

CURING MEDICARE

*A Doctor's View on How Our Health Care
System Is Failing Older Americans
and How We Can Fix It*

ANDY LAZRIS, MD

WITH A FOREWORD BY SHANNON BROWNLEE

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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 underwent additional extensive training to acquire a title that I can tack on after my MD. But most significantly, through my training and subsequent conferences I mastered the regulatory minutiae and Medicare rules that impact much of geriatric medicine in the twenty-first century. I currently direct several assisted-living facilities and retirement communities, as well as a nursing home. When I talk to the nursing staff, I usually focus on a pragmatic area of health care that will alter the way they care for their aged patients.

In this particular talk I distributed a handout enumerating the many pitfalls 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 repeated multiple times in my talk, treating them in the facility itself instead of a hospital is typically more humane and beneficial. The talk went

over particularly well, because the nurses and aides understood the futility of hospitalization from their ample experience and enjoyed discussing the topic.

Later that night, however, I got word that one of the nurses who attended the talk had sent a ninety-eight-year-old woman with dementia 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. Her arm had been poked with needles and she'd been made to undergo a head scan, something that must have been frightening to her. She was also exposed to potentially harmful medicines, dangerous infections, a high likelihood of treatment mistakes, and a hospital that pushes the most aggressive 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 trauma.

I was not surprised 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. I understood 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 residents with dementia, 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, while the latter is a geriatrician's nightmare. The former is also cheap and humane, while the latter is horribly expensive, compromising the financial health of our Medicare system and turning patients into unwitting victims

of unnecessary and futile aggressive treatment. Unfortunately, it is the latter that is becoming the norm in the treatment of geriatric patients. And the most tragic part is that Medicare itself is financing and encouraging that expensive and ineffective approach.

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. My critique is part of a larger social debate that is developing about the goals of modern medicine in particular and the health-care system in general. Many patients, physicians, other health-care professionals, and health-care organizations—including unions, foundations, patient-safety organizations, and politicians—are becoming increasingly concerned about the principles and practices that escalate health-care costs and put patients at risk.

Over the past few years I have read dozens of books warning of the perils of overtreatment for patients of all ages, especially those who are old and frail. Shannon Brownlee's best-selling book *Overtreatment* focuses on the general problem of unnecessary and unsafe medical treatments. Books by Nortin Hadler (*The Last Well Person* and *Rethinking Aging*) and H. Gilbert Welch (*Overdiagnosed*) explore the medical facts regarding many widely accepted tests, medicines, and procedures. Richard Deyo's book *Watch Your Back* zeros in on one particular aspect of the edifice of overtreatment—unnecessary and dangerous treatments for the back pain that cripples millions of Americans—while Gayle Sulik's *Pink Ribbon Blues* demonstrates how the medical establishment can distort health information with detrimental results. In 2015, Stephen Schimpff's *Fixing the Primary Care Crisis* explored how current strategies have thwarted the doctor-patient relationship, and how enabling better doctor-patient discourse at the primary-care level will lead to better care, lower cost, and higher satisfaction with the system. As I finish this book, I have read *Being Mortal*, surgeon Atul Gawande's eloquent plea for a reconsideration of futile treatment at the end of life, and Angelo Volandes's book *The Conversation*, which tries to help patients and physicians navigate discussions that can lead to less aggressive and more appropriate care during terminal illness.

My book is a part of this larger discussion. Its subject is the crisis in primary and geriatric care. I consider this vexing issue by exploring how one of our most critical health-care programs, Medicare, has become one of the most influential proponents of the kind of aggressive, specialist-oriented

care that is driving up health-care costs and increasing the suffering of the elderly and their families. After decades of practice and reflection, I have come to this conclusion far more in disappointment than anger (although I certainly have some of both).

In fact, I love the idea of Medicare. I studied it as a history student at Brown University. I believe in its central role in our health-care system. Its creation has saved countless lives and improved the quality of life for all elderly Americans. It provides millions of Americans who would otherwise lack health-care insurance with access to health-care services. As a financing mechanism it is far more efficient than the private insurance that has been one of the primary cost escalators in our system and which encourages fragmentation of, as well as aggressive and inappropriate care for, millions.

