Being Mortal

INTRODUCTION

BRIEF BIOGRAPHY OF ATUL GAWANDE

Gawande was born in Brooklyn, New York. He is the son of two Indian immigrants to the United States, both of whom were physicians. When he was young, his family moved to Athens, Ohio. He then earned a bachelor's degree in biology and political science from Stanford University in 1987 and joined Al Gore's presidential campaign in 1988. He then became a Rhodes Scholar and earned an M.A. in Philosophy, Politics, and Economics at Oxford. After beginning Harvard Medical School in 1990, Gawande took a brief break to become Bill Clinton's healthcare lieutenant during the 1992 campaign and then became a senior advisor in the Department of Health and Human Services after Clinton's inauguration. He returned to medical school in 1993 and then graduated in 1995. Subsequently, Gawande earned a Master of Public health from the Harvard School of Public Health in 1999. After beginning his residency, Gawande began writing for Slate and then contributing to *The New Yorker*, leading him to write his first book, *Complications*, in 2002. In 2006, he became a MacArthur Fellow for his work investigating modern surgical practices and medical ethics. In 2007, he became director of the WHO's effort to reduce surgical deaths. He wrote his second book, *Better*, in 2007, and then his third, *The Checklist Manifesto*, in 2009. He published *Being Mortal* in 2014, which became a #1 *New York Times* bestseller. In June 2018, he became the CEO for Haven Healthcare, formed by Warren Buffett, Jeff Bezos, and Jamie Dimon. He stepped down from the position in May 2020, and Joe Biden appointed him to his COVID-19 task force in Fall 2020. He is currently a surgeon at Brigham and Women's Hospital in Boston and lives with his wife Kathleen and three children in Newtown, Massachusetts.

HISTORICAL CONTEXT

In *Being Mortal*, Gawande examines the many medical and social factors that have led to the United States' current end-of-life institutions. First, improvements in medicine—particularly following World War II—have enabled us to have much longer lives. Antibiotics, public health measures, and improvements in surgery have all enabled us to cure and treat formerly fatal illnesses and injuries. While average life expectancy was under 50 in 1900, today it is in the late 70s. Additionally, this increase in medicine led to the growth of hospitals, as doctors were able to cure more ailments. But when the chronically ill and elderly took up too many of those hospital beds, separate custodial residences sprung up, leading to the modern nursing home. Socioeconomic factors have also led to fewer elderly people living with children until their deaths. This is due to many factors: before, one child—often the youngest daughter—lived with parents in their home until their deaths. Now, because people are having fewer children and are having children at younger ages, these children often reach at least middle age before the death of their parents. In addition, as women increasingly join the workforce, it has become more difficult to juggle jobs, families, and the care of elderly parents. The elderly have also become more financially independent, thanks to the Social Security Act of 1935 and the advent of pensions in the United States. As a result, the elderly often sell their homes rather than handing them down, further popularizing retirement homes, assisted living, and nursing homes.

RELATED LITERARY WORKS

Gawande has written three other books that focus on improving medical practices in the United States: *The Checklist Manifesto*, *Better*, and *Complications*. Another memoir that focuses both on death and illness from the perspective of a doctor and patient is Paul Kalanithi's posthumously published book *When Breath Becomes Air*, which details his time as a neurosurgeon and then his battle with stage IV lung cancer. Other memoirs about terminal illness include Nina Riggs's *The Bright Hour* and Michael Korda's *Passing*. In addition, Samuel Harrington's *At Peace* and Diane Rehm's *When My Time Comes* examine end-of-life care and assisted suicide, respectively. Finally, two books that address how to talk about death include Shep Nuland's *How We Die* and Michael Hebb's *Let's Talk About Death*. In Being Mortal, Gawande also draws on Tolstoy's *The Death of Ivan Ilyich* and Daniel Kahneman's *Thinking, Fast and Slow*.

KEY FACTS

- **Full Title:** Being Mortal: Medicine and What Matters in the End
- **When Written:** 2007-2014
- **Where Written:** Boston, Massachusetts
- **When Published:** October 7, 2014
- **Literary Period:** Contemporary
- **Genre:** Nonfiction, memoir
- **Setting:** Boston, Massachusetts; Athens, Ohio
- **Climax:** Gawande's father passes away
- **Point of View:** First person, from Gawande's perspective

EXTRA CREDIT

First In Print. Several of Gawande's chapters were first published as *New Yorker* articles.

Film on the Frontlines. *Being Mortal* was made into a TV documentary as a part of PBS's Frontline series. It was nominated for an Emmy award.

PLOT SUMMARY

Dr. Atul Gawande explains that, as a medical student, he was never really taught to help patients cope with death—only how to save lives. He writes that while medicine allows people to live longer and better, it turns aging and death into medical processes. Gawande aims to explore how the experience of aging and dying has changed, and how it might be improved.

In the first chapter, Gawande highlights two different cases of aging: his wife's grandmother Alice, and his own paternal grandfather Sitaram. Sitaram lives to 110—at the end of his life, he is cared for by his family even as he insists on still running his farm in India. Alice, by contrast, has lived alone for almost three decades after her husband died of a heart attack when she was 56. Historically, living with family in old age has been more common, but as people live longer, it has created tensions between parents and children over how each can live. As the elderly became more financially independent due to pensions, they found freedom in retirement communities and being able to live away from children. Gawande notes that Alice's case is a sign of progress, but it does raise the question of what to do when the elderly can no longer live independently: when Alice turns 84, her health and memory begin to deteriorate.

In the second chapter, Gawande explains how modern medicine has allowed people to recover from various illnesses, infections, and injuries that used to be a death sentence. Even incurable cancers are now treatable. But medicine has also changed the way people think about old age, viewing aging as a failure or weakness rather than a normal process. Because aging is an uncomfortable topic, people avoid it, but this has created problems, as well. Most people don't save enough for retirement even though people are living much longer, and there aren't enough geriatricians to care for the growing elderly population, even though geriatricians markedly improve people's quality of life in old age.

Chapter 3 focuses on Felix and Bella Silverstone, an elderly couple living in a retirement home. When they are both in their 80s, Bella's health deteriorates and she breaks both legs, causing her to be moved to a nursing home unit in their retirement community. But seeing how the staff treats Bella like a rag doll rather than a person as they dress and bathe her, Felix asks to return to their home so they can have more control over their situation. Four days after Bella's casts come off, she dies, and Felix is heartened by the fact that she got to spend her final days in her own home. Gawande then returns to Alice's story: as a result of her waning health, she moves to a retirement home and then a nursing home when she falls and breaks her hip. But feeling that she has no control over her life, she chooses not to tell the staff when she starts vomiting blood, and the next day, she passes away.

Chapter 4 follows Lou Sanders and his daughter Shelley. When Lou's health declines and he can no longer live alone, he moves in with Shelley. But he is frustrated with his lack of control over food, the television, and when he can see friends. Similarly, Shelley feels the burden of having to care for her father on top of caring for a family and having a job, so they start to look for an assisted living facility. Gawande describes the origins of assisted living: Keren Brown Wilson, one of assisted living's originators, wanted to create a residence in which the elderly could have assistance, but also privacy and autonomy. While initially assisted living was very successful—increasing people's autonomy without sacrificing their health—over time it has become a stepping stone to nursing homes, rather than an alternative to them. Lou spends a year in assisted living but his health continues to worsen, so Shelley decides to look for a nursing home despite his adamant protests.

Other people have tried different ways to reform assisted living and nursing homes. For example, Bill Thomas introduced plants, animals, and children as a way to get residents more engaged in life and to give them purpose. Other facilities reorganize residences to make them homes with communal spaces so that people can engage with each other. The point is to give people the freedom to choose how to live their lives. Lou moves into the Leonard Florence Center, one of the places that organizes residents into homes—with single rooms—and allows them to determine their schedules. This simple difference makes Lou feel that he still has a place in the world.

In Chapter 6, Gawande returns to the topic of doctors' failure to understand their terminal patients' needs. He brings up the example of Sara Monopoli, a 34-year-old patient diagnosed with advanced stage IV lung cancer. Her oncologist Paul Marcoux suggests a variety of chemotherapy options, as Sara doesn't want to focus on survival statistics (median survival is about a year). Sara undergoes four rounds of chemotherapy, none of which improve her tumors—but the chemo does lead her to have a suppressed immune system. Because of this, she gets pneumonia and her breathing becomes extremely labored. Despite her protests that she does not want to die in the **hospital**, the constant pursuit of treatment leads her to pass away in the hospital as a result of her pneumonia.

Hospice care focuses on alleviating suffering and helping people take advantage of the time they have left, and it is an alternative to traditional treatments and surgeries. Gawande illustrates how hospice care not only improves people's well-being, but often it actually helps people live longer than traditional medicine.

