Dying in 559 Beds: Efficiency, "Best Buys," and the Ethics of Standardization in National Health Care

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In *The Notebooks of Malte Laurids Brigge*, the "heavy, difficult book" begun in Rome during the winter of 1903–4 and not finished until 1910 in Paris, Rilke employs a series of rapid, jolting impressions to express his pervasive concern with death and his distress about the institutional character of death among the poor. To convey an image of poverty, he describes the worn furniture of a cheap rented room: "if I were not poor I would rent another room with furniture not so worn out, not so full of former occupants, as the furniture here. At first it really cost me an effort to lean my head on this arm-chair; for there is a certain greasy-grey hollow in its green covering, into which all heads seem to fit."[1] To portray the nature of dying in medical institutions for the poor, he describes the Hôtel-Dieu, the hospital for the poor, across the plaza from the Cathedral of Paris: "This excellent hôtel is very ancient. Even in King Clovis' time people died in it in a number of beds. Now they are dying there in 559 beds. Factory-like, of course. Where production is so enormous an individual death is not so nicely carried out; but then that doesn't matter. It is quantity that counts."[2] And to describe the actual medical course of dying among the poor and sometimes even the rich, he creates the notion of what might be called the "official" death for a given disease, that is, its standard or most likely outcome: "the wish to have a death of one's own is growing ever rarer. . . . One dies just as it comes; one dies the death that belongs to the disease one has, for since one has come to know all diseases, one knows, too, that the different lethal

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*For their comments, I would like to thank Larry Brown, Paul Menzel, Dan Brock, Allen Buchanan, and participants in the Seventh Utah Conference on Ethics and Health, January 17–18, 1991, where an earlier version of this essay was originally presented.

terminations belong to the diseases and not to the people; and the sick person has so to speak nothing to do."[3]

In this short essay I'd like to take Rilke's rather enigmatic, impressionist descriptions seriously, not just to discover what it is that disturbs him about the medical character of dying among the turn-of-the-century European poor, but to see what this extraordinary poet's intuitions might tell us about turn-of-the-next-century national health care. What troubles Rilke most, I think, is what we might call the prospect of *standardization:* the tendency of a system to treat people under its control in a uniform, regulated, unindividualized way—robbing them, Rilke hints, of the capacity to function fully as persons. The poor are the immediate victims, since they are economically powerless to resist; but even the rich can be co-opted by expectations in medicine which have the same standardizing and hence dehumanizing effect.

The prospect of standardization is, in Rilke's view, associated with large numbers and severe cost pressures: the poor are "dying in 559 beds" in a dismally equipped hospital funded only by charity. But it is this association of numbers and costs that invites us to consider the relevance of Rilke's concerns for contemporary national health care systems: after all, national health systems involve both very large numbers and very severe cost pressures. Nor is there any way to relieve either of these pressures: by definition, a national health system involves the largest possible numbers, since everyone is to be eligible for care; and, as in any health system, a national health system is continuously subject to increasing cost pressures for which there is no natural solution. Since there is always need for more rapid and effective cure of disease, for better ways of controlling chronic conditions, for more reliable relief of pain with fewer side effects, and for more effective preventive efforts, and since there are always more patients who would benefit from these developments, there will always be cost pressures associated with providing better health care. Furthermore, since all patients eventually die, there is no natural bound to the resources in labor or technology which could be used to try to ease or postpone this event.

EFFICIENCY IN NATIONAL HEALTH CARE

In the face of very large numbers and continuing cost pressures, a national health system will have, at least in principle, a predictable goal: the development of greater efficiency (also often called cost-effectiveness[4]) in the treatment and cure of disease and in the control of chronic conditions. It will continuously work to restructure its practices, including its medical practices, so as to achieve cure or control for less money. The early symptoms of this tendency are already apparent, in the current transitional medical climate, in the so-called "outcomes revolution,"[5] evident in some sectors of U.S. medicine and followed with interest by many European observers. This reorientation of treatment evaluation practices seeks to change medicine's conservative reliance on conventional patterns of practice to direct inspection of the results obtained from specific procedures, that is, it looks not so much at whether the procedures physicians employ conform to a standard of practice as at what results these procedures actually get. As outcomes are correlated with procedures, it is then possible to formulate efficient, cost-effective practice guidelines for the profession. For example, the federal Agency for Health Care Policy and Research has already begun the development of practice guidelines for six common conditions—angina pectoris, benign prostatic hypertrophy, gallstones, arthritis of the hip, conditions of the uterus, and low back pain—which now occasion treatment amounting to more than half of inpatient surgery.[6] The effort here, at least in principle, is to identify those procedures which are effective in treatment, discarding those which are not; to identify criteria under which they should be performed; and to stipulate ways of measuring morbidity and mortality that will realistically reflect the effectiveness of the procedure given a specific severity of illness—or, in short, to identify the most effective way to cure or control these disease conditions, which can then be correlated with cost considerations.