But Medicare is far more than a financing mechanism that brings health care to the elderly. As we will see in this book, the Centers for Medicare and Medicaid Services (CMS) promulgates policies and practices that determine the forms of care it will allow and subsequently what kind of care the elderly receive, where they receive it, and who delivers that care. Medicare also serves as a model that many other health insurance companies follow. For instance, once Medicare sets its rates, enforces rules, or implements new programs, most commercial insurances mimic those changes. I have been immersed in the intricacies of Medicare policies and politics for the past twenty-five years. In the course of my career I've read the debates in Congress and among the intellectual elites about its future, listened to politicians and academic giants dissect its flaws, studied Medicare's own solutions to its woes, and read how the lay press perceives its impending collapse and how it may be saved.

Most important, as an internist whose practice has focused on geriatrics, caring for the old, every day I live under the shadow of CMS's rules, regulations, and reimbursement. What I have come to understand is that Medicare has not escaped the imperatives and priorities of the broader American health-care system. Medicare, which Congress created in 1965 to provide health insurance for the elderly, inherited these imperatives and priorities and has—sometimes unwittingly, sometimes deliberately, sometimes out of sheer exhaustion—reinforced these priorities. Some of those who are fighting for a more rational health-care system brandish as their slogan “Medicare for All.” As a financing mechanism for a tax-supported

national health-care system, this may be a wise idea. As a model of policies and practices that guide the delivery of health-care services to the elderly, it needs to be examined critically. We need to think about the kinds of services and priorities that CMS promotes, whether for the elderly, or potentially for every American, before simply superimposing the Medicare system on a more general model of care.

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, I must write notes as it instructs, and even my interactions with families and patients are controlled by its regulations. The problem is that Medicare has been deeply influenced by the kind of contemporary 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. As we will discuss further in this book, physicians in the United States have been taught and “incentivized” to deliver this kind of care. The media has pushed it, and many patients—even some of the oldest—are fueled in their misconception by doctors, the press, drug companies, and the very zeitgeist of the American way of life to believe the false credo that more is better. 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.

The sad reality is that Medicare has become an active partner in our national obsession with illness. Americans think they are sick and perpetually search for cure and resolution, especially as they age.¹ 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.² The public—from patients and their families to doctors, experts, politicians, and journalists—believe that with enough perseverance, our health-care delivery system is capable of virtually anything, even reversing the ravages of aging. From that perch of false information, and with incentives pushing them, many patients and their families plunge into a sea of aggressive care, often unwittingly.

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. Plenty of people dispute this claim, and in some cases I agree with them, but I will not address that debate in my book. Most of my subjects are the oldest and sickest of our Medicare patients, and among these, many have dementia, live in assisted-living facilities and nursing homes, and 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 all too often turns a 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 driven into the claws of medical excess.

A century or so ago US 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 the United States.) 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 the belief spread that all illness, even the illness of age itself, would fall prey to the ingenuity of medicine. People no longer had to get sick and die. By utilizing all 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 proliferated, 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 was the first to attempt creating a comprehensive, inclusive health-care system, but his effort was ultimately thwarted by the perception, despised in the United States, that his reform would lead to rationing of care.³ Similar arguments also destroyed President Clinton’s attempted reform efforts and emasculated President Obama’s Affordable Care Act (ACA). 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 Medicare sparking a socialized medical system that would compromise medical standards in the United States, lower the level of excellence in research and care, and lead ultimately to rationing. The AMA (American Medical Association) especially fought to stop Medicare's enactment,⁴ 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 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 doctors and hospitals strong and independent, that it actually gained financially from the plan's enactment.⁵ 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 the United States requiring health care. The population over age sixty-five, before Medicare started caring for them, accounted for about 8 percent of the population, or 12 million people. By 2009 the elderly represented 12.8 percent of the population, nearly tripling to 35 million people. By 2050 the elderly are expected to be 20 percent of the US population, exploding to 88.5 million people. Among 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.⁶ 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 5 million Americans are diagnosed as having Alzheimer's, and that number is expected to reach 7 million by 2025. The cost of caring for those people is estimated at \$203 billion, over half of which is paid by Medicare. The total cost of care is expected to reach \$1.2 trillion by 2050.⁷ In 2015 Medicare spent \$112.7 billion caring for people with dementia, constituting almost 20 percent of total expenditure. The cost per recipient incurred by Medicare is \$21,585 annually for those with dementia, and \$8191 for those without.⁸ Currently 61 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.⁹ Because Medicare pays so little to help care for people with dementia in their homes, often families have to hospitalize 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 from its inception Medicare has focused on and finances 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** go 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 certain 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 secondary insurance cost, receive 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 form, 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, which 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.¹⁰ 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 prohibited the government from negotiating with pharmaceutical companies to create a formulary of reasonably priced medicines, a strategy that other federal agencies, such as the Department of Veterans Affairs (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.¹¹ In a medical landscape cluttered by high-priced drugs that promise the elderly miraculous results, 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. 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 2012.¹² The cost of care escalates for the oldest of Medicare's recipients. In 2011 the per capita cost among Medicare recipients over eighty-five was nearly double the amount spent on younger people (\$13,788 versus \$7,859). The cost of those who reported they were in poor health was even higher, with the costliest 5 percent of beneficiaries accounting for 40 percent of all Medicare spending. Many of these people are very old, dealing with dementia, and living in institutions.¹³ Many 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 spent for their care likely causes more harm, as we will show. A 2013 *Washington Post* article highlighted that in the US medical system, 1 percent of patients exhaust 21 percent of total health-care costs, at a price of \$88,000 per person per year.¹⁴ 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 related to Medicare's payment structure.