In the final two chapters, Gawande highlights the importance of discussing a person's priorities for the end of their life, as he does with his own father, who is also a surgeon. When his father is in his 70s, doctors discover a tumor in his spinal cord tumor. A surgeon, Edward Benzel, offers him surgery, but he also helps identify Gawande's father's priorities. Realizing how important keeping his career is to Gawande's father, Benzel suggests that he wait on surgery. This prioritizes his well-being over the possibility of longer survival, particularly as he knows that surgery has a risk of making him quadriplegic. Putting the surgery off allows Gawande's father to continue working for another two and a half years, which was incredibly important to him.

Gawande tries to emulate Benzel's ability to identify his father's priorities and give advice according to those priorities. He works with a patient, Jewel Douglass, who has a tumor pressing on her bowels, causing her to vomit everything she eats. He knows that he could suggest a slew of treatments and surgeries, but he acknowledges that the treatments come with complications. In the end, Douglass asks him to go through with the surgery only if it seems relatively safe. When Gawande begins the surgery and sees that it would be risky, he decides instead to alleviate her pain and not risk her health further. Douglass then elects hospice care and spends her final two weeks surrounded by family and friends.

Gawande's father is now ready for surgery as his condition worsens. Before surgery, he and his father have a conversation about what kind of end-of-life care would be tolerable for him, even though the subject is difficult. Gawande's father explains that he doesn't want to stay alive on a ventilator or feeding tube, and he is more afraid of being quadriplegic than dying. This conversation proves critical, as complications arise during his surgery and Gawande uses his father's guidance to instruct Benzel to continue with the surgery. As a result, his father doesn't lose any motor function and staves off his tumor's progress for a time. Eventually, however, Gawande's father grows worse, and he knows that he doesn't want chemotherapy. He elects for hospice care and passes away soon after, surrounded by family.

Gawande concludes by reiterating that when it comes to aging, illness, and dying, everyone should understand their hopes, fears, and trade-offs, and every doctor should help patients have these conversations. Though discussing death is difficult, helping people in their final phase of life has been Gawande's most fulfilling experience.

CHARACTERS

MAJOR CHARACTERS

Dr. Atul Gawande – Dr. Atul Gawande is the author and narrator of *Being Mortal*. The book not only makes a general argument for how medicine and end-of-life care should be improved, but it also chronicles Gawande's personal struggle to help his terminally ill patients with the process of dying. For much of his time as a surgeon, Gawande feels ill-equipped to talk about death with his patients because it is an uncomfortable topic. But as a result, he often simply presents treatment options to his patients without realistically helping them understand their disease or weighing the options adequately. For example, he treats a woman named Sara Monopoli, who is terminally ill with stage IV lung cancer but who also has unrelated thyroid cancer. Knowing that Sara is likely to die, he recommends that they hold off on surgery for the thyroid cancer, but he isn't fully honest with her about her short life expectancy. Later, Gawande realizes that he needs to be more open with his patients and help them through difficult decisions so that they can prioritize what matters most to them. He then treats a woman named Jewel Douglass, who has a tumor pressing on her bowels that causes her to vomit up everything she eats. She wants to be able to eat again, but she doesn't want to risk surgery that will cause more complications. Knowing these priorities, Gawande suggests he begin the surgery by assessing how risky it looks—and if it looks too complicated, he will simply ease her pain instead, which is what he ends up doing. After Douglass passes away, her daughter thanks Gawande for giving the family time with her. Gawande also has difficult conversations with his own father, who learns he has a spinal cord tumor. They navigate difficult conversations with honesty and compassion, enabling his father to have a final phase of life that is worthwhile to him. Thus, Gawande shows his own progress, both in having difficult conversations with people like his father, and in being a doctor who helps patients assess their own priorities and focus on their well-being rather than simple survival.

Gawande's Father – Gawande's father is a surgeon who immigrated from a rural village in India to pursue opportunity in America. He is largely healthy until his 70s, when he starts to experience neck pain and tingling fingertips. Over the next few years, the pain progresses and numbness spreads through his left hand. An MRI reveals that he has a tumor in his spinal cord, and Gawande's father immediately sees two expert surgeons. The first suggests he have surgery to remove the tumor as soon as possible, downplaying the possible complications. But the second, Edward Benzel, identifies Gawande's father's priorities. Knowing how important Gawande's father's job is to him, and seeing that Gawande's father is more afraid of becoming quadriplegic as a result of the surgery than of the problems the tumor is causing, Benzel suggests that Gawande's father wait to have surgery. This allows Gawande's father to continue his surgery practice for two additional years. Then, only when he starts to lose strength and have trouble walking, does he decide to undergo surgery. This prompts Gawande and his father to have a difficult conversation about the kind of life that is worthwhile to him, and Gawande's father impresses on his son that he doesn't want to be a burden, doesn't want to become quadriplegic, and doesn't want to be put on a ventilator or feeding tube. This conversation, while difficult, is immensely important when complications arise during Gawande's father's operation, and Gawande guides Benzel to go through with the surgery because that has a better chance of preventing Gawande's father from becoming quadriplegic. Luckily, the surgery goes well and Gawande's father doesn't lose any motor function. However, gradually the cancer does grow despite the surgery. He refuses to get any more treatments, instead receiving hospice care and focusing on time with his family. The hospice care greatly reduces his suffering, and in the end, he dies surrounded by his wife and children. Gawande states that helping his father through this difficult time was painful, but also incredibly fulfilling as his father lived and died the way he wanted to.

Jewel Douglass – Jewel Douglass is one of Gawande's patients. Douglass is 72 years old and has metastatic ovarian cancer when Gawande begins treating her. After three rounds of chemotherapy, a tumor begins pressing against her bowels and she vomits up everything she eats. Gawande knows that it's unlikely she'll live for more than a year or two. Rather than simply providing her with treatment options as he might usually, Gawande helps Jewel identify her priorities so that he can advise her on the best treatment options. When she says that she wants to be able to eat again, but doesn't want to take unnecessary risks in surgery, Gawande comes up with a compromise. He states that he will open her up, but if he sees that removing the tumor would be too complicated, he will stop and recommend hospice care instead. This is exactly what ends up happening, and Jewel spends her last two weeks surrounded by family and friends—what her daughter later calls a "perfect ending." Because Gawande was realistic with Douglass and advised her based on her priorities, she was able to die in the way that she wanted.

Lou Sanders – Lou is Shelley's father. Lou is widowed at 70 and lives independently until he is 88 years old, at which point he is diagnosed with Parkinson's disease, has trouble with his memory, and starts to have dangerous falls. He refuses to look at retirement homes, but Shelley worries about him living alone. He moves in with Shelley and her husband Tom, but he is frustrated by the lack of autonomy—over the food, the television, when he can have friends over. Shelley also grows overwhelmed, and she moves Lou to an assisted living facility. There, Lou grows withdrawn, as the facility has mostly women and he feels lonely. When his condition worsens even more, Shelley contemplates placing him in a nursing home, feeling that he needs full-time care. However, they find a place called the Leonard Florence Center for living, which is organized not into rooms but into homes with single bedrooms and communal spaces. Lou gets to determine his schedule around bathing and eating, giving him greater autonomy, and consequently making him feel that he still has a place in the world.

Sara Monopoli – Sara Monopoli is one of Gawande's patients. Sara is diagnosed with stage IV lung cancer at 34 years old. Her oncologist, Paul Marcoux, provides her with several different chemotherapy options, but he is hesitant to tell her that she likely only has about a year to live. Gawande also treats her for a second, unrelated thyroid cancer, but he also avoids talking with her realistically about how much time she has left. Sara undergoes four rounds of chemotherapy, none of which help her prognosis. She tells her family that she doesn't want to die in the **hospital**, but because the doctors keep giving her treatment options with some hope for increasing her lifespan, she jumps at the chance for each one. But ultimately this actually hurts her: her immune system is so suppressed from the chemotherapy that she lands in the hospital with severe pneumonia and passes away. Gawande views her case as a failure on the doctors' part to help her confront her mortality and talk about the treatment options that best fit what she wanted.

Alice Hobson – Alice Hobson is Kathleen Hobson's grandmother and Jim Hobson's mother. Gawande meets Alice when he and Kathleen start dating. Alice lives independently until she is 84 years old, when she starts to fall and become confused. She crashes her **car** and gets scammed out of $7,000, leading her and Jim to look for retirement homes for her. However, the retirement facility never truly feels like home to her, and she becomes depressed. After a particularly bad fall, she breaks her hip and is forced to move to the nursing home unit. There, she grows even more despondent, as she feels that she has no control over her own life. One day she develops abdominal pain and vomits blood without telling anybody, and the next day she passes away. This illustrates the failure of these kinds of institutions, which prioritize safety at the expense of autonomy and meaning in the residents' lives.

