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BEING MORTAL: MEDICINE AND
WHAT MATTERS IN THE END
BY ATUL GAWANDE

TARA DARLING¹

In his fourth and most recent book, Atul Gawande, surgeon, writer, public health researcher, and professor at Harvard School of Public Health and Harvard Medical School, authored an emotional and moving work entitled, *Being Mortal: Medicine and What Matters in the End*.² This 2014 work is likely to play a pivotal role in how doctors interact with their patients as both attempt to come to terms with the patient's mortality. Gawande, through exceptional storytelling, recounting experiences with his patients, describes how medical professionals can engage in "hard conversations"³ with their patients to identify what is most important to the individual and to subsequently devise a plan which recognizes the individual's goals at the end stages of life. This book is not only for those practicing medicine, but is for all readers who will one day have to cope when "things fall apart"⁴ and find a way to gather the "courage"⁵ to move forward. *Being Mortal* is comprised of eight chapters, which seemingly represent the natural process of coping that human beings tend to go through when they learn they are dying. In the beginning of the book, Gawande explains that having a purpose in life is often what pushes us to keep fighting for our health as we age or become ill; however, as the book evolves, Gawande comforts the reader by acknowledging that once we reach a point at which returning to our previous baseline – living the life we once had – is unattainable, it is acceptable to find a new purpose in life and accept that our battle may be lost. Gawande writes *Being Mortal* from a first person narrative perspective. Gawande allows the reader to understand the struggles that doctors face when discussing end-of-life decisions with their patients by incorporating conversations with his colleagues into the

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² ATUL GAWANDE, *BEING MORTAL: MEDICINE AND WHAT MATTERS IN THE END* (2014).

³ *Id.* at 191 (Chapter 7, entitled "Hard Conversations").

⁴ *Id.* at 25 (Chapter 2, entitled "Things Fall Apart").

⁵ *Id.* at 231 (Chapter 8, entitled "Courage").

book. Gawande also provides the reader with an opportunity to experience how individuals and their loved ones feel when a devastating diagnosis is received by providing the dialogue between the patient and the doctor at this time. Gawande draws conclusions based on these conversations and uses data, from numerous sources, to solidify his findings.

Being Mortal has many strong points and the most powerful are summarized as follows. Firstly, Gawande acknowledges the difficulty doctors have when they are faced with having hard conversations with their patients. Secondly, Gawande highlights the challenges doctors have in recognizing an individual's wishes and desires. Lastly, Gawande addresses how medical professionals' mindsets can be switched from "we have to do something" to "how do we deal with this?"

Gawande explores these three points in Chapters 6 and 7, entitled Letting Go and Hard Conversations, respectively. Gawande encourages doctors to engage in difficult conversations with patients despite the likelihood that these conversations, at least to begin with, tend to cause anger and sadness. However, by engaging in subsequent conversations that expand upon the initial difficult conversation, it is likely to lead to the development of a course of action that will be implemented when the patient's situation worsens. This dialogue between doctor and patient lends to the discovery of what trade-offs the patient is willing and not willing to make. For example, Susan Block, a palliative care specialist, with whom Gawande spoke when writing this book, stated that she and her father engaged in a hard conversation before he underwent a dangerous surgery. Block recalls asking her father "how much [he] was willing to go through to have a shot at being alive and what level of being alive is tolerable to [him]." Block's father stated, "Well, if I'm able to eat chocolate ice cream and watch football on TV, then I'm willing to stay alive. I'm willing to go through a lot of pain if I have a shot at that."⁶ The result of conversations like these can be profound. Gawande cites a 2010 study from the Massachusetts General Hospital to illustrate the important role hard conversations can play in end-of-life decision-making.⁷ In this study of 151 patients with stage IV lung cancer, half of the patients received the usual oncology care while the other half, in addition to the usual care, received visits from a palliative care specialist.⁸ During conversations with patients, the palliative care specialists discussed

⁶ *Id.* at 183.

⁷ *Id.* at 177.