A similar though unnamed emphasis on outcomes has long been at work in the development of associated practices such as preventative guidelines and early diagnosis programs, including screening programs, prophylactic care, instruction in self-help, genetic counseling, and so on. Here, it is assumed that prevention or early identification of a disease offers a more efficient way of controlling or curing it than medical intervention could provide at a later point in the expected course of the disease. The impulse behind these programs might be described as akin to the concerns to be expected in a national health program, inasmuch as the effort is to save money, as well as human costs, for the population as a whole. To be sure, some authors have pointed out that screening and early-risk-identification programs can prove more expensive because they identify disease which then requires treatment but which would otherwise go untreated;[7] partisan bickering then begins when it is observed that money to be expended in prevention programs in a non-national system comes out of different pockets from those that would realize the savings. Nevertheless, in a well-designed national system, this need not be so,[8] and it remains the case that such programs are in general both more humane and more efficient—if not initially cheaper—ways of responding to disease.

Thus it appears that both the development of practice guidelines and the development of prevention and risk-identification programs have in common that feature which Rilke suggests is the root of the problem of dehumanization in medicine: they invite "standardization." After all, practice guidelines have the effect of stipulating to the physician how a given disease condition is to be managed; prevention and risk-identification programs initially treat all subjects uniformly, subjecting them to the same screening procedures, and then feed those identified as positive risks into the health care system for treatment under its practice guidelines. Both thus increase the likelihood that all patients with a given condition will be treated in a uniform, "standardized" way. To be sure, similar developments may also occur in market-based, non-national health care organizations; nevertheless, the distinctive problem of standardization will be most acute in a national health system for which efficiency in care is the principal objective.

Of course, to suggest that a national health system would predictably make efficiency in cure or control of disease its central objective is in certain ways an ideal view: it assumes that the system's administrators and professionals, including physicians, are not functioning primarily from greed or other ulterior motives, that the system is well run and efficiently administered, that the development of bureaucracy within the system is not so complete as to take on self-perpetuating characteristics, and that other distortions have not corrupted the system. It overlooks the bells and whistles a national health system might have to add, perhaps at the cost of other efficient care, in order to maintain political support.[9] It also assumes that available funds are limited and that, as we have seen, health needs are never fully satisfied. But these conditions aside, a well-run national health system should nevertheless be more likely than a commercial health system to promote efficiency in providing health care. Were it not the case that the various factors involved are much too complex to admit such simplistic comparisons, it would be tempting to point out that the substantially better health status of the populations of the major industrialized nations with national health care systems than that of U.S. citizens suggests just such results: these populations, it would seem, get more efficient health care: care that is as good or better than that in the United States at substantially less cost.

Well-run, competitive, commercial health care systems also seek to be efficient, of course, but they seek to be efficient in ways that enhance their own profitability. For example, providers are likely to try to increase their market share in providing a particular service—whether or not the service is actually effective in curing or controlling disease. Providers, at least those who are not also payers, have less incentive to seek effective care than to expand the quantity of care provided, especially when the patient has little way of determining whether the care is necessary, since care is the source of their profit; this is the familiar phenomenon of overtreatment, a phenomenon directly addressed by federal controls such as DRGs. Other strategies, such as offering amenities and advertising directly to patients, represent additional techniques for stimulating demand for services in a profit-motivated system. In contrast, payers in a profit-motivated system, unlike providers, seek to limit their obligations as a way of enhancing their profits; this strategy is currently most evident in the insurance industry's attempt to move away from community rating, in which all insurees within a geographic region are assumed to pose the same risk, to a refusal to cover specific individuals and members of high-risk groups. But a national health system, though both provider and payer, will pursue neither of these strategies; it cannot seek to increase market share by overtreatment, since there are no competitors from whom to take away business; and it cannot seek to exclude high-risk individuals, since it is mandated to cover everyone. It is therefore forced to seek efficiency in providing the services it is required to give to all, since under limited funding there is no other way for it to function.

Thus, the essential features of a national health system, and those features which encourage it to strive for "health-targeted" efficiency in providing care, are the mandate to provide care under a limited resource pool for very large numbers—everybody—and a lack of competitors in doing so. These features will be especially pronounced in a well-run national provider system under which physicians and other providers are employees of the state; but they will also characterize a national insurance system in which reimbursement schedules are tight and explicit enough to control physician and other provider autonomy by limiting options for practice. In either form of national system, if physician and other provider activity is controlled by practice guidelines which have been developed on the basis of demonstrated effectiveness in achieving specific outcomes, and if, furthermore, the system is mandated to provide care for all, there will be no internal incentive to provide more care in general or more care for some people than is needed. While there will still be pressures to exclude some types of treatment, there can be no pressures to exclude individuals or high-risk groups. In general, neither overtreatment nor risk-exclusion will be favored. To be sure, we already notice some of these altered trends in our current transitional system: quelling overtreatment is already a goal in some components of U.S. health care, including federal and state programs like Medicaid and Medicare, the VA, and large health maintenance organizations which, operating almost like mini-national health systems, are their own payers as well as providers. Resisting exclusion is also becoming a goal, at least in some states—for instance, in those attempting to expand Medicaid coverage or to develop insurance pools for persons deemed uninsurable by commercial firms.

EFFICIENCY AND "BEST BUYS"

If health-targeted efficiency is predictably to be the central goal in a national health system, as distinct from the profit-targeted efficiency to be expected in competitive commercial systems, it is essential to explore what forms health-targeted efficiency might take and to consider whether these forms of efficiency would give rise to the kind of standardization and consequent dehumanization against which Rilke warns. In the absence of corrupting features, we can expect a national health system to be a system in which cost pressures operate to influence the formulation of practice guidelines, and in which the least expensive way of achieving the best outcomes will be designated as the standard regulating all medical care. Leaving aside for the moment the scientific and research difficulties of measuring outcomes and developing practice guidelines, as well as the administrative difficulties of promoting universal use of them, one way a national health system's tendency to favor health-targeted efficiency might take shape is in selecting not the *best* way to cure or control disease but the most efficient, cost-effective way to do so. A national health system operating under substantial cost pressures might thus employ—to use the term *Consumer Reports* made famous—not the best procedures for curing illness, but the "best buy" in procedures for doing so. Examples of best buys in procedures, as distinguished from the best procedures for treating the same conditions, include a number of modalities which are markedly cheaper than their "best" counterparts but still give nearly as good results. These might include, for example, the use of hydrochlorothiazide instead of ace inhibitors for hypertension; the use of medical rather than surgical methods of treating appendicitis; the use of traditional rather than low-osmolality contrast mediums in radiologic imaging; the use of cheaper, nonprescription niacin instead of the prescription drug cholestyramine in controlling serum cholesterol; the use of medical rather than surgical methods of treating coronary heart disease; reliance on nonrepair rather than reconstruction in ACL-MCL ligament knee injuries; medical rather than surgical methods of treating ulcers; and the use of aspirin in place of nonsteroidal antiinflammatory drugs or NSAIDS. Perhaps the most visible controversy over best versus best-buy options has been that involving the thrombolytic agents TPA and streptokinase for use following myocardial infarction (MI): despite the results of the major Gissi-2 and Isis-3 studies concluding that the two drugs are of equal efficacy in saving the lives of heart-attack patients, some physicians continue to insist that although streptokinase, at as little as $76 a dose, may be a best buy, the $2,200-per-dose TPA is nevertheless best.

Traditionally, considerations of the effectiveness of a procedure have in principle been given greater weight in the United States than considerations of cost: this is why the United States has developed a medical system providing care that, while very, very good, is also very, very expensive: its medical system has been providing first-class care, at least for some people, and has not, until recently, worried much about the price. It has insisted on the best, not on best buys. The prospect of a national health system seeking full efficiency in providing care for all but operating under budget limitations, however, forces us to consider whether it ought to turn to best buys in medicine rather than the traditional best in order to make ends meet.

To be sure, what counts as a best buy is a function of the amount of resources available, following the intuitive notion that a best buy is the best item of its kind one can get for the money one has available. If resources are not very limited the best buy will be nearly as good as the best; under greater scarcity, however, the difference between them will be pronounced. In either case, a national health system relying on fully demonstrated cost-effective best-buy practice guidelines or standards of practice for all medical and associated services would provide, in theory at least, the most benefits for the least cost for all persons. This would provide an alternative way of putting into practice the notion of "decent minimum": access to all services for all persons, but services of lesser efficacy.

Developing practice guidelines or standards of practice based either on best or on best-buy treatments is itself a form of standardization: such guidelines attempt to describe and put into practice a uniform way of providing care for each disease condition, thus producing results for each patient which are uniformly effective to the same degree. In general, by codifying and regularizing uniform ways of treating specific conditions, well-developed practice guidelines benefit all patients with such conditions except the few statistical outliers—that is, patients who would have responded better to some less orthodox form of treatment. But a carefully developed practice guideline will have few if any such patients and, more important, it will be impossible to predict which individuals they are; for if it were possible to predict which patients would respond better to some other form of treatment, this fact would call for the development of a new practice guideline for this specific subgroup. Thus, practice guidelines are, in principle, maximally effective. Of course, in real life, under any system, practice guidelines in some contentious areas of medicine are likely to be adopted not just on the basis of unequivocal, exhaustive reporting of clinical experience and impeccable scientific research but on the basis of political pressures from various groups partial on less-than-scientific grounds to one form of treatment or another. Then too, the development of practice guidelines presents other problems—most notably, the problems of how such guidelines can be challenged, if accepted practice is uniform and there is no way short of formal, controlled trials to gather contrary findings; whether the disincentives for challenging guidelines would stifle clinical progress in medicine; whether they would provide too easy a target for litigation; as well as the problem mentioned earlier of ensuring universal compliance.[10] Furthermore, there are continuing problems about measuring the efficacy of treatment, about weighing the value of various objectives (e.g., pain control versus rehabilitation), and about weighing nonmedical factors such as the value of privacy or confidentiality. Yet these problems do not outweigh the overwhelming utility of efficient practice guidelines in a cost-pressured system. In contrast to a market system in which some patients get precisely the treatment they need but other patients are undertreated, overtreated, treated inappropriately, or not treated at all, depending on what incentives affect the physicians who provide their care, a system based on practice guidelines—uniform throughout the medical system, and universally observed—would provide the most efficient care for all patients.

But, of course, the development of "best-buy" practice guidelines under cost constraints involves standardization at a lower level of effectiveness than when "best" guidelines are used. Discussion of disparate levels of care in medicine is already familiar talk in proposals for two-tiered health care systems, but the conjecture here about what a national health program would favor is different. It considers an alternative form of two-tiered national health system, one which relies for cost savings neither on excluding individuals from treatment (as would be prohibited in a national health system in any case) nor on excluding certain conditions or procedures, such as transplants (a form of tiering which invites political pressure from advocacy groups for patients with specific diseases), but which instead establishes two (or perhaps more) sets of practice guidelines to be employed depending on whether the patient is receiving publicly funded or privately paid care. Of course, two-tiered systems provide little protection against erosion of the lower tier; if overall funding for a public system is meager, the gap between highest-quality-possible care and most-efficient-given-the-budget-limitations care (that is, between best and best-buy care) could be quite large indeed, even though all persons would be eligible for care. Nevertheless, this form of a two-tiered system, under which best-buy care would be provided for the publicly funded and best care for those who could cover the additional cost, is demonstrably more just than other forms of public/private tiering (if any tiered system can be said to be just), since it imposes the liabilities of less adequate, lower-tier care equally on all publicly funded persons rather than, as in an exclusion system, on some few individuals from that group.

RILKE'S PARADOX? BEST AND BEST-BUY SYSTEMS

Is it possible that a gap of this sort is the real problem which Rilke's concerns with standardization would have us address, though of course there were no practice guidelines in turn-of-the-century France? The Hôtel-Dieu, committed to providing for all the poor with limited charitable resources, would no doubt have had to practice a crude kind of cost-efficiency, of which standardization of practice would have been an earmark. Perhaps it is this standardization that Rilke observes: "They are dying in 559 beds," he writes, "factory-like, of course." He continues this ironic industrial metaphor: "Where production is so enormous an individual death is not so nicely carried out; but then that doesn't matter. It is quantity that counts." Of course, Rilke might be objecting simply to the medicalization of death generally or to a kind of crude regimentation in medicine that pays little real attention to outcomes or the results of health care—that is, to either socially or medically callous warehousing of the dying—but his argument is still more interesting if we assume that the Hôtel-Dieu is doing the best it can to treat its patients' illnesses and that the standardization Rilke is objecting to involves practices as efficient as possible given the medical science of the time. Whether or not this is what Rilke saw, it is what Rilke lets us see.

Yet what we see is paradox. If we look closely at Rilke's concerns, we see that the issue of standardization in medical care is much more complex than we might at first expect, and that even his images of illness and poverty do not support any general rejection of standardization or the apparent claim that it dehumanizes people. Consider, for instance, his image for the depersonalized condition of the poor: if he were not poor he would rent another room, he says, and describes the effort it has cost him to lean his head on the armchair in the room he currently occupies. The armchair has a greasy-gray hollow into which all heads seem to fit—the heads of the previous, equally poor and transitory occupants of this shabby room. Not all of these occupants have been of the same physical size, but they have all been obliged to accommodate themselves to the same green armchair and it is the fact that persons are forced by circumstances to accommodate themselves to a standardized item neither chosen by them nor suited to them that is the basis of Rilke's complaint. But is it a complaint that would also apply to an efficient national health system based on best-buy standards of practice, even one stretched by an inadequately funded attempt to provide health care for all to the point where its "decent minimum," as stipulated by its lower-tier standards, is set quite low? To be sure, complaints about standardization, uniformity, and regimentation are a staple of naive objection to social-welfare systems generally; but Rilke's objection is much more subtle in its comment on the special nature of health care.

After all, Rilke's argument against standardization initially appears altogether inadequate in the health care context. Indeed, it does not even work for the furniture of rooming houses. However dispiriting a thing it may be, an item of furniture like the green armchair in his room is remarkably efficient. Given cost pressures so severe that an armchair appropriately adapted to each new occupant cannot be provided, this unappealing green chair manages to accommodate everyone: "all heads seem to fit." It would of course be preferable for each individual to live in a better-equipped room with furniture of his or her own; but for the poor, it is this shabby room or nowhere at all. And it is this chair, used by all the previous down-and-out tenants, or no chair at all. Given no possibility of expanding the pool of resources available in this situation, the green armchair actually serves its purpose remarkably well: "all heads seem to fit."

Analogously, in health care, it is preferable to receive "standardized" lower-tier health care, including treatment stipulated in standards of practice and in mass prevention and identification programs, than to receive no care at all. Better to fit one's head into the greasy-gray hollow in the green armchair than to sit on the floor. Of course, one might idealistically spurn the armchair, preferring to camp on the floor, but the analogy does not work in medicine: unless one rejects health care altogether or some components of it for extraneous reasons (for example, on religious grounds, on the basis of fears about specific procedures, or on the basis of differing values about risk) or because the risk of iatrogenic complication is high, some health care is better than none at all. After all, the consequence of no treatment may be dysfunction, pain, or death, and it is never rational to prefer these to probable cure or restoration of function, except perhaps on outside grounds.

Thus, in a cost-pressured national health system, one may imagine a two-tiered system with dual practice guidelines. In such a system, for example, appendicitis patients in the lower tier, who would be treated medically rather than surgically, might have a slightly greater chance of dying than those in the upper tier, but nobody would risk the substantially greater chance of dying that exclusion from treatment altogether would entail. Patients in the lower tier would use niacin rather than cholestyramine, but they would still be getting medical supervision of their cholesterol levels. Knee patients in the lower tier could expect conservative treatment of their ACL-MCL injuries, and while this would leave them unable to play certain sports and risk some instability, they could still function fairly well in most activities. Patients getting medical rather than surgical treatment of their ulcers would do nearly as well; and in all these circumstances, no patient would risk being entirely excluded from treatment. Although patients undergoing radiologic contrast studies would get traditional rather than low-osmolality contrast mediums and would therefore be at greater risk of anaphylactic reactions, no patient would be denied necessary diagnostic procedures. And whether or not TPA might eventually prove to have some therapeutic advantage over streptokinase, lower-tier patients would get streptokinase, while upper-tier patients (or their physicians) might be permitted a choice; yet all heart attack patients would receive effective thrombolytic therapy.[11] Of course, a two-tiered system risks allowing a substantial gap to develop between the upper and the lower tiers; on the other hand, if, as in Canada, the system prohibited a second tier (as I believe justice ultimately requires), political pressures would operate to keep the level of the single tier as high as possible. In either case, however, incentives characterizing a system under cost pressures, without competition, mandating care for all, would—if it were a system attentive enough to the requirements of justice to reject exclusion practices that impose unequal liabilities on persons—encourage the development of practice standards for maximally efficient health-targeted care. Thus, whether a national health system is a single-tiered or two-tiered one (or perhaps has multiple tiers), standardization is not the disadvantage a cursory reading of Rilke or inspection of our own stereotypes might seem to suggest but is, on the contrary, the mechanism of its principal advantage. Of course, "standardization" does not mean utter uniformity in every detail of medical practice, and it does not require routinized interactions, inflexible schedules, physicians with indistinguishable smiles and identical bedside manners, or examining rooms all painted the same color. It refers only to adoption of the most effective practice where differences in practice make demonstrable differences in outcome, and it requires only the discarding of demonstrably ineffective, less effective, or damaging ways of doing things. Variety can flourish, but not uselessness or harmfulness, and because uselessness and harmfulness do not flourish, such a system provides the most effective care for all. Tied to considerations of cost, such a system would provide the most efficient care under cost-limiting constraints. This, I have argued, would most likely be the case, barring other corruptions, in a national health system that is noncompetitive but cost pressured and mandated to provide care for all.

But it would be hasty to conclude that Rilke's intuitions are simply wrong and that there is no moral problem raised by the prospect of standardization—even by the prospect of the sort of thoroughgoing standardization one might expect from a genuinely efficient national health system. Rilke describes dying at the Hôtel-Dieu as "factory-like," a situation where "production is enormous" and it is "quantity that counts." But if it is "factory-like" that all items of a kind are treated in the same way, and if "production is enormous" means that everyone gets what he or she needs, then there is no moral problem here. Quantity *does* count: that is the whole point of national health systems, to ensure that everyone gets the health care he or she needs.

Yet there is something else to notice about Rilke's observations: they are focused on a specific kind of health care, and the point he has to make has special application in this setting. What the patients in the 559 beds of the Hôtel-Dieu are doing is *dying*: this is a hospital for incurables, for terminal cases, as distinct from the Maison d'Accouchement, the obstetric hospital, and the Val-de-Grace, the military hospital, down the street. The division of these hospitals in Rilke's turn-of-the-century Paris reflects a distinction central in his observations: there is something different about dying, and it is in dying as distinct from other medical events that the moral problems raised by standardization arise. It is not just that Rilke is obsessed with the notion of death—as not only Rilke but the Existentialists influenced by him would also be—but that he sees that there is something different from other medical situations about this process.

EFFICIENCY IN DYING

What, then, is disturbing about the "factory-like production" of deaths in the 559 beds of the Hôtel-Dieu? No one cares anymore for a "finely-finished death," Rilke laments. "No one. Even the rich, who could after all afford this luxury of dying in full detail, are beginning to be careless and indifferent; the wish to have a death of one's own is growing ever rarer."[12] But if our account of efficiency in medical care is correct, surely the "factory-like production" of deaths would not raise any moral problem, unless of course it were accompanied by callousness, abuse, or cruelty—peripheral institutional problems which are not part of our focus here.

But this brings us to the central problem: the very notions of "standards of practice" and "practice guidelines" cannot function in the same way in dying as they do for the treatment of other medical conditions, because these are concepts that make central reference to the medical outcome to be attained. The procedure or medical treatment to be designated as standard in a practice guideline for a given condition is the one which is most effective in producing cure or control of the condition within the limits of resources available: it is the most efficient, cost-effective manner of producing a given outcome. But the sense in which death is the "outcome" of medical treatment is a very different one from the one associated with measurements of efficacy in standards of practice, as, for instance, cure of appendicitis is the outcome of appendectomy or control of kidney failure is the outcome of dialysis. Unlike cure or the control of a chronic condition, death is not the *objective* of medical treatment and not the outcome in terms of which efficacy can be measured. Medical treatment does not aim at death; medical treatment aims at cure or the control of a condition, and death occurs only if it fails rather than succeeds. Thus, there can be no such thing as an "efficient" or "cost-effective" way of dying, since, except in the specific final procedure of euthanasia, death cannot be the objective of treatment. Even in the hospice care provided to terminally ill patients, death is not the objective, although it is the expected, unresisted outcome; on the contrary, the objective, to use the rhetoric associated with this important movement, is the fullest, best possible living of the last moments of life. If death were the objective, either in ordinary medical care or in hospice care, efficient dying would be that which gets the process over with in the shortest and hence cheapest possible time—but this is what few patients or physicians would regard as ideal and what no national health or similar system ought to encourage. This is not to encourage the prolongation of life, but it is not to encourage arbitrarily abrupt termination of life either. Cheap, rapid dying may be a personal goal for some patients but ought not be imposed as an institutional or societal one.

But if there can be no such thing as "efficient dying," there can be no standards of practice for dying either, even when the dying is expected to follow the usual pattern of a predictable downhill course in a familiar fatal disease—advanced colon cancer, for instance, or kidney failure or lung disease. At best, one could string together a series of procedures, each governed by its own practice guidelines, for the events or medical episodes along the way of this downhill course—for example, a procedure to relieve tumor pressure on a nerve, therapy for congestive heart failure, treatment to relieve respiratory distress—but this is to view dying as a series of isolated, discrete events and to miss, as it were, the forest for the trees. If dying is seen as an integral process, not just as a series of interconnected medical failures, understanding it in the terms appropriate to other areas of medicine cannot fully succeed. There is no best buy in dying, though there may be best buys in specific sorts of symptom relief; there is no standard, efficient pattern that dying ought to follow. This is not to romanticize dying but only to remark that viewing it in the way appropriate to other medical conditions is to cut off from view what we most ought to see: it is a circumstance in which efficiency is beside the point.

It might be suggested that Rilke's overwhelming concern with death raises only a tangential issue in medicine. But this is hardly so, especially given the cost-related issues that fuel pressures for national health care. After all, according to the various figures so frequently cited in discussions of health care's high cost, an immense proportion of health care dollars are spent in the last month, two months, or half-year of life. Of course, the last month, two months, or half-year of life can be identified only retrospectively, and not all patients were "dying" during those periods. Nevertheless, in a society in which approximately three of every four deaths occur as a result of degenerative disease (cancer, heart disease, stroke, liver, kidney and other organ failure, AIDS, neurological diseases, etc.) and deaths from acute, rapidly fatal parasitic and infectious diseases and trauma are comparatively few, the issue of how dying is to take place in a cost-pressured, efficiency-oriented system, as a just national health system must be, is no trivial matter and cannot remain of peripheral interest only.

In Rilke's view, most systems—not only that of charity care for the poor of Paris at the Hôtel-Dieu but also Europe's private sanatoria for the wealthy—do function in effect by imposing standardized practices even in terminal cases. "One dies the death that belongs to the disease one has," Rilke remarks, "for since one has come to know all diseases, one knows, too, that the different lethal terminations belong to the diseases and not to the people; and the sick person has so to speak nothing to do." This is what I've called the notion of the "official" death, and it is what one might expect were standards of practice formulated to govern the whole scope of that series of medical events characteristic of specific downhill, terminal courses.

It is this standardization in dying that Rilke sees as particularly dehumanizing; he writes, sarcastically, "In sanatoria, where people die so willingly and with so much gratitude to doctors and nurses, they die from one of the deaths attached to the institution; that is favorably regarded."[14]

Of course, one might argue that the objective of medical care in dying is the achievement of the longest life possible consistent with the least suffering; thus, there is a "standard of practice" in the broader sense even for dying. Indeed, this seems to be the assumption of contemporary terminal care: there is a course deemed to be the easiest, which the patient can be expected and encouraged to follow. But Rilke—and here it is difficult and important to be sensitive to his intuition—would regard this as an imposition of values where, because there is no objective goal for medical care, there is no legitimate basis for doing so. While some dying patients might regard a terminal period weighing maximized life against minimized pain as preferable, others might prefer it some other way. As an illustration, Rilke creates the extraordinary character Chamberlain Christoph Detlev Brigge, whose death was "two months long and so loud that it could be heard as far off as the manor farm."[15] To be sure, Rilke romanticizes a vigorous, rebellious, almost athletic dying—a value judgment there is no need for us to accept—but what he thus succeeds in pointing out is that there is no reason at all why everyone should die in the same way. Such contemporary devices as Living Wills may seem to protect individual choice, but they are not very robust: in general, advance directives mean only that one's course through the standard progression of dying can be interrupted after one is no longer competent, typically quite late in the game. The wish to have "a death of one's own" ought to be recognized, indeed admired, Rilke insists, and in this he is clearly right, since because it is not like other medical processes there is no compelling reason for it to be any one, uniform way. Indeed, diversity may be the best protection against manipulation and abuse. It is precisely the having of "a death of one's own," however, that the standardization of practice, clearly so efficient and beneficial in other areas of medicine, would preclude. Being treated for appendicitis or hypertension or ulcers or ACL-MCL knee injuries or myocardial infarction "factory-like" in 559 beds (assuming the personal character of the care provided is humane, not literally factory-like, and the institutional environment reasonably pleasant) would present no moral problem, because treating these conditions in the most efficient way would increase all 559 patients' chances of cure, especially where no patients risk nontreatment. But dying is different, and it is not morally appropriate for a system governed by principles of efficiency to impose a standard expectation of how this final period of an individual's life should play itself out. Perhaps it is appropriate for a society to reassess its communal expectations about the nature of old age and medical responses to dying, as Daniel Callahan would recommend,[16] but it is not the role of a single, sole-provider system in effect to decide or enforce this.

A national health care system may certainly be greeted with enthusiasm on many grounds (and I strongly support its adoption in the United States), but—especially where very large proportions of its resources are at stake—it may also pose substantial moral problems. I think these risks are greatest in matters of dying. Of course, competitive, for-profit health care systems also pose moral risks concerning dying, though these risks will differ as a function of the different incentives under which these various systems operate. A particular risk in competitive, free-market systems is a function of incentives to increase the quantity and technical quality of care performed: this may take the form of lengthening the process of dying so as to be able to provide more care, a practice which has been the focus of much public sentiment against the "prolongation" of dying. I think the risks in dying we can expect to see posed under a national health care system will be less damaging to individual welfare than those we are now subject to in our current health care environment, even in the more complex real world than the idealized version considered here, but that does not mean we can pretend there are none. Nor is it the case that the ethical issues a national health care system will generate, for all its advantages, will be limited to the matter of dying, but they will be particularly conspicuous in this difficult area.

NOTES

1. Rainer Maria Rilke, *The Notebooks of Malte Laurids Brigge* (New York: Norton, 1964), p. 49.

2. Ibid., p. 17.

3. Ibid., pp. 17–18, punctuation slightly altered.

4. While it is equivalent to the sense in which I will be using the term "efficient," I will generally avoid the term "cost-effective" because it is so frequently misapplied and misunderstood. For instance, "cost-effective" is variously used to mean "cost saving," "effective," "cost saving, with an equal

(or better) outcome," and "having an additional benefit worth the additional cost" (see Peter Doubilet, Milton C. Weinstein, and Barbara J. McNeil, "Use and Misuse of the Term 'Cost Effective' in Medicine," *New England Journal of Medicine* [hereafter *NEJM*] 314 [January 23, 1986]: 253–55).

5. Arnold S. Relman, M.D., "Assessment and Accountability: The Third Revolution in Medical Care," *NEJM* 319 (November 3, 1988): 1220–22.

6. John E. Wennberg, "Outcomes Research, Cost Containment, and the Fear of Health Care Rationing," *NEJM* 323 (October 25, 1990): 1202.

7. See, e.g., Louise B. Russell, *Is Prevention Better than Cure?* Studies in Social Economics (Washington, D.C.: Brookings Institution, 1986).

8. On why national and non-national systems are different, see Norman Daniels, "Why Saying No to Patients in the United States Is So Hard," *NEJM* 314 (May 22, 1986): 138–83.

9. Robert P. Huefner points out this risk.

10. On the problem of litigation, see Paul M. Ellwood, M.D., "Outcomes Management: A Technology of Patient Experience," Shattuck Lecture, *NEJM* 318 (June 9, 1988): 1555. On universal compliance, see Jonathan Lomas et al., "Do Practice Guidelines Guide Practice?" *NEJM* 321 (November 9, 1989): 1306–11.

11. On the discussion of these last two examples in one Canadian province, see Adam L. Linton and C. David Naylor, "Organized Medicine and the Assessment of Technology: Lessons from Ontario," *NEJM* 323 (November 22, 1990): 1463–67.

12. Rilke, *Notebooks*, p. 17.

13. S. Jay Olshansky and A. Brian Ault, "The Fourth Stage of the Epidemiologic Transition: The Age of Delayed Degenerative Diseases," in Timothy M. Smeeding et al., eds., *Should Medical Care Be Rationed by Age?* (Totowa, N.J.: Rowman & Littlefield, 1987), p. 17.

14. Rilke, *Notebooks*, p. 18.

15. Ibid.

16. Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* (New York: Simon and Schuster, 1987), and his subsequent *What Kind of Life?*