Keren Brown Wilson – Keren Brown Wilson is one of the originators of the concept of assisted living. She initially wanted to create a place where the elderly and disabled could live with autonomy despite their physical limitations—an alternative to nursing homes. She was inspired to do this by her mother, Jessie, who suffered a stroke at 55 years old and was paralyzed on one side of her body. She created her first facility, Park Place, in 1983. The facility was a huge success, maintaining the residents' health but also increasing their satisfaction over those living in nursing homes. She gradually built 184 residences in 18 states, but the idea became so popular that developers used the term "assisted living" for almost anything. Gradually, assisted living became not an alternative to nursing homes, but rather a stepping stone to them.

Shelley – Shelley is Lou's daughter. When Lou is 88, his health starts to deteriorate, so Shelley has him move in with her. This not only makes Lou feel that he has lost control over his life, but it also places huge burdens on Shelley. Shelley has to bathe him, cook for him, and manage his medications—on top of having a job and two kids to care for. The situation ultimately becomes untenable, which is why Shelley and Lou decide he should go to an assisted living facility. When Lou's health grows even worse, Shelley contemplates moving him to a nursing home, despite his adamant protests. This dynamic reflects that between many elderly people and their children: the children want safety for the parents, while the parents want autonomy for themselves.

Felix Silverstone – Felix Silverstone is a national leader in geriatrics and Bella Silverstone's husband. Gawande meets Felix when he is 87 years old. Felix and Bella live in a retirement home, and Felix takes care of Bella as she becomes blind and frail. However, when she falls one day and breaks both legs, they are forced to move to a nursing home unit in their residence. Seeing how the staff treats Bella like a patient rather than a person, he has the staff move them back to their home. This becomes crucial for Felix and Bella, because four days after her casts come off, she passes away. He is glad that he was able to restore some control and comfort in the final weeks of Bella's life.

Bella Silverstone – Bella Silverstone is Felix's wife. In her late 80s, Bella's vision degenerates and she becomes very frail. She and Felix live together in a retirement home until one day she falls and breaks both legs. As a result, she moves to a nursing home unit and staff members have to help her bathe and dress, making Bella feel that she has no control over her life or her actions. Seeing her helplessness, Felix moves her back to their apartment. This proves crucial, as four days after her casts come off, she passes away. But Felix is glad that he could provide her with some autonomy and comfort in the final days of her life, knowing that these things are just as crucial as safety.

Dr. Paul Marcoux – Paul Marcoux is Gawande's colleague and Sara Monopoli's oncologist. Marcoux provides Sara with many treatment options for her terminal lung cancer, but he never truly helps her confront the reality of her disease. While he knows that his treatments can buy her maybe a year or two, he recognizes that she probably hopes they'll extend her life by decades. While Sara states that she doesn't want to die in the **hospital**, her four rounds of chemotherapy ultimately suppress her immune system and she dies in the hospital from pneumonia. Thus, the inability to help Sara understand her imminent death prevents her from truly assessing her priorities and dying in the way that she wishes.

Jack – Jack is Susan Block's father. At 74 years old, doctors discover that he has a spinal cord tumor and they have to operate on him to prevent him from becoming quadriplegic, though the surgery also has severe risks. He and Susan have a difficult but ultimately necessary conversation, in which he tells her that if he can eat ice cream and watch football, he wants to continue living. This proves crucial, as complications arise in the surgery and Block uses this metric to instruct the doctors to save his life. While Jack loses some motor function and recovery is difficult, he is still able to write two books—their conversation enabled him to recover meaningful time.

Sitaram/Gawande's Grandfather – Sitaram is Gawande's paternal grandfather, who lived in a rural village in India, built his farm from nothing, and lived to be 110. Sitaram maintained control of his farm until he died, even going out on horseback every night to survey it. But this came at the cost of some autonomy: he had to be constantly surrounded by family, and tensions often arose as to how to handle the business. This illustrates how when elderly parents and children live together until the parents' death, it often limits both the children's and parents' freedom, particularly because medicine now allows people to live to a much older age.

Laura Carstensen – Laura Carstensen is a Stanford psychologist who studies the changes in people's motivations over time. She was inspired to pursue this work when she was involved in a nearly fatal car crash at 21 years old, and she realized that her priorities shifted drastically from wondering what she would do with her life to trying to spend valuable time with family and friends. She conducts several studies over the course of her career which prove that people's motivations and priorities change drastically not based on age, but based on how much time they believe they have left to live.

Joseph Lazaroff – Lazaroff is one of Gawande's first patients, when Gawande is a junior resident at his **hospital**. Lazaroff is in his 60s and has metastatic prostate cancer, and when one day he can't control his right leg or bowels, he elects to undergo surgery rather than enter hospice. While the surgery is technically successful, he never recovers from it, passing away two weeks later on a ventilator. Looking back on the incident, Gawande observes that the doctors failed Lazaroff because they didn't properly communicate that the surgery would not give him back his old life.

Bill Thomas – Bill Thomas is the medical director of a nursing home. When he realizes how dejected many of the residents are, he devises a plan to bring animals, plants, and children into the nursing home. This provides the residents with a greater sense of purpose and meaning as they pitch in to care for the animals and plants and play with the children. This is one example of a person trying to change up the traditional model of nursing homes to better serve its residents.

Susan Block – Susan Block is a palliative care specialist at Gawande's **hospital**. She personally understands the importance of having difficult conversations with patients, as she had a difficult conversation with her father Jack before a risky surgery about what kind of life would be acceptable to him. But when complications arose during the surgery, she was grateful to have had the conversation, because only by having it could she properly guide the doctors on how to treat her father.

Peg Bachelder – Peg Bachelder is Gawande's daughter's piano teacher who has a rare soft-tissue cancer. After running out of cancer treatment options, Gawande convinces Peg to try hospice care. With hospice, Peg is able to live an additional six weeks, have concerts with her students, and say goodbye to the people she loves, indicating the value of this kind of care over traditional treatment options.

Gawande's Mother – Gawande's mother is a doctor who immigrated from India. She struggles to come to terms with Gawande's father's impending death, but she (along with Gawande) helps him assess his priorities in the final phase of his life and work with doctors and nurses to enable him to achieve those goals.

Jessie Richardson – Jessie Richardson is Keren Brown Wilson's mother. Wilson was inspired to build her assisted living facility to help Jessie, who suffered a stroke at 55 and became paralyzed on one side of her body. Wilson wanted to create a place for her mother where she could maintain autonomy despite her physical limitations.

Sarah Creed – Sarah Creed is a hospice worker with Gawande's **hospital**. She explains to Gawande that the goal of hospice is to allow people with terminal illnesses to have the fullest lives possible in the present. Her treatment focuses on freedom from pain and maintaining mental awareness, not on lifespan or cures.

MINOR CHARACTERS

Jim Hobson – Jim is Alice Hobson's son, Kathleen's father, and Gawande's father-in-law. When Alice starts to fall, he helps her find a retirement community.

Gopikabai/Gawande's Grandmother – Gopikabai is Gawande's grandmother and Sitaram's wife, who died before she was 30 years old from a fatal case of malaria.

Kathleen Hobson – Kathleen is Gawande's wife and Alice Hobson's granddaughter.

Dr. Juergen Bludau – Bludau is the head geriatrician at Gawande's **hospital**.

Lee Cox – Lee Cox is one of Sarah Creed's hospice patients.

Dave Galloway – Dave Galloway is one of Sarah Creed's hospice patients.

Rich – Rich is Sara Monopoli's husband.

Tom – Tom is Shelley's husband.

Dr. Edward Benzel A neurosurgeon at the Cleveland Clinic who helps Gawande's father to understand the risks of both his tumor and the surgery for removing that tumor.

TERMS

Assisted Living – Assisted living is a type of residential facility that serves elderly and disabled people who are unable to live fully independently. One of assisted living's originators, **Keren Brown Wilson**, wanted to create a place where people could live with assistance but also maintain their autonomy. She wanted them to live in their own apartments with control over food, temperatures, and who comes into their home and when. Due to Wilson's first facility's success in 1983, she expanded to 184 residences by 2000. However, other people began to pick up on the idea, and assisted living gradually expanded so much that the essentially became a stop on the way to a nursing home, rather than an alternative to it.

Geriatrician – A geriatrician is an expert in the health and care of the elderly. **Gawande** illustrates in *Being Mortal* that seeing a geriatrician rather than a regular primary care physician markedly improves people's health in old age. However, Gawande points out that fewer people than ever are becoming geriatricians despite the population becoming generally older.

Hospice – Hospice care is a type of palliative care for people with terminal diseases, focusing on relieving suffering rather than improving chances of survival. Hospice is a treatment choice for people who have less than six months to live, wherein they choose to receive pain medications and nursing support at home rather than traditional treatments and surgeries focused on curing the disease. The goal of hospice is to focus on well-being in the moment. Ironically, **Gawande** illustrates that hospice not only lessens suffering, but also it can actually help people live longer than those who choose traditional treatments.

Metastatic – The word metastatic describes cancers that have spread to other parts of the body than the part in which the cancer originated. It usually indicates a severe form of cancer.