⁸ *Id.*

patient goals and priorities in the event the condition worsened.⁹ The study found that the patients who engaged in conversations stopped chemotherapy sooner, entered hospice care much earlier, experienced less suffering, and lived 25 percent longer than patients who did not have similar conversations.¹⁰

Gawande acknowledges that many doctors, when facing difficult end-of-life decisions, often fall back on their default: “Do Something. Fix Something.”¹¹ He himself recalls times when he prescribed treatment that he knew was unlikely to improve the patient’s condition but did so in the hope that a miracle might happen.¹² Sadly, these miracles rarely occur. Gawande states, “understanding the finitude of one’s time can be a gift.”¹³ Throughout Chapter 7, Gawande explains how doctors can switch from the mindset of fixing to the mindset of helping, thus aiding the patient in understanding and appreciating the time that is left. These conversations can lead to the creation of a common goal between doctor, patient, and family members which can help the patient live for the best possible “today” instead of sacrificing time now for time later. Discovering what matters most to the patient can give the remainder of life greater meaning and provide the patient with a purpose with which to move forward. Not surprising, yet comforting, these conversations also assist family members when the patient’s condition does in fact worsen because they do not have to ask themselves what the patient would want—they already know. Although Gawande recognizes that the primary function of medical schools is to teach its students how to save lives not how to appropriately and sensitively address mortality, a doctor’s ability to converse with patients is important.

Although *Being Mortal* has many strong points, there is one area of significant weakness. Gawande fails to more fully explore solutions to the declining numbers of geriatricians and the falling number of medical students applying to training programs in adult primary care. Gawande writes that he himself did not “fully grasp the nature of the expertise involved [in geriatrics], or how important it could be for all of us” until he visited his hospital’s geriatric clinic.¹⁴ In Chapter 2, entitled Things Fall Apart, Gawande references remarkable results from a study conducted by the division of geriatrics at the University

⁹ *Id.*

¹⁰ *Id.* at 177-78.

¹¹ *Id.* at 174.

¹² *Id.* at 165-73.

¹³ *Id.* at 209.

¹⁴ *Id.* at 37.

of Minnesota.¹⁵ However, only a short time later, this division was forced to shut down because of its financial losses.¹⁶ Gawande also highlights additional problems that prevent medical students from entering the geriatrics field. Gawande describes an overall negative attitude about treating elderly patients because of the variety of ailments and illnesses they commonly suffer. Furthermore, income in geriatrics and adult primary care is the lowest in the medical field.

Gawande leaves the reader questioning what can be done to fix this dire problem as the elderly population continues to grow rapidly yet the number of certified geriatricians the medical profession put in practice between 1996 and 2010 fell by 25%.¹⁷ Gawande also references the dwindling numbers of applications to training programs in adult primary care.¹⁸ *Being Mortal* acknowledges the impact geriatricians can have on patient's lives; however at the end of the book the reader demands to know what will change the medical students' perspectives and encourage them to enter the field of geriatric care.

Being Mortal is a valuable contribution to the field of medicine because it offers a path to redefine the doctor-patient relationship for patients near the end-of-life. Rather than continuing treatment that may shorten the lives of dying patients and prevent them from having another good day, doctors can have conversations with their patients to discover the patient's wishes and desires. As Gawande explains, each individual is different. They are different in terms of the treatment they wish to endure and in terms of their personal desires and goals. Whatever an individual's desires, the doctor should now have the tools to approach the topic, have the conversations, and help the patient have the best day "today."

Gawande helps to illustrate that although discussing end-of-life decisions with patients is uncomfortable, unpleasant, and difficult, these conversations are necessary because the outcomes can be profound. For example, take Gawande's description of practices at Gundersen Lutheran Hospital in La Crosse, Wisconsin. In the early 1990s, local medical leaders in La Crosse campaigned to have doctors and patients discuss end-of-life wishes.¹⁹ The medical professionals implemented a plan in which each patient admitted to a hospital, nursing home, or assisted living facility in La Crosse would answer a short multiple choice form asking questions like whether they wanted to be resuscitated if their heart stopped or whether they wanted to be

¹⁵ *Id.* at 44-45.

¹⁶ *Id.* at 45.

¹⁷ *Id.* at 36.

¹⁸ *Id.*

¹⁹ *Id.* at 179.

treated with antibiotics.²⁰ By 1996, eighty-five percent of La Crosse residents who died had advance directives in place, which were almost always acknowledged and followed by their doctors.²¹ The results were significant—La Crosse residents have a life-expectancy that outpaces the national mean by one year and La Crosse simultaneously reduced its end-of-life costs to about half the national average.²²

