probably less than a page long, and would tell you it’s as simple as that. Because it really is. Once you are out there and live in the shadow of Medicare, it doesn’t take a brain surgeon to figure it all out. In fact, the last thing you want is for a brain surgeon to try to figure it all out.

With this book I hope to demonstrate why Medicare is failing and how to effectively fix it, while showing how the beauty of aging can be so dangerously poisoned by allowing the status quo to persevere. Not everyone is Mrs. A. But that is who the system should be rewarding, and right now it is doing just the opposite. And unless it changes course, Medicare will not be as fortunate as Mrs. A.; it will die a difficult and costly death.

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