Nursing Home – A nursing home is a facility in which elderly people both live and receive healthcare. People usually enter nursing homes when they can no longer live independently and need help with basics such as eating, dressing, and bathing. **Gawande** describes how nursing homes grew out of hospitals, because as the population aged, the elderly took up too much space in hospital beds and so they lobbied the government for separate facilities to house them. Gawande argues that the problem with nursing homes is that they focus on safety to the detriment of things that make life meaningful, such as a sense of purpose, time with family, and the ability to control one's schedule.

Palliative Care – Palliative care is a type of medical care that focuses on relieving suffering. Hospice care is a type of palliative care.

Quadriplegic – Someone who is quadriplegic is paralyzed in all four limbs. In *Being Mortal*, when **Gawande**'s **father** learns that he has a spinal cord tumor, he fears becoming quadriplegic more than anything.

THEMES

In LitCharts literature guides, each theme gets its own color-coded icon. These icons make it easy to track where the themes occur most prominently throughout the work. If you don't have a color printer, you can still use the icons to track themes in black and white.

MEDICINE, SURVIVAL, AND WELL-BEING

Being Mortal explores the modern experience of death and illness. As a practicing doctor and surgeon for over two decades, author Atul Gawande has seen firsthand how medical progress has lengthened and strengthened people's lives. However, the book primarily focuses on how both patients and doctors fail to grasp and fully communicate medicine's limits, particularly as people approach death. While doctors' and patients' impulses are often to pursue treatments no matter the odds of success, this approach often leads people to suffer more and deprives them of closure. *Being Mortal* suggests that while medicine does have major benefits in helping people survive, a person's mere survival should not come at the cost of their overall well-being.

Several case studies of patients with terminal illnesses reveal how the desire to live longer at any cost can hurt patients' well-being and sometimes shorten their lives as a result. Gawande is an intern on the neurosurgery service when he meets Joseph Lazaroff. Lazaroff is in his 60s and has a widely metastatic (spreading) prostate cancer that paralyzed his right leg. Knowing that Lazaroff only has a few months to live, doctors offer him comfort care or surgery to remove a growing tumor mass in his spine. They hope the surgery can halt his paralysis, but recovery will be difficult: the operation could both shorten and worsen his life. Still, Lazaroff chooses to go through with it. While the operation is a technical success, Lazaroff never recovers from the procedure and dies two weeks later. Gawande concludes that the doctors failed, because they knew that Lazaroff's life would never look the same, even with the surgery. They prioritized Lazaroff's mere survival over his well-being, but this cost him his survival anyway.

Sara Monopoli, a 34-year-old woman diagnosed with terminal lung cancer, finds herself in a similar situation as Lazaroff. Each successive round of chemotherapy leaves her with more side effects: fatigue, shortness of breath, and loss of strength. Sara expresses to her husband, Rich, that she doesn't want to die in the **hospital**, but the doctors continue to provide her with more treatments that might stop the tumor growth. When she finally reaches a breaking point—landing in the emergency room with pneumonia due to her suppressed immune system from the chemotherapy—the family tells the doctors to stop trying to treat her cancer. But that same day, Sara falls unconscious and passes away. Gawande acknowledges that "[Sara] may well have lived longer without any of [the treatments]." Her death highlights the doctors' failure to be realistic about what medicine can do and the cost of that failure: Sara may have lost precious time at the end of her life, she lost her well-being, and she didn't have the death she wanted.

Gawande then shows the beauty of acknowledging medicine's limits and how doing so can improve people's well-being in their final days. Gawande's father, who is also a surgeon, learns that he has a spinal cord tumor, which is making his hands numb and his neck hurt. The family sees two surgeons to discuss surgery, and each surgeon explains that they would perform the same procedure. The first explains that Gawande's father needs the surgery as quickly as possible and that it would have no serious risks. The second, Edward Benzel, emphasizes the risks of the surgery and explains that it is possible for Gawande's father to put it off so that he can continue his own surgery practice until his condition worsens. Benzel recognizes what matters most to Gawande's father—his career as a surgeon—and helps him make a decision accordingly. This allows Gawande's father to continue his passion for an extra two and a half years before getting the surgery. Observing how Benzel helps Gawande's father make the decision that's right for him, Gawande thinks, this is "the way [he] ought to make [his] own decisions with [his] own patients—the way we all ought to in medicine." Like Benzel, Gawande recognizes that his father's well-being and purpose in life is more important to him than pursuing the scant hope of patients living longer.

Gawande implements this strategy when he meets a woman named Jewel Douglass, whose metastatic ovarian cancer is pressing on her bowels and making her vomit up everything she eats. Gawande is realistic with her, telling her that if they performed surgery, it could cause complications and worsen her condition, but it is the only way to restore her ability to eat. If she doesn't want to do the surgery, they can arrange for hospice care at home (hospice care focuses on maintaining a person's comfort and quality of life rather than curing their illness). This allows them to come to a compromise: Jewel asks him to go forward with the surgery, but if it looks too risky when he tries to unblock her bowels, he should stop. This is what ultimately ends up happening, and so Jewel goes into hospice care. She lives for two additional weeks, surrounded by friends and family. Later, her daughter Susan thanks Gawande, explaining that it was a "perfect ending" to Jewel's life. Acknowledging the limits of medicine rather than relentlessly pursuing treatment enables Jewel to die in the way that she wants.

Gawande reviews how hospice care can help maintain a patient's well-being. Hospice care means patients are forgoing hospital treatments and choosing pain relief in their final days. Studies show that many patients see no difference in survival time if they do or do not choose hospice, and some even live longer. With this, Gawande argues that ordinary medicine is so concerned with survival and fixing problems that it not only increases a patient's suffering, but it can actually cut their lifespan as a result. Of course, hospice also uses medicine—it is simply medicine in service of well-being, treating the symptoms of a patient's condition to make them more comfortable. Comparing hospice care to relentless treatments and surgeries, Gawande highlights the need for doctors and patients more broadly to prioritize quality of life instead of survival.

SAFETY VS. AUTONOMY

Being Mortal considers the various residential options that people can choose in their last phase of life—like remaining with family, moving to an assisted living facility, or living in a nursing home—and why these options often seem unappealing. One of the key patterns Gawande finds across these options is that elderly people have to give up autonomy in the name of safety, but this makes older people feel as if they have no control over or meaning in their lives. The book thus suggests that there are more important things in end-of-life care than safety: namely, providing people independence and control over their own lives and maintaining a sense of purpose.

Throughout history and across the globe, it has been most common for an elderly person whose health is deteriorating to live with their children, but this arrangement can rob both adult children and their aging parents of their autonomy. Gawande introduces the topic through his grandfather, Sitaram, who was a farmer in a rural village in India. Sitaram lives to 110, and even in his last years, he tours his farm on horseback every day and is revered for his wisdom. But he is only able to live this way by staying with and receiving care from family at all times. And he gets in tense battles with the younger generations over control of the finances, property, and even basic decisions about how they can live. For example, Gawande's father moves to America to pursue economic opportunity—but he can only do so because other siblings remain behind to care for Sitaram, thus robbing them of that same opportunity. To protect Sitaram's safety, both Sitaram and his children have to forgo some degree of autonomy over their lives.

Lou Sanders and his daughter Shelley experience the same tension. As an 85-year-old widower, Lou begins to have falls in his home, his memory wanes, and he is diagnosed with Parkinson's disease. Concerned for Lou's safety, Shelley brings him to live with her. But as a result, Shelley has to care for her father in addition to having a full-time job and caring for her two teenage children. The demands on her are many; meanwhile, Lou no longer has control over the food he eats, the volume of the television, or when he can have friends over to visit. The situation becomes impossible for them and they begin to look for nursing homes, illustrating the at times untenable nature of living with family because of how it impacts a patient's ability to make their own decisions.

Because nursing homes prioritize safety and care, they are often no better at providing elderly people with independence. Gawande's wife, Kathleen, has a grandmother named Alice Hobson. Alice is very independent and lives alone until she is 84, when she begins to become confused easily and starts to fall. Despite her hesitation, she moves to a retirement home that also has the capacity for round-the-clock care when she needs it. But she is miserable there—it doesn't feel like her home. After a few more falls, Alice breaks her hip and moves into a skilled nursing unit. There, she has even less autonomy: she eats, bathes, and dresses when the nurses tell her to. Soon after, when Alice develops abdominal pain and vomits blood, she decides not to tell the nurses, and a day later, she passes away. This story suggests that Alice's safety came at the expense of her control over her life and feelings of meaning and purpose, to the point where she no longer had the will to live.

Bella Silverstone faces similar obstacles toward the end of her life, as she loses her vision and cognitive function and ultimately falls and breaks both legs. She needs intense nursing care, so she moves to the nursing home floor of her retirement home. The staff provides greater safety and care there, but Bella's husband, Felix, describes how the staff tends to her "more as a patient than a person." They treat her like a rag doll as they dress and bathe her, essentially depriving her of any control over her life and body. Felix has Bella moved back to their home for the remaining six weeks of her recovery, where she receives less assistance. Even though she may have been theoretically less safe with Felix at home, it makes Bella much happier because she feels more control over her own life.

