Personal Aspects of Cost Accounting

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My oldest brother, Donn, born in 1923, died recently. He was one of the brightest, most intellectual people I have ever known. He spent his life as a teacher, first of high school students, then of life and living it to congregations of Protestants. In the course of his travels around the world, running schools, he contracted intestinal amebiasis. He dated his "troubles" to that onset (whether it was causative is anyone's guess), but by 1984 he had marked idiopathic ischemic myocardiopathy with an ejection fraction of 17 percent on cardiac catheterization. He was dutifully told of the dismal prognosis and the lack of utility of surgical treatment, and he made peace with himself and others around him. He did not, however, succumb—he simply became more feeble and had less reserve (of every kind). He and his wife therefore went to China to work in an import-export business that required someone of integrity but little stamina to be on site. This environment exposed him to a far different type of medicine and an altogether different outlook on life. It seemed to strengthen his already somewhat mystical approach to life and its vicissitudes.

He came home to rest in the early 1990s, whereupon his friends and congregation built him a parish house in which to relax and continue to teach every other Sunday to a small but devoted following. In March 1995 he began to require the benefits of our modern, high-tech medical care system.

Beset by the usual uncertainties of reliance on and access to a generalist, he and his well-intentioned family and advisors sought care and treatment from a series of highly skilled, technologically attuned, subspecialty trained physicians. Singly and in groups, they were caring, conscientious, thoughtful, and careful practitioners of their art. Not one of them remained in charge long enough to develop a long-term view, nor did any assume the mantle of total responsibility for planning the "what we will do, how long will we do it, and what should be the desired outcome" kinds of issues.

Between March and November, I estimate that roughly $300,000 to $500,000 were expended by various third parties as Donn bounced from one physician or facility to another (he had no funds, save Medicare coverage; it was something neither about which he worried nor for which he had remotely prepared). Some shifts in care were geographically induced (sick while away from home), some occasioned by well-meaning but noneffacacious advice ("I know someone with that problem and Dr. So-and-so did a wonderful job"; "Have you tried the [fill in your own favorite, he heard them all] clinic?"), and some precipitated by a caring-but-guilt-ridden family who could not bear to see him suffer the multisystem effects of a failing heart ("Someone else must be able to do something!").

I visited him as I could, pressed by my own agenda and hampered by distance. We talked when he felt like it, and I listened to the clamor of those facing the daily task of giving kindness to a soul losing its way. I expressed my own mordant, experience-generated recommendations, but they were too strident and to-a-point, which others were not ready to accept (though Donn was, I thought). With good intentions he was diuresed, digitalized, after-load reduced, ultrasounded, thallium-stressed, MUGAed, cathed, scintigraphied, bypassed, dobutamined, cardioverted (some of these several times) by each new steward of his diminishing ship of state. He even had his pleurae scarified to lessen the constant, terrifying effusion. He was finally sent home with kind hospice and morphine, the only succor and tool that could really allow him to slip away in a "care and comfort" mode.

I muse on these events in my current role as a resource allocator in a large health care system.

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No one intended the cost to be so great, nor the outcome so poor; no one, given the clarity of retrospect and the chance to do it again, would have done all that was done. The man should have been allowed to sit on his porch and die peacefully, much earlier than that event actually transpired, I think to myself. Is it any wonder our current system is wildly expensive? Does malice, ignorance, and mean-spiritedness really run rampant, or has the decision tree not been properly written in our medical schools? Must politicians, lawyers, business people (a euphemism for bottom-line types), and uninformed journalists be our guides from this thicket? I hope not! But unless each individual physician seizes each individual case by its medical and fiscal throat, we shall have none to blame but ourselves.

Must the solution require team thinking? Are we so fractionated, so limited in our personal outlooks, that we have no room for the group or national needs as opposed to those of the individual patient? These are hard choices; my immediate worry, as I speak to the panoply of folk rendering care, is that the consideration of allowing life to ebb as a natural process was not even considered or discussed among the professionals or family members. Yet these are good, highly trained, altruistically motivated people, not charlatans. Should we allow uncaring actuaries to read us a list of "whens," or should we seize the moment to think about this issue at the crucial time in each case that all physicians (of whatever stripe) can recognize more capably then anyone else?

Donn and his hard-pressed family are resting now. Someone else (all of us!) has borne the costs. New patients are brought daily to coronary care units in similar straits, none with conditions that were easily diagnosed or for which a prognosis could be described prospectively. The escalation of expenditures, balanced against the immediacy or noncost(!) of one more test or procedure, make easy decisions impossible. Change is all about us; one case makes little more than another anecdote, but this one is very personal to me and my current position. How will we handle the next one? Better, I hope; one step at a time, I guess.