Can thorough and aggressive medical care help prolong life and improve its quality for our oldest patients? The very idea that overutilization of health care leads to improved outcomes has been debunked repeatedly, something we will explore extensively in this book.¹⁵ 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.¹⁶ So, often erroneously, we extrapolate data from younger patients, or we accept 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 that supports its efficacy.¹⁷ And thus we send our oldest and frailest patients on a journey that is costly both to 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.¹⁸

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 care to treat women with estrogen after menopause, and it was deemed 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 and to deny patients with congestive heart failure beta-blocker drugs.

There are so many examples where science and dogma are turned on their heads, leaving us doctors to ascertain reality for ourselves. 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, while I frequently cite the literature that is out there, in this book I rely on my own experience as a geriatric doctor to reach many of my conclusions.

My own career as a doctor has demonstrated to me the futility of pursuing excessively thorough care for many elderly patients, while revealing to me the wall Medicare has enacted that prevents 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, with a population made up of many ethnic Portuguese who had been there for generations, Taunton was home to large numbers of working-class families who rarely moved away. And although they lived half an 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 local doctors. They trusted us, they listened to us, they respected us, and they treated us with unfettered kindness.

In Taunton in those days 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 was, cuddled upstairs in a small bedroom with a hospital bed and a large, metal lifting mechanism (called a Hoyer Lift) next to 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 spoke a few words in Portuguese that her daughters translated for me, typically general pleasantries rather than anything of particular substance. I would listen as she or her daughters expressed any concerns. We reviewed her medicines, stopping any that seemed no longer needed or not beneficial. I took her blood pressure, and listened to her heart and lungs, a step required of all 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, such as 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 the wisdom of Medicare paying me for doing so little.

One dreary winter day 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 main concern that day. 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 woven 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 as 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 many of my other patients in Taunton in those days. 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 this for the perfect ending to a relatively stress-free aging process.

Contrast that to an adult 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 a renowned hospital far from his home, my once carefree patient became consumed by stress, and finally did die, of a heart attack,

not anything to do with his PSA. After 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 from Mrs. A. 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., be kept comfortable, 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. Such reformers 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 are not given the power or authority to slow the overuse of resources. Medicare encourages patients and families to be aggressive, and it pays specialists and hospitals generously to be aggressive; primary-care providers are often sidelined while needlessly aggressive care is administered.

It is thus not surprising that some of my most frail patients, and their families, 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 the decisions about their

welfare, 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.

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., who was far more ill than Mrs. A had been. She was old and had dementia, although independent until only recently when a series of medical insults had left her weak and confined to a nursing home. She now relied on 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 adult 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.¹⁹ 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 treat them.²⁰ 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 they 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 endorsement of Medicare, the health-care profession unleashes the full force of its medical resources at problems that are not fixable and merely lead to death.²¹ 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 and who usually do not want to be "saved."