The third option the book offers is assisted living facilities, which attempt to restore autonomy to seniors by making them feel much more purposeful and in control—and as a result, they are much happier. Keren Brown Wilson, one of the originators of the concept of assisted living facilities, wanted to create a place where people could maintain their autonomy despite physical limitations. She gave people private apartments with doors that locked, allowed them to have control over temperature settings, food, and who came into their apartment. A study of Wilson's first facility showed that this arrangement didn't negatively impact their health and safety. In fact, it actually *increased* patients' satisfaction, as well as their physical and cognitive functions. Thus, autonomy doesn't have to come at the expense of safety—having autonomy can actually make people safer as well as happier. Gawande returns to Lou Sanders, who lives for a brief period in a typical facility and is miserable. He then moves into an innovative assisted living facility, which has single rooms, looks like a home, and gives residents control over when they eat, bathe, and sleep. The fact that Lou can determine his own activities makes him feel that "he still [has] a place in this world." The approaches to elderly care that prioritize safety—living with one's children or living in a nursing home—are deeply unsatisfying for most patients, which speaks to the idea that safety alone isn't enough to give life meaning. In contrast, assisted living can be so successful—and often so beloved by its residents—because it helps elderly people maintain a sense of purpose and autonomy.

DESTIGMATIZING DEATH AND ILLNESS

Gawande acknowledges that death and illness are uncomfortable topics for most people, as people tend to avoid confronting their own mortality. And yet, he illustrates how vital it is to talk openly about these issues, so that people aren't completely caught off guard as they reach old age. Part of the book's aim, then, is to demonstrate that death, illness, and aging are all normal, and to destigmatize discussing these topics with family. The book illustrates that only through this acknowledgement that death is a normal part of life, and honest discussion about what happens when people reach that time, are people able to identify their priorities and die in the way that they wish.

The book's opening chapters describe the process of aging very specifically, illuminating how it is an inevitable process. Gawande spells out how medicine has changed our lives fundamentally: instead of dying quickly from a particular disease, many people fall victim to the "accumulated crumbling of one's bodily systems." The book spells out the different ways in which our lungs, eyes, joints, heart, and brains all age, and Gawande emphasizes how these processes are completely normal. But these processes of decay are not appealing, which is why people so often avoid the topic. This avoidance has huge consequences, not least of which is that avoiding the topics of death and illness gives us unrealistic expectations of aging. People often promote unlikely examples of maintaining vitality in old age, like a 97-year-old who runs marathons, as if those examples are accurate representations of what old age will look and feel like for most people. As a result, Gawande writes, "when our bodies fail to live up to this fantasy, we feel as if we somehow have something to apologize for." Because people so often refuse to acknowledge the reality of death, death can often feel like failure to both patients and doctors, which then leads people to try to avoid the topic even further.

But while people may want to avoid the topic of death, being proactive about discussing illness and death can markedly improve how people live and die. The book discusses palliative care and hospice care, which are medical options that specifically alleviate suffering either in addition to or in place of traditional surgeries and treatments. In one study of stage IV lung cancer, half of participants received oncology care, while the other half received oncology care *and* had discussions with a palliative care specialist. Those who saw a palliative care specialist stopped chemotherapy sooner, entered hospice earlier, experienced less suffering, and lived 25 percent longer than those who didn't see the specialist. As Gawande concludes, "If end-of life discussions were an experimental drug, the FDA would approve it." In other words, the actions people take after discussing their wishes for the end of their lives can both lessen suffering and help them actually live longer.

In 1991, the town of La Crosse, Wisconsin, widely implemented a simple form for people to fill out when they are admitted to **hospitals**, nursing homes, and assisted living facilities, asking patients about their wishes in the event of needing severe medical interventions to keep people alive (e.g., intubation and mechanical ventilation). The form ensures that people have thought and/or talked about what they want for their end-of-life care *before* they reach a crisis. As a result, La Crosse has unusually low end-of-life costs, and patients spend half as many days in the hospital as the national average in their last six months of life—but their life expectancy outpaces the national average by a year. Again, the study indicates that confronting mortality, though uncomfortable, helps people make more fulfilling decisions that improve their health.

Gawande acknowledges how difficult these discussions can be—particularly when he has to discuss death with his own father—but facing the topic of death can ultimately lead a patient (and their family) to have more fulfilling final days. Gawande's colleague, Susan Block, is a palliative care specialist whose 74-year-old father, Jack, discovers that he has a tumor growing in his spinal cord. Though the subject is uncomfortable, Susan asks her father what quality of life is tolerable to him, because they worry that surgery may leave him paralyzed. He explains that if he can still watch football and eat ice cream, he would want to continue living. Block recounts later that she is glad to have had the conversation, because when complications arise in the surgery, Block uses her father's guidance to instruct the surgeons to save his life, as they tell her that he'll still be able to watch TV and eat ice cream. Without that conversation, Block might have made the wrong decision: she might have let her father go too soon or condemned him to a life he didn't want. Only by discussing difficult topics does Jack get to live out his final days as he wishes.

The same situation happens with Gawande's own father, who also develops a tumor in his spinal cord and must undergo surgery. Gawande's father insists that he doesn't want a life of paralysis: he is more afraid of being quadriplegic (paralyzed in all four limbs) than dying. This conversation becomes crucial, because his surgery also has complications, and Benzel (the surgeon) asks Gawande how to proceed. When Gawande learns that his father is more likely to become quadriplegic if they don't continue the surgery, he instructs Benzel to continue. As a result, his father recovers from the surgery and doesn't lose any major mobility. Gawande later relays that helping his father through this difficult moment was "simultaneously among the most painful and most privileged experiences of [his] life." The book acknowledges that while death never becomes comfortable, facing these difficult topics is crucial to helping people live out their last days in the way that they want.

THE EVOLUTION OF END-OF-LIFE CARE

Gawande spends much of the book providing historical context for modern end-of-life care in the United States, including the rise of **hospitals** and nursing homes, and the impact of Social Security and pensions on aging. By providing this background, the book explores how social, economic, and technological progress has enabled people to live much longer lives. However, this progress has also created a new host of problems surrounding people's ability to lead satisfying lives in their old age. Ultimately, Gawande calls for a reform of medical care for the elderly, retirement homes, and nursing homes, arguing that these changes will help people live more meaningful and financially sustainable lives in their old age, not just longer ones.

Due to advancements in medicine, humans have greatly increased life expectancy, but the medical field doesn't have doctors who are equipped to care for the increasing number of elderly people. Life expectancy was under 50 in 1900, climbed to more than 60 by the 1930s, and today, it is in the late 70s in the United States thanks to improvements in medicine. In 30 years, there will be as many 80 year-olds as 5-year-olds. No longer are people debilitated by simple infections or common conditions like high blood pressure, showing the clear benefits of medical advancements. At the same time, medicine has been slow to account for the care of the elderly, which has only become more vital as more people reach old age. While the elderly population is growing rapidly, the number of geriatricians (doctors who handle the care of elderly people specifically) in the United States has fallen 25% between 1996 and 2010. Partly this has to do with money, as incomes among geriatricians are among the lowest in medicine. But partly, this has to do with the fact that a lot of doctors don't like taking care of the elderly. In one year, fewer than 300 doctors will complete geriatrics training in the United States, which isn't enough to replace the geriatricians going into retirement. Because of this, Gawande argues that it is necessary to overhaul this type of care. To meet the growing demand, the existing geriatricians should train primary care doctors in caring for the very old.

While increased financial independence has allowed people to retire in their sixties, the greatly increased lifespan of older Americans has put a major strain on American financial institutions. With the passing of the Social Security Act of 1935, elderly people became more financially independent. These factors led to the development of retirement communities, as retirees looked for places that would help them live out their "leisure years." This was a major improvement—prior to this, many elderly people worked until they were completely physically debilitated, and if they weren't wealthy and didn't have family to stay with, they lived in poorhouses. Yet at the same time, retirement communities have created their own problems, particularly now that people are living significantly longer. People are putting less money aside in savings for old age now than they have at any time since the Great Depression, but because people are living longer, the cost of retiring is going up as people spend more years of their lives in retirement homes. While the average income for people over 80 is $15,000, the average rent for a retirement community is $32,000 a year, while entry fees are $60,000 to $120,000 on top of that. Because of the cost of retirement and lack of income, more than half of elderly people in the U.S. have to go on government assistance to afford it. Thus, these communities may have given people places to live, but greater reform is necessary to help people save for this phase of their lives.