Further, Gawande encourages professionals in the medical field to recognize the need for facilities that offer patients a rich opportunity to have a life worth living. Gawande recognizes that when deciding where to send our loved ones as they age and become ill, we, as concerned family members, often make a determination based on where we would be most comfortable leaving them. Generally, we are comfortable leaving them somewhere safe. Gawande states that we create “a life designed to be safe but empty of anything they [the elderly] care about.”²³ By encouraging the creation and expansion of facilities that give the elderly a reason to live and recognizing what is important to the individual, we can make their lives more enjoyable even as the hardships of old age continue. Keren Brown Wilson, a pioneer in the creation of assisted living facilities, recognizes that although the elderly may not be able to provide for many of their needs themselves, they still desire autonomy and freedom.²⁴ The original skilled nursing facilities which provided for as much independence as reasonably possible have now been “mutated . . . into a menagerie of watered-down versions with fewer services.”²⁵

In Chapter 5, entitled *A Better Life*, Gawande describes the type of facilities that have been successful in providing a life with meaning to the elderly. Gawande describes one facility, Chase Memorial Nursing Home (hereinafter “Chase”), which built on Wilson’s idea for assisted living facilities. Bill Thomas, Chase’s medical director, attempted to fight what he described as the “Three Plagues of nursing home existence: boredom, loneliness, and helplessness” through spontaneity, companionship, and mutual care and support.²⁶ By allowing residents to choose what time they wake up, what activities they engage in, and what foods they eat provides a degree of autonomy for individuals whose lives depend on help from others. Chase provided life, in a literal sense, to its residents by introducing gardens, live

²⁰ *Id.*

²¹ *Id.*

²² *Id.* at 178, 180.

²³ *Id.* at 109.

²⁴ *Id.* at 87.

²⁵ *Id.* at 101.

²⁶ *Id.* at 116.

plants, animals, and children into the facility. Chase reduced the number of prescriptions required per resident to half of that of a nursing home without such innovations, decreased total drug costs by 38 percent, and decreased deaths by 15 percent.²⁷ Unfortunately, Chase is an exception to typical nursing homes found throughout the nation. However, Gawande allows the reader to believe that perhaps now is the time to revisit Wilson's idea of skilled nursing facilities and implement imaginative ideas.

Throughout *Being Mortal*, Gawande successfully portrays the difficulties that both doctors and patients face when dealing with the end stages of life. Rather than continuing the old practice of providing treatment when the chances of restoration to the previous condition are minimal, Gawande provides doctors with the tools to revolutionize the medical field. If doctors learn how to implement Gawande's techniques, patients will be able to confront their mortality but still have the ability to live the rest of their days with a new-found purpose.

Although *Being Mortal* is helpful to those in the medical field, it is also helpful to those who currently practice or plan to practice in the field of Elder Law. Attorneys who are involved in preparing their clients for old age have to engage in difficult, and often unpleasant, conversations with their clients. Gawande's advice to medical professionals can be transferred to attorneys. Perhaps it is possible to prepare the legal client for the difficulties that are to come by engaging in these conversations with a new outlook, and thereby discovering what is most meaningful to the client, and preparing a plan tailored to the client's goals. Often times, the client avoids having these conversations because of a reluctance to confront mortality; however, a time may come when the client no longer has the mental capacity or physical ability to take care of themselves and make decisions. By developing a relationship with clients when they are still capable and by ascertaining their values, lawyers may prepare a plan that can offer comfort to clients and their loved ones.

Being Mortal is certain to have a lasting impact on its readers, regardless of their backgrounds. To illustrate this point, I had to look no further than my own personal experience. In 2012, between semesters in my first year of law school, my Grandma Lu fell seriously ill and was hospitalized. Sadly, she never recovered. Both before and during my Grandma's illness, she refused to confront her own mortality, often stating, "Oh, God forbid!" when the subject was brought up. The conversation usually ended there – her doctors never pressed

²⁷ *Id.* at 123.

her to divulge more information and neither did my family. When she fell into a coma during her hospitalization, we were distraught. Not only were we faced with losing the most treasured member of our family, but we were forced to make decisions based on what we thought my Grandma would choose, when in reality we truly had no idea. Even two years later, the haunting questions still confront us – Did we do what she would have wanted? Did we give up too soon? Should we have made her undergo that treatment?

There is a strong possibility that if either my Grandma's doctors or my family members read *Being Mortal* long before my Grandma became sick, we could have engaged in a dialogue that would have prepared us for what was to come. Gawande highlights that these conversations are both challenging and difficult to have. Knowing my Grandma's personality, I am sure she would have been resistant to having them; however, if we employed these tools and put them to use the way Gawande urges us to, my Grandma's suffering may have been shortened and my family and I may have found solace in knowing that we did what we *knew* my Grandma wanted.