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, forced to bow to the financial realities of our current geriatric health-care system.²²

In the following pages we will explore Medicare's continued advocacy of aggressive medical care despite suffocating costs and poor outcomes from that approach, and will examine why Medicare seems unable to control that excess or redefine geriatric medical care so that it can sensibly address the changing population that it serves. This book is not an assault on Medicare, which is an invaluable program that has transformed the care of our elderly, but rather is a critical analysis of how Medicare's priorities may be leading to the very poor and expensive care that its reformers seek to change. As a primary-care doctor I am immersed in Medicare daily. I see how it impacts my ability to care for patients and my patients' ability to access the care they want for themselves. In fact, the very reason I wrote this

book is because I value Medicare, and I seek to lend a voice to those who are calling for common-sense changes. As we will see, Medicare in its current incarnation is both unsustainable and counterproductive in the quest to achieve the high-quality cost-effective health care that most doctors and their patients crave. Its reforms, many of which have driven doctors out of the system and which stymie my ability to care for my patients every day, are also leading us down a road no less rosy than the system they are trying to repair. In fact, to paraphrase an almost Orwellian zinger that distresses every primary-care doctor I know, we are now being implored to practice “quality” and “value” care using mechanisms that are the very antithesis of quality and value; the individuality of each patient is lost in the homogenization of health-care delivery that relies on quantifiable metrics that doctors must spend much of their time documenting in computers rather than looking patients in the eyes and having more meaningful conversations. If we are going to really cure Medicare, we must move our gaze to the doctor’s office and see how the current system and its complex array of reforms color the interaction between doctor and patient, between patient and the health-care-delivery system, between quality geriatric care and the realities of what Medicare offers its recipients. When we look at it in that context, I believe we are moving in a very dangerous direction, but one that can be easily righted with the input of doctors and patients rather than pundits and professional reformers.

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, and unless we provide our elderly with the comfort and dignity that the vast majority of them seek, 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 become the norm. But that should be our ultimate goal.

DEFINING QUALITY

The Quest for Numerical Perfection

Everyone dies of something. Every time a new complication develops, the doctor will assign it a name, giving you another diagnosis. . . . Each diagnosis has a potential treatment, which the doctors will dutifully tell you about— if you haven't already looked it up on line.

IRA BYOCK, *The Best Care Possible*

The pharmaceutical industry has thrived in this country because people believe that medicines are both essential and useful to repair a variety of dangerous and bothersome conditions, something that is especially true in the elderly. Whether treating aberrant numbers (blood pressure, cholesterol, sugar, etc.) or helping to resolve nuisance conditions like urinary incontinence and confusion, drugs flood our elderly patients' bodies. But many medications have dubious efficacy and can be frankly dangerous. Often they are used to treat problems that do not meaningfully improve, and more often they instigate troublesome symptoms, drug interactions, and harmful side effects.

Medicare does not itself compel patients to take more medicines; our national drug obsession is a much more complex phenomenon than can be ascribed simply to Medicare. But especially since the advent of Medicare D and the adaption of clinical performance measures (labeled as quality indicators by CMS) to grade doctor quality, Medicare is playing

a larger role in encouraging and financing excessive medication use. And as we discussed, Medicare D places minimal restrictions on what drugs patients can take, and does not negotiate with pharmaceutical companies to secure medicines that are lower in cost but equally efficacious. Said one doctor who has studied this problem: “If the government’s real goal were to increase senior citizens’ access to the most effective medicine, its first step would have been to determine the best care based on the best scientific evidence available, helping patients and doctors to make informed decisions. Instead, the medicine prescription drug bill simply opens the public coffers to pay the price for expensive brand name drugs.”¹

As significantly, Medicare as part of its reform effort is grading doctors based on the quality of their care, something that also can actually lead to more medication use. Through two programs primarily—the Physician Quality Reporting System (PQRS) and Accountable Care Organizations (ACOs), both of which we will discuss in detail later—Medicare is compelling doctors to produce evidence that they are following quality indicators as defined by CMS. We as physicians are required to complete an established set of questions, many of which have little relevance to our particular patients, and to demonstrate that we are in compliance with a variety of such indicators, something that will eventually help determine some of what we are paid. It is felt that such pay-for-performance strategies will help doctors practice better medicine and save the system money. It is a laborious and expensive process for us, and often it pushes us to mindlessly fill out scripted checklists when our time could be better spent having meaningful discussions with our patients. Since every elderly patient has a unique set of wants and needs, and each one offers unique challenges that make templated responses virtually useless, Medicare’s attempt to impose quality standards on us yields more busywork than meaningful change.