Initially, nursing homes were initially meant to ease hospitals' burdens and provide better care for the elderly, but as the institutions have evolved, they've fallen short of this goal. After World War II, medical advancements in antibiotics, other drugs, and surgery led to a proliferation of hospitals, which could now cure more ailments like high blood pressure, kidney failure, and bacterial infections. And because old people became more independent rather than living with family, they often wound up in hospitals for the last phase of their lives due to their many ailments. Beds filled up, and the hospitals lobbied the government for relief. In 1954, lawmakers provided funding to help hospitals build separate units for patients needing an extended period of recovery—which became the modern nursing home. And so, Gawande argues, the systems we've devised for the elderly are inadequate because they are "almost always designed to solve some other problem" (hospital overcrowding, for instance) and don't actually take into account the elderly's needs. Thus, *Being Mortal* suggests that nursing homes need to be reformed in order to be more than simply a place to live and receive basic care.

With new medicine and economic progress, many people's lives have improved—but new problems have arisen, too. As Gawande writes, "Making lives meaningful in old age is new. It therefore requires more imagination and invention than making them merely safe does." *Being Mortal* thus sheds a light on the need to reform the U.S.'s institutions to make people's newfound old age financially sustainable, technologically possible, and psychologically meaningful.

SYMBOLS

Symbols appear in **teal text** throughout the Summary and Analysis sections of this LitChart.

CARS

Cars symbolize a person's ability to control their own life—and for the elderly, revoking driving privileges embodies how their autonomy is often sacrificed for the sake of safety. Cars are a classic symbol of freedom, providing people with greater mobility. That association is even stronger for the elderly, who particularly rely on cars to be mobile and who value their independence more than most, knowing that they likely cannot maintain that independence for much longer. For example, Felix Silverstone is an 87-year-old man who relishes being able to drive. One day Gawande accompanies Felix on an errand and gets nervous, knowing that the very old are the highest-risk drivers on the road. But as Felix drives and rolls down his window, Gawande observes how Felix is "glad simply to be on the road." The association between the car and freedom provides Felix with a sense that he still has autonomy in his life—even if his driving may not make for the safest situation.

This lack of safety is evident in another case, that of Alice Hobson. Alice gets into a car accident in her late 80s when she mistakes the accelerator for the brake. Luckily no one is hurt, but it is this incident that contributes to Alice realizing that she needs assistance and can no longer live independently. Although she wants to maintain autonomy, her lack of control over the car means that she has to give up some of that autonomy in order to maintain safety. This association is strengthened when Alice moves into a retirement home and thinks that her car is stolen the very next day. When it turns out that she simply parked it in the wrong lot, she is mortified and gives up her car. This simultaneous loss of freedom with the car, and the loss of autonomy at the retirement home, shows how so many people like Alice are forced to give up some of their control and freedom in pursuit of maintaining their safety.

HOSPITAL

Hospitals represent both the great advantages and limitations of modern medicine. Initially, hospitals primarily helped poor people gain some comfort as they died—most doctors treated people in their own homes. But after World War II (with improvements in antibiotics, surgery, and other treatments), hospitals transformed from symbols of sickness and death to places of hope and healing, reflecting the new benefits of modern medicine. Yet at the same time, hospitals have also become symbols of its limitations. Many people who have severe conditions or incurable diseases, including Joseph Lazaroff and Sara Monopoli, tell family and friends that they don't want to die in the hospital. But because both doctors and patients constantly consider additional treatments that have a scant possibility of helping patients live longer, patients continue to receive more and more treatments and surgeries at the hospitals. These treatments can often lead patients to a kind of death that they do not want, as Lazaroff and Monopoli both die in the hospital due to complications from treatments.

In these cases, hospitals symbolize some of the problems with over-medicalizing death: because the medical system doesn't prioritize well-being over lifespan, people spend their last days in this sterile hospital environment, barely conscious and intubated or on ventilators, rather than having meaningful goodbyes with family. While hospitals do often allow people to live longer, they also ultimately reveal that medicine does not always cure or save people, and society has to be willing to acknowledge these limits.

QUOTES

Note: all page numbers for the quotes below refer to the Metropolitan Books edition of *Being Mortal* published in 2014.

Introduction Quotes

What worried us was knowledge. While we knew how to sympathize, we weren't at all certain we would know how to properly diagnose and treat. We paid our medical tuition to learn about the inner process of the body, the intricate mechanisms of its pathologies, and the vast trove of discoveries and technologies that have accumulated to stop them. We didn't imagine we needed to think about much else. So we put Ivan Ilyich out of our heads.

Yet within a few years, when I came to experience surgical training and practice, I encountered patients forced to confront the realities of decline and mortality, and it did not take long to realize how unready I was to help them.

Related Characters: Dr. Atul Gawande (speaker)

Related Themes:

Page Number: 3

Explanation and Analysis

In Gawande's introduction to *Being Mortal*, he recalls how in medical school, reading Tolstoy's *The Death of Ivan Ilyich*, the students were more concerned with making sure they had proper information to treat illnesses and save lives than with helping people through their deaths. Ivan Ilyich, the main character of the book, grows unhappy that people are treating him as having an illness, rather than pitying him as someone who is dying. In putting Ivan Ilyich "out of [their] heads," Gawande implies that the students felt that they didn't need to concern themselves with the main character's plight. Instead, Gawande emphasizes the students' true worries: rattling off the concrete types of information that he and others imagined would help them in their practices.

Yet as Gawande emphasizes here, this dynamic of doctors ignoring Ilyich's emotional need to have his impending death acknowledged is precisely the issue that is plaguing doctors today, even as medical students believed that they would never treat anyone so unsympathetically. As Gawande shows in example after example in the book, it is not that the doctors aren't sympathetic to their patient's plight. Instead, they focus on helping patients live as long as humanly possible. And like patients themselves, doctors often choose to avoid discussing death because it is uncomfortable. Both of these strategies, however, create problems for patients, in that sometimes they rob patients of well-being in their end of life. This is true of Ivan Ilyich, where doctors treat him as ill rather than dying—trying to convince him that he has hope of survival—and don't let him have the closure of knowing that he is soon to die. By including himself in this issue, Gawande shows how crucial it is to try to rectify these problems in the medical profession as a whole—and it foreshadows how Gawande will have to confront mortality alongside his patients in the book.

> You don't have to spend much time with the elderly or those with terminal illness to see how often medicine fails the people it is supposed to help. The waning days of our lives are given over to treatments that addle our brains and sap our bodies for a sliver's chance of benefit. They are spent in institutions—nursing homes and intensive care units—where regimented, anonymous routines cut us off from all the things that matter to us in life. Our reluctance to honestly examine the experience of aging and dying has increased the harm we inflict on people and denied them the basic comforts they most need. Lacking a coherent view of how people might live successfully all the way to their very end, we have allowed our fates to be controlled by the imperatives of medicine, technology, and strangers.

Related Characters: Dr. Atul Gawande (speaker), Joseph Lazaroff

Related Themes:

Page Number: 9

Explanation and Analysis

Gawande concludes his introduction by establishing all of the major themes in his book. First, he emphasizes some of the failures of the medical profession: how doctors often prioritize "a sliver's chance of benefit," but at the cost of treatments that can severely harm people in their final days. In other words, they often prioritize survival over well-being. As Gawande shows through many examples, including that of Joseph Lazaroff in this chapter, sometimes pursuing greater longevity can actually worsen (and even shorten) people's lives. Both patients and doctors need to be realistic about this prospect.

Gawande also introduces the idea that the institutions society has built for the elderly—nursing homes and other facilities—prioritize safety over autonomy and meaning in life. He emphasizes that while medicine and technology have enabled us to live longer and healthier lives, they have also created problems with which society has not yet fully grappled.

This brings up Gawande's last major theme, which is that people often avoid the topic of death and illness. But only when people "honestly examine" these issues can they then figure out what matters most in their last phase of life, and only after figuring out these priorities can society reform institutions to reflect those priorities.

Chapter 1 Quotes

> The fascinating thing is that, over time, it doesn't seem that the elderly have been especially sorry to see the children go. Historians find that the elderly of the industrial era did not suffer economically and were not unhappy to be left on their own. Instead, with growing economies, a shift in the pattern of property ownership occurred. As children departed home for opportunities elsewhere, parents who lived long lives found they could rent or even sell their land instead of handing it down. Rising incomes, and then pension systems, enabled more and more people to accumulate savings and property, allowing them to maintain economic control of their lives in old age and freeing them from the need to work until death or total disability. The radical concept of "retirement" started to take shape.

Related Characters: Dr. Atul Gawande (speaker), Sitaram/Gawande's Grandfather

Related Themes:

Page Number: 20-21

Explanation and Analysis

In this chapter, Gawande explores the history of how people have navigated living situations in old age. Throughout most of history, at least one child remained to take care of their parents, but now, parents are much more likely to live alone. Gawande examines the economic and social factors that contributed to this change: first, people are living longer, are having fewer children, and stop having children earlier. These factors combine to mean that parents often live to see all of their children reach adulthood, and having one child remain robs those children of their autonomy over their life's path. This is what happens to Gawande's uncles and aunts, many of whom remained in his grandfather Sitaram's home to take care of him until he was 110.

