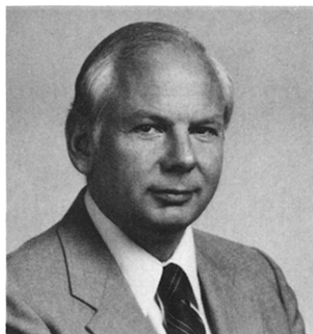


## EDITOR'S PAGE

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### Death of a Friend: "I Want to Die!"

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I took care of Mr. L for many years. He was 90 years old and had lived a full and productive life. He had end-stage heart failure secondary to recurrent myocardial infarction, although his mental faculties were preserved. He was receiving appropriate heart failure and anti-ischemia medications, but his condition gradually deteriorated despite my best efforts. He had been admitted to hospital three times in the past year with worsening heart failure and had nearly died twice. Part of our friendship related to our common religious roots and the fact that he had known my parents. Mostly, our friendship related to the rapport we felt between us, and the many times we laughed together and had serious philosophical discussions together. His second wife had recently died of cancer, and at the end of another hospital stay he posed a difficult question: "Doctor, why are you keeping me alive? I want to die! I can't do anything at home, and I know I won't get better. Why are you keeping me alive?" I understood that his question partly reflected his firm belief in an afterlife and a reassociation with departed loved ones. It was also clear that as his quality of life approached zero, longevity had become meaningless. I reflected on the several ethical issues associated with his question.

**Cost of terminal care of the elderly.** Does Mr. L, the prototypic example of the high cost of Medicare expenditures just before death, represent "futile care"? Was I guilty of contributing to these excess costs? Data suggest that the 5% of Medicare recipients who die each year consume up to 30% of the Medicare expenditures that year (1). Costs during the last month of life are nearly 40% of the last year of life. Recently, however, Emanuel and Emanuel (2) wrote a thoughtful article entitled "The economics of dying—the illusion of cost savings at the end of life." In a compelling discussion, they estimate that reduction of the use of aggres-

sive life-sustaining measures for dying patients will save, at best, 3.3% of the total health care expenditures. Thus, although end of life care is expensive, these costs may be difficult to control.

**Advance directives.** Mr. L. and I carefully discussed the meaning of a do not resuscitate (DNR) order. After learning that the probability of survival to discharge with cardiopulmonary resuscitation (CPR) was 0% to 5%, he agreed that such a DNR order should be written (3). He felt comfortable with this, although many families of patients do not.

**Who determines whether standard therapy should be withdrawn?** Mr. L. was receiving standard therapy for severe congestive heart failure that did not include any extraordinary measures. He asked me to stop all medications during his hospital stay. I didn't because we clearly had helped him, and it seemed inappropriate because of the good clinical response.

Several weeks later, however, he called me on the phone and repeated his statement, "I want to die." After two different phone conversations, he indicated that he was going to stop all medications and that he hoped it was all right to do that. I reassured him that this was his decision, and although I could not tell him to stop all medications, I understood his decision. I said goodbye to him over the phone, and a few days later I received a call that he had died.

Since Mr. L's death, I have reflected on this experience and wondered whether we tried too hard to prolong his life. As physicians we are much more comfortable in our role of saving life as opposed to allowing life to end. We are even less comfortable in the role of ending life. We understand the concept of futile care, but it is difficult to empathize with Dr. Kevorkian. Withholding aggressive care is a comfortable concept in some terminally ill patients, but withholding standard care is much more difficult other than to support a patient's decision to do it.

If the future of our medical care system is to emphasize cost-savings, we may have more difficult ethical decisions to

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make. Data suggest, however, that even advance directives or living wills don't appreciably alter the cost of care (4). Hospice care may reduce medical costs by one-fourth for selected patients during the last 6 months of life but cannot be applicable to all situations (5). Sometimes family members may want more aggressive management than seems appropriate or is even wanted by the patient. The statement, "We want everything possible done for mother," may perhaps reflect the guilt that children feel if they haven't been that close to their mother when she was well.

In any event, I believe that we should continue our traditional role as an advocate for the patient. Quantity and quality of life must be carefully balanced in our management of individual patients. We must err on the side of prolonging life rather than ending it. Above all we must know our patients as friends. Caring for the Mr. L's of the world is the

great opportunity of our profession. I will always remember his statement—"I want to die."

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