Quality indicators have another dark side, one that can increase unnecessary testing and treatment in the elderly. By forcing us to comply with specific standards, Medicare expects us to order tests and prescribe drugs that we, and our patients, may not believe to be beneficial. By tying the quality of our care (and ultimately a portion of our salary) to the achievement of those standards, Medicare is pushing us to act in a way that may

actually be counterproductive to quality care. Many indicators are designed to persuade doctors to evaluate and treat abnormal numbers. High blood pressure, high cholesterol, high sugars, abnormal bone density results, low heart ejection fraction, irregular heart rhythms—all of these have specific guidelines that script what is deemed to be appropriate testing and treatment. To be fair, many of Medicare's quality indicators are more reasonable than other clinical-practice guidelines, many of which seek aggressive care for virtually every abnormal number in the elderly. But virtually none of Medicare's quality guidelines encourage doctors to *avoid* testing for and treating these abnormal numbers even in the very oldest of our patients; at best, they encourage some testing and treating, and are silent about overtreatment. Just how important is it to treat abnormal numbers in the elderly? That is the crux of what we have to explore, for its answer illuminates much of what is wrong with Medicare and how to fix it.

Numbers

As an internal-medicine resident at the University of Virginia, I spent time in a rural clinic in Orange County working with two excellent doctors. One day they sent me to see a farmer who was in his mid-90s and still worked his farm independently. When I saw the man he seemed strong and young, very calm, fairly sharp, and nimble on his feet. I examined him and found nothing particularly wrong except for his blood pressure, which was close to 220/110 from my recollection. To me this finding was startling. I rechecked it a few times, and the results did not change. The man took no medicines and had no serious medical problems. He felt very well.

I talked to one of the clinic doctors and insisted that we treat the man for his dangerously elevated blood pressure. We had all read the new SHEP (Systolic Hypertension in the Elderly) study that demonstrated the dangers of high blood pressure in the elderly,² and thus we needed to be more vigilant in treating pressure elevations among our older patients. The doctor bucked, but I convinced him to allow me to use a very mild blood pressure medicine, and the patient agreed. I told him I would go out there next week and check the pressure again. Well, next week never came. Several

days after starting the medicine, the man died. Coincidence? Unlikely. My guess, now that I have more extensive real-life experience with the elderly, is that the man had very narrow arteries to his heart and brain and kidneys, and he needed every bit of that high blood pressure to keep the blood flowing to his vital organs. In fact, his body's natural auto regulation system probably pushed that pressure up to keep him alive. When I gave him a pill to make his numbers look better, I unintentionally dismantled his body's coping mechanism by decreasing that necessary pressure and thus instigated his demise.

This is not an isolated event. Number obsession has reached a fever pitch among the elderly and those who care for them. Numbers are everything, even if we are not quite sure what those numbers should be for each individual. As one doctor states in his book on medical excess: America's elderly know their numbers "and are hell bent to be normal."³ It may be blood pressure, pulse, sugar, cholesterol, kidney function, bone density, thyroid level, blood count, vitamin levels; there are dozens of numbers that can be measured, fussed over, and fixed with medicines. As people age, their numbers deteriorate and diverge from what is deemed "normal"; the more we look, the more we will find, and the more medicine we will need to dispense to fix.

We know from science and experience that the aggressive treatment of numerical abnormalities in the elderly, especially in conditions like diabetes and hypertension, frequently causes side effects, worsening physical and mental function, and an impaired quality of life without extending lifespan or even preventing major adverse outcomes (such as strokes, heart attacks, and cancer) in a measurably significant way. Medicines can fix numbers, but rarely do they improve a geriatric patient's life. In fact, the more we toss into an elderly body, the more interactions and complications will occur. As we will see, low numbers are typically much more immediately dangerous than high ones; I have seen many more people injured and even killed by aggressive treatment that drops their numbers than by benign neglect. But such a reality does not deter the US medical community from employing an array of medications in pursuit of numerical perfection. If the lore of what defines quality medical care starts anywhere, it is in the theater of medications, where numbers are perceived to be beacons, pills are touted as saviors, and those who push the pills and fix the numbers are our medical saints.

I am frequently told by my patients, and those caring for them, that I have to be more vigilant in monitoring and fixing numbers. Physical therapists and home care nurses e-mail me about blood pressures or sugars that are too high; they often have an alarmist tone when they convey the information, expecting me to intervene quickly. Nursing homes, as we will see, measure and expect immediate treatment for an infinitude of numbers, from thyroid levels to blood pressures, sugars, and a large variety of labs. My patients see specialists, emergency room doctors, and even family members who frighten them about their abnormal numbers. Often these abnormal numbers are merely blips, the results of tests taken at inopportune times when patients are in pain, stressed, ill. Sometimes the numbers are not even very high, but they have crossed some imaginary line between normal and dangerous. The assumption by many who contact me is that once that line is crossed, then a stroke or heart attack or perhaps even death is imminent.

Since numbers can be easily measured, and since so many of them can be “fixed” with medicines, patients often swallow handfuls of pills to push their numbers back to the acceptable side of normal, after which they can be monitored in a variety of ways to ensure the numbers stay in line. And if the numbers start to migrate away from what we have deemed to be normal, more medicines and tests will naturally flow through their frail bodies. But what are normal numbers for the elderly, and does fixing abnormal numbers impart any meaningful clinical benefit to our patients?

We can measure numbers many ways. Tests, labs, vital signs: for every patient, we can compile numbers that come to define them. Then we label our patients with diseases that correspond to their errant numbers. They may have high blood pressure, high cholesterol, diabetes, osteoporosis, hypothyroidism, anemia, dementia, and one of any number of conditions that we can treat and then monitor through copious lifelong testing. In my practice the pursuit of numerical excellence is one of the primary reasons patients see me and an army of specialists on a regular basis. Many doctors who have studied our health-care system believe that the medical community is intentionally manufacturing disease by using these numbers because the medical community thrives when more people are sick. Some state that we are turning aging itself into a disease.⁴ Locating a number that equates to an illness and that can be altered with medicine is seems to many people like a productive use of medical science these days.

To best assess the value of measuring and improving numbers in our elderly patients we have only two tools: experience and scientific investigations. The former is a subjective means of assessment that doctors like me utilize based on what years of practicing medicine have taught us, while the latter is alleged to be more objective and universally applicable. The truth is that most studies done on medications do not involve older people, as elderly patients typically are excluded from medication studies.⁵ The studies that do have an older cohort rarely involve elderly participants on multiple medicines and with numerous medical problems resembling the majority of older patients for whom I care. Also, most studies are sponsored by drug companies, and when the results of those studies diverge from what the pharmaceuticals desire, the studies are not published.⁶ Thus, when we assess the impact of disease and medication on older patients, we are using very little data that is reliable and meaningful.

When we do evaluate studies about numbers and the medicines used to treat those numbers, we must be aware of a very important nuance in the statistical presentation of data, something of which I have only recently become aware in my medical career. Most studies report their results in terms of *relative risk and benefit*. Those numbers could seem very impressive and make a test or treatment appear much more significant than it really is clinically. *Absolute risk and benefit*, however, is a much more revealing number, although rarely reported in the press or medical literature. In addition, it is important that the endpoint of a study reveals a *clinically significant* result. For instance, we do not care if a certain drug improves someone's number; we do care if the drug, by improving the number, helps them be healthier or live longer. Pharmaceutical companies that sell medicines and sponsor studies, medical researchers who gain prominence from demonstrating significant findings from their studies, and even members of the medical community who seek justification for aggressively labeling and treating disease all rely on the allure of relative risk. A small risk to a patient who has an abnormal number (such as high blood pressure), or a small improvement in the patient's health from fixing that number, can be magnified into what seems to be a huge benefit when results are conveyed by relative risk and benefit rather than absolute risk and benefit.