Additionally, economic progress—like the rising incomes and pensions that Gawande references here—enables greater financial independence for the elderly and consequently allows them more control over their lives. All in all, these factors combine to give both parents and children greater agency over their lives, which is a crucial part of maintaining meaning and purpose. Later in this chapter and others, Gawande explores some of the potential issues with this system, but here he shows how this is unequivocal progress over his grandfather's situation.

Chapter 2 Quotes

The progress of medicine and public health has been an incredible boon—people get to live longer, healthier, more productive lives than ever before. Yet traveling along these altered paths, we regard living in the downhill stretches with a kind of embarrassment. We need help, often for long periods of time, and regard that as a weakness rather than as the new normal and expected state of affairs. We're always trotting out some story of a ninety-seven-year-old who runs marathons, as if such cases were not miracles of biological luck but reasonable expectations for all. Then, when our bodies fail to live up to this fantasy, we feel as if we somehow have something to apologize for.

Related Characters: Dr. Atul Gawande (speaker)

Related Themes:

Page Number: 28

Explanation and Analysis

In this passage, Gawande emphasizes some of the consequences of our medical progress and resulting increased longevity. While modern medicine and public health has given the majority of people much longer and healthier lives, it has also produced some unfortunate side effects. Primarily, it has bolstered our denial of death and our embarrassment over the last period of our lives. Particularly, it has enabled widespread fantasy—like the 97-year-old marathon runner that Gawande depicts here—about what the last phase of our lives might look like.

Yet this chapter, and the book as a whole, illustrates that most people will not achieve this fantasy of easy old age. And not being able to live up to it often prompts shame, causing people to avoid the subject of disability, illness, and death entirely. Mortality is an uncomfortable subject, but Gawande suggests here that it is necessary to tackle it and not to regard it as some kind of failure. The passage illustrates Gawande's aim to provide a starting point for discussing death, hoping to destigmatize it so that people feel less embarrassed and more realistic about their end of life. Only by honestly confronting reality are people then able to shape how they want to die.

Equally worrying, and far less recognized, medicine has been slow to confront the very changes that it has been responsible for—or to apply the knowledge we have about how to make old age better. Although the elderly population is growing rapidly, the number of certified geriatricians the medical profession has put in practice has actually fallen in the United States by 25 percent between 1996 and 2010. Applications to training programs in adult primary care medicine have plummeted, while fields like plastic surgery and radiology receive applications in record numbers. Partly this has to do with money—incomes in geriatrics and adult primary care are among the lowest in medicine. And partly, whether we admit it or not, a lot of doctors don't like taking care of the elderly.

Related Characters: Dr. Atul Gawande (speaker)

Related Themes:

Page Number: 36

Explanation and Analysis

Part of *Being Mortal*'s aim is to explore the ramifications of medical and economic progress on society, and here Gawande introduces an issue that has yet to be solved. While the elderly population is growing due to increased longevity, there are fewer geriatricians. This reflects the fact that society doesn't prioritize the elderly, as doctors who care for the elderly are among the lowest paid. This is in part due to the fact that the elderly are difficult to treat, in part because elderly people often have many ailments. Doctors often find it difficult to treat people unless they can identify a discrete problem: it is easier to treat people for something doctors can fix, rather than trying to support their overall health. Geriatricians know that they are fighting a losing battle, but they do important work to help people maintain their alertness and alleviate pain through the final phase of life.

Gawande also brings up this issue in the hopes that reform can be achieved. As he notes later in the chapter, studies have shown that seeing geriatricians in old age as opposed to regular physicians significantly improves health. Thus, trying to ensure that we have enough geriatricians, or that physicians receive geriatric training, is crucial for all people's long-term health.

> But the dismal finances of geriatrics are only a symptom of a deeper reality: people have not insisted on a change in priorities. We all like new medical gizmos and demand that policy makers ensure they are paid for. We want doctors who promise to fix things. But geriatricians? Who clamors for geriatricians? What geriatricians do—bolster our resilience in old age, our capacity to weather what comes—is both difficult and unappealingly limited. It requires attention to the body and its alterations. It requires vigilance over nutrition, medications, and living situations. And it requires each of us to contemplate the unfixables in our life, the decline we will unavoidably face, in order to make the small changes necessary to reshape it. When the prevailing fantasy is that we can be ageless, the geriatrician's uncomfortable demand is that we accept we are not.

Related Characters: Dr. Atul Gawande (speaker), Dr. Juergen Bludau

Related Themes:

Page Number: 46

Explanation and Analysis

When Gawande sits in on his colleague Juergen Bludau's geriatrics appointments, Gawande gains a newfound respect for geriatricians. Gawande acknowledges in this passage that Bludau and other geriatricians do what many doctors do not: promote overall well-being over survival. As Gawande hints at, patients often want doctors who are able to "fix" them, a common refrain throughout *Being Mortal*. And yet, constantly trying to "fix" things allows people to avoid the subject of death, as they put off the idea that they may not recover from certain illnesses or conditions. However, this avoids the reality that some illnesses or conditions are not worth fighting because doing so will likely worsen people's health during the end of their lives.

Geriatricians acknowledge the "unfixables" in people's lives. Even if this presents patients with an uncomfortable reality, overall it increases their well-being. As Gawande noted earlier in the chapter, seeing a geriatrician as opposed to a regular doctor leads to markedly better health in old age. This is because geriatricians acknowledge reality and try to "shape" it to the best of their ability, not deny it to the point where it actually makes patients worse off. In this way, Gawande points out one of the key problems with most doctors: they prioritize survival at the cost of well-being. Gawande also highlights the need for both patients and doctors to confront mortality in order to provide the best kinds of treatments for patients.

Chapter 3 Quotes

> Their apartment was only a floor away. But somehow that made all the difference. Exactly why can be hard to pinpoint. Felix still ended up hiring an around-the-clock staff of nurses and aides. And the remaining six weeks until the casts could come off were physically exhausting for him. Yet he was relieved. He and Bella felt more control over her life. She was in her own place, in her own bed, with him beside her. And that mattered tremendously to him. Because four days after the casts came off, four days after she'd begun walking again, she died.

Related Characters: Dr. Atul Gawande (speaker), Bella Silverstone, Felix Silverstone

Related Themes:

Page Number: 58-59

Explanation and Analysis

After Bella Silverstone falls and snaps both her fibulas, she and her husband Felix move to a nursing home floor for better care—until Felix recognizes how much she benefits from being in her own home and moves her back. Here, Gawande demonstrates how crucial that decision was. Even though it was theoretically less safe and more difficult to move Bella back into her home, the positive change is also key. The move helps both Bella and Felix regain the crucial autonomy that they lacked on the nursing home floor. Even though they didn't necessarily have more control over some aspects of their lives, they were able to dictate what was most important to them: sleeping together, being together, and sharing a home together.

The fact that Bella dies just four days after this ordeal is tragic, but it emphasizes the necessity of identifying priorities in cases of serious illness or injury. Bella didn't know that she would die soon after getting her casts off, but Felix identifying the things that mattered to Bella was crucial in allowing her to die where and with whom she wanted. And more than that, as Gawande suggests, being able to honor her priorities enabled Felix to feel good about the decisions he made, too, buoying his heart even at a time of great loss. Thus, allowing people to die in the way that they want can help both those who are dying and also their loved ones.

> But hospitals couldn't solve the debilities of chronic illness and advancing age, and they began to fill up with people who had nowhere to go. The hospitals lobbied the government for help, and in 1954 lawmakers provided funding to enable them to build separate custodial units for patients needing an extended period of "recovery." That was the beginning of the modern nursing home. They were never created to help people facing dependency in old age. They were created to clear out hospital beds—which is why they were called "nursing" homes.

Related Characters: Dr. Atul Gawande (speaker)

Related Themes:

Related Symbols:

Page Number: 70-71

Explanation and Analysis

In this passage, Gawande describes the shift of housing the elderly with chronic illnesses from hospitals to the advent of nursing homes. It highlights the inherent problems with nursing homes being extensions of hospitals. Hospitals symbolize care and the advantages of medicine, and their proliferation after World War II was an important step in medicine's progress. More and more people had access to hospitals, and therefore more and more people could be cured and treated for illnesses and injuries that were previously debilitating.

Yet nursing homes highlight the limitations of hospitals. Hospitals were unable handle the influx of people with chronic illnesses, and thus nursing homes essentially became extensions of hospitals to deal with elderly and disabled people and free up beds in regular hospitals. However, the style of treatment in hospitals and nursing homes is essentially the same, even though the patient populations are fundamentally different. Nursing homes, like hospitals, deprive people of autonomy with the goal of caring for people and making them safe. But safety isn't adequate for a meaningful life. The point is not solely to focus on survival and safety, but also on well-being and purpose. Thus, even though medicine has given us longer lives, society still hasn't fully figured out the best way to provide people with meaning and purpose when living independently isn't wholly possible.

> This is the consequence of a society that faces the final phase of the human life cycle by trying not to think about it. We end up with institutions that address any number of societal goals—from freeing up hospital beds to taking burdens off families' hands to coping with poverty among the elderly—but never the goal that matters to the people who reside in them: how to make life worth living when we're weak and frail and can't fend for ourselves anymore.

Related Characters: Dr. Atul Gawande (speaker)

Related Themes:

Related Symbols:

Page Number: 76-77

Explanation and Analysis

As Gawande provides the historical context for the advent of nursing homes, he makes clear that while these institutions have helped solve some problems, they have created other problems. Nursing homes were a byproduct of increased longevity and better hospital care, leading more frail and sick elderly people to go to hospital and then to this separate nursing facility—which is why they are called "nursing homes." But while hospitals (and their offshoots) can have great benefits, they are not places in which people find much meaning or purpose in life. And so this has led to a situation in which people spend the final months—if not years—of their lives in a place where the only goal is to keep them alive, not to figure out how to give them some control over those lives and find purpose in them.

Gawande also highlights how this dynamic is an outgrowth of people's instincts not to talk about death and aging. Most people choose not to think about these institutions until they or their parents are entering them, at which point residing in one seems inevitable. But part of Gawande's intention in the book is to spur conversation about these kinds of institutions and to find ways to reform them so that they actually cater to their residents, rather than simply unburdening hospitals or family members.

Chapter 4 Quotes

> Taking care of a debilitated, elderly person in our medicalized era is an overwhelming combination of the technological and the custodial. […] The burdens for today's caregiver have actually increased from what they would have been a century ago. Shelley had become a round-the-clock concierge/chauffeur/schedule manager/medication-and-technology troubleshooter, in addition to cook/maid/attendant, not to mention income earner. Last-minute cancellations by health aides and changes in medical appointments played havoc with her performance at work, and everything played havoc with her emotions at home. Just to take an overnight trip with her family, she had to hire someone to stay with Lou, and even then a crisis would scuttle the plans. One time, she went on a Caribbean vacation with her husband and kids but had to return after just three days. Lou needed her.

Related Characters: Dr. Atul Gawande (speaker), Lou Sanders, Shelley

Related Themes: ⚠ 🏠

Page Number: 85-86

Explanation and Analysis

In this passage, Gawande examines the burdens piling up between Shelley and her father Lou because Lou has moved into her home. Not only does Lou lose a degree of autonomy because he is no longer the master of his own home, but Shelley loses autonomy as well. Much of her schedule is now dictated by his needs, and in addition to having a job and kids to juggle, she also has to take care of her father. This shows how untenable living with family is for some older people. While changing demographics have led to women like Shelley juggling a job and kids, society rarely discusses the burden having to take care of an older parent on top of that. The laundry list of jobs that Gawande spells out emphasizes just how many new tasks Shelley has acquired in taking care of her father.

These overwhelming tasks illustrate how the U.S.'s current system is failing. When people like Lou want to avoid nursing homes at all costs, there are also massive difficulties with having to stay with one's child. As Gawande discusses, assisted living and other places that try to restore autonomy to the elderly are important, but they haven't gained widespread popularity yet. Dynamics like Shelley and Lou's are still somewhat common when a person can no longer live independently, leaving everyone frustrated.

> Fifteen years later, when she was a scholar, the experience led her to formulate a hypothesis: how we seek to spend our time may depend on how much time we perceive ourselves to have. When you are young and healthy, you believe you will live forever. […] When horizons are measured in decades, which might as well be infinity to human beings, you most desire all that stuff at the top of Maslow's pyramid—achievement, creativity and other attributes of "self-actualization." But as your horizons contract—when you see the future ahead of you as finite and uncertain—your focus shifts to the here and now, to everyday pleasures and the people closest to you.

Related Characters: Dr. Atul Gawande (speaker), Laura Carstensen

Related Themes: ⚠ ☠

Page Number: 96

Explanation and Analysis

Laura Carstensen is a psychologist who studies human motivation in relation to people's perception of how long they have to live. Her studies are a refutation of Maslow's hierarchy of needs. In the hierarchy of needs, Maslow asserts that people must fulfill basic needs like food, shelter, and safety before pursuing things like love and status. But here, Carstensen complicates that theory, illustrating that people's motivations are not static—they shift greatly over time. Carstensen's study affirms Gawande's idea that confronting death is crucial to helping people assess their priorities. Carstensen's findings reflect this, as people who are more aware of their limited time shift their priorities to the "here and now," as Gawande writes. For people with terminal illnesses, being aware of this limited time is crucial so that they can shift from fighting for survival to making the time that they have more meaningful.

The shift in priorities recurs throughout *Being Mortal*, as older people care less about things like safety and more about the ability to experience "everyday pleasures. "This is often what makes nursing homes so miserable for many people, as they are deprived of the ability to enjoy those everyday pleasures in order to live longer or more safely.

Chapter 5 Quotes

“He agreed, with the indifference of a person who knows he will soon be gone,” Thomas said. But he began to change. “The changes were subtle at first. Mr. L. would position himself in bed so that he could watch the activities of his new charges.” He began to advise the staff who came to care for his birds about what they liked and how they were doing. The birds were drawing him out. For Thomas, it was the perfect demonstration of his theory about what living things provide. In place of boredom, they offer spontaneity. In place of loneliness, they offer companionship. In place of helplessness, they offer a chance to take care of another being. […] Three months later, he moved out and back into his home. Thomas is convinced the program saved his life.

Related Characters: Dr. Atul Gawande, Bill Thomas (speaker), Alice Hobson

Related Themes:

Page Number: 124-125

Explanation and Analysis

Bill Thomas, who runs Chase Memorial Nursing Home in New Berlin, New York, describes his experiment of introducing animals, children, and plants into his nursing home to liven the place up. The results illustrate the deep need for reform in nursing homes. Thomas shows that these reforms are so crucial that they can actually save people’s lives. Something as simple as a parakeet actually rescues Mr. L., who had become withdrawn and hopeless, from the kind of fate that Alice Hobson experienced.

Thomas recognizes that the nursing homes were never fully intended to cater to the emotional needs of the people living in them, and his outside-the-box reforms aim to remedy that. While Thomas can’t reform the entire nursing home system, he can make a difference in his own facility. Gawande uses him as an example to show how simple reforms can make a huge difference for the people living in these facilities.

The irony is that many of the nursing home staff were opposed to his reforms, deeming them too difficult or a violation of the facility’s codes. But Thomas sees the need for people to find purpose and meaning in something outside of themselves, rather than simply being concerned with safety and making people miserable as a result.

The problem with medicine and the institutions it has spawned for the care of the sick and the old is not that they have had an incorrect view of what makes life significant. The problem is that they have had almost no view at all. Medicine’s focus is narrow. Medical professionals concentrate on repair of health, not sustenance of the soul. Yet—and this is the painful paradox—we have decided that they should be the ones who largely define how we live in our waning days. For more than half a century now, we have treated the trials of sickness, aging, and mortality as medical concerns. It’s been an experiment in social engineering, putting our fates in the hands of people valued more for their technical prowess than for their understanding of human needs.

Related Characters: Dr. Atul Gawande (speaker), Bill Thomas

Related Themes:

Related Symbols:

Page Number: 128

Explanation and Analysis

As Gawande describes how people like Bill Thomas are trying to make life in nursing homes more meaningful and purposeful—in Thomas’s case, by introducing children and animals—he illustrates why people thinking in innovative ways is so important. For institutions like nursing homes, which largely grew out of medical institutions and hospitals, they were never created as places for people to live and find fulfillment, and so that aspect of their existence has largely been ignored in favor of safety.

As Gawande illustrates here, this goes hand in hand with the fact that medicine focuses on survival rather than well-being. Doctors often try to fix people as much as possible without considering their mental and emotional state as a whole. This connects back to Gawande’s opening passage, in which he recognized that after medical school, he understood how inadequate he was at helping people understand and work through the reality of their situation, which is sometimes what people need the most. Thus, this passage calls on the medical field as a whole—both doctors and institutions like hospitals and nursing homes—to understand patients’ needs better and help them through the processes of aging and dying.

Chapter 6 Quotes

The difference between standard medical care and hospice is not the difference between treating and doing nothing, she explained. The difference was in the priorities. In ordinary medicine, the goal is to extend life. We'll sacrifice the quality of your existence now—by performing surgery, providing chemotherapy, putting you in intensive care—for the chance of gaining time later. Hospice deploys nurses, doctors, chaplains, and social workers to help people with a fatal illness have the fullest possible lives right now—much as nursing home reformers deploy staff to help people with severe disabilities. In terminal illness that means focusing on objectives like freedom from pain and discomfort, or maintaining mental awareness for as long as feasible, or getting out with family once in a while—not on whether Cox's life would be longer or shorter. Nonetheless, when she was transferred to hospice care, her doctