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Surgery Rate Late in Life Surprises Researchers

By GINA KOLATA

Surgery is surprisingly common in older people during the last year, month and even week of life, researchers reported Wednesday, a finding that is likely to stoke, but not resolve, the debate over whether medical care is overused and needlessly driving up medical costs.

The most comprehensive examination of operations performed on [Medicare](#) recipients in the final year of life found that nationally in 2008, nearly one recipient in three had surgery in the last year of life. Nearly one in five had surgery in the last month of life. Nearly one in 10 had surgery in the last week of life.

The very oldest patients were less likely to have surgery. Those who were 65 had a 38.4 percent chance of having surgery in the last year of life. For 80-year-olds, the chance was 35.3 percent, but the rates fell off more sharply from there, declining by a third by age 90.

But such analyses are controversial. By looking only at people who died, researchers can get a skewed picture of what is taking place, critics say.

“Because the patient died, you can’t assume that the treatment and therapies were not of value,” said Dr. Peter B. Bach of Memorial Sloan-Kettering Cancer Center. “Although in that individual, things may not have worked out, you have no insight into whether the decision to operate was appropriate.” Nor is it known how many similar patients who had that same surgery did not die.

But the sheer number of operations at the end of life was unexpected, said the researchers, at Harvard School of Public Health. They added that they did not know why the operations had been done. Some undoubtedly were necessary to relieve pain and suffering or to prolong life. But, they said, they know from experience that doctors often operate to repair something that can be fixed but that will not save a dying patient, avoiding the difficult discussions with patients about

their prognosis and whether the surgery will improve or compromise their quality of life.

In their study, published Wednesday in *The Lancet*, the investigators analyzed data for all the 1,802,029 Medicare recipients 65 and older who died in 2008. In addition to the number of operations nationally, they reported marked regional variations in the use of surgery at the end of life. For example, the rate of surgery in Honolulu was a third of that in Gary, Ind.

“Honolulu and Gary, Ind., can’t both be doing it right,” said Dr. Ashish Jha, an associate professor of health policy at Harvard and the lead author of the study.

But regional variations in health care have been controversial because it is not clear whether they reflect true differences in patient needs or in health care practices or regional differences in health care payment rules, Dr. Bach said.

Dr. Scott Ramsey, an economist and a physician who is director of [cancer](#) outcomes research at the Fred Hutchinson Cancer Research Center in Seattle, faulted the researchers for citing regional differences but then suggesting a long list of factors that might be causing them, including the health of the population, the patterns of medical practice, and the availability of [hospice care](#) and other end-of-life services.

Their list of potential explanations “covers about everything and says absolutely nothing,” Dr. Ramsey said.

But the researchers said their study — done from public records and with no financing — probably pointed to a real problem in American medicine: surgery, which can be painful, expensive and debilitating, is tempting for doctors and patients alike.

“I will admit to being guilty of this,” Dr. Jha said. “Often we say, ‘If you have this intervention, we will be able to fix that problem. You have an intestinal blockage. Surgery will fix it.’ But will it let you walk out of the hospital alive? Will it let you return to your old life?”

Dr. Mark McClellan, a former commissioner of the Centers for Medicare and Medicaid Services, who directs the Engelberg Center for Health Care Reform at the Brookings Institution, said, “Evidence like this — and a lot of previous evidence, directly from patients and their families — shows that we need much better support for patients and their families when they have serious illnesses and may need intensive treatments.”

Dr. Jha said he and his colleagues were continuing to study the causes and consequences of surgery at the end of life, adding, “It is hard to take these data and make clear policy recommendations about what is appropriate and what is not.”

But he said he had no doubt that the difficult conversations that should precede a decision to operate all too often never occurred.

“As clinicians, we often end up focusing on something narrow and small that we think we can fix,” Dr. Jha said. “That leads us down the path of surgical intervention. But what the patient cares about is not going to get fixed.”

Dr. Jha provided a recent example from his hospital. A man had metastatic [pancreatic cancer](#) and was dying. A month earlier, he had been working and looked fine.

“No one had talked to him about how close he was to death,” Dr. Jha said. “It’s the worst kind of conversation to have.”

Instead, doctors did an [endoscopy](#) and a [colonoscopy](#) because the man had internal bleeding. Then they did abdominal surgery. “We did all of this because we were trying desperately to find something we could fix,” Dr. Jha said.

The man died of a complication from the surgery.

“The tragedy is what we should have done for him but didn’t,” Dr. Jha said. “We should have given him time to have the conversation he wanted to have with his family. You can’t do that when you are in pain from surgery, groggy from [anesthesia](#). We should have controlled his pain. We should have controlled his nausea.”

Instead, Dr. Jha said, “we sent him to the O.R.”