Consider that a lottery in this country has a huge payoff, and you learn that there is a fivefold higher chance of winning if you buy a ticket in Ohio instead of Maryland, where you live. Is it worth flying to Ohio to buy some

tickets? The relative chance of winning in Ohio is five times higher, or 500 percent better, than if you purchase a ticket in Maryland, an impressive number and perhaps worthy of a plane ticket. That is relative benefit. But the absolute benefit is much less impressive. If the chance of winning in Maryland is one in ten million, and the chance of winning in Ohio is five in ten million, then the absolute benefit of traveling to Ohio is a four in ten million increased chance of winning, a much less appealing advantage. A five-times relative benefit is really a four-in-ten-million absolute benefit. Thus, although in medical literature we hear almost exclusively about the relative benefit and risk of certain medicines and treatments, that number typically obscures the more relevant truth revealed by absolute risk and benefit.

It is important, then, to evaluate certain clinical situations where medicines are used to fix abnormal numbers in the elderly and to ascertain whether, in absolute terms, such interventions are justified. We also need to determine whether the risks of treating those numbers in the elderly are, in absolute terms, of concern to us. Medicare and the ACA, among other groups, are trying to assess and grade physician quality by tying it to the measurement and fixing of numbers and various medical conditions. This is being touted as a major thrust of reform: paying doctors for quality performance is perceived to be a revolutionary means of saving Medicare. But the validity of such an approach lies hidden in the numbers themselves. The question is: Can we achieve improved health-care outcomes in the elderly at a reduced cost by measuring and fixing numbers through models such as Medicare's quality indicators? The answer to that question reveals a deeply rooted flaw in our geriatric health-care delivery system, a flaw that has blinded many of those who are now trying to reform Medicare, and one that we will explore throughout this book.

The Case of A-fib

Medicare Quality Indicators state that all people over age 18 who are deemed to be high risk for stroke by specified criteria [which include virtually all of the elderly] should take Warfarin or a similar anticoagulant.⁷

The treatment of atrial fibrillation (A-fib) with warfarin (brand name Coumadin) is a good illustration of how relative risk can be a misleading

means of evaluating a treatment. A-fib is a condition common in the elderly where the heart beats irregularly and rapidly. The primary difficulty with A-fib is that clots can accumulate in the heart and cause strokes. To prevent this complication, doctors place patients on blood thinners such as warfarin, an old rat poison that prevents clots from developing. In fact, people with A-fib on warfarin have 50 percent fewer strokes than do people with A-fib on aspirin.⁸ Because of such impressive results, virtually all doctors recommend the use of warfarin in their older patients. Its use is standard care and it is part of every clinical performance measure to which doctors are supposed to adhere. For most of my career, I never questioned its unassailable necessity; after all, why risk a stroke when there is such an effective treatment available?

But numbers can be deceptive. Fifty percent reduction is a relative benefit. In fact, the chance of an older person with A-fib getting a stroke is close to 6 percent a year. With aspirin that number moves down toward 4 percent. With warfarin that number is closer to 2 percent.⁹ True, warfarin confers a 50 percent risk reduction compared to aspirin, but that is because it cuts the risk of stroke in half compared to aspirin, reducing it from 2.5 percent with aspirin to 1.4 percent with warfarin.¹⁰ Also, as many as half the strokes that occur are minor and leave no lasting effects, so the clinically relevant improvement is half of those numbers, or a 6/1000 decrease in the number of disabling strokes in people who take warfarin instead of aspirin. That is the absolute risk reduction. Looking at it another way, there is a 99.3 percent chance of averting a clinically relevant stroke with warfarin, and a 98.7 percent chance of averting a stroke with aspirin. When my patients hear about a 50 percent reduction in stroke, they are petrified about using aspirin instead of warfarin, despite their fears of warfarin. When I tell my patients about the absolute risk reduction, however, many of them prefer to take their chances and use aspirin, especially my patients who are older and are on many other medicines.

Why not just use warfarin? Major strokes can be devastating, so even a small risk reduction can be significant. The problem is that warfarin is not a benign drug. It interacts with virtually every medicine and food, from tea, to Tylenol, to a dinner salad. Patients must check their blood levels frequently; failure to do so could result in either ineffective doses or toxic doses. Patients on warfarin bleed more, sometimes dangerously so, especially if they fall down, and especially if they are over eighty. Studies suggest that the risk of serious bleeding ranges from 4 to 7 percent (40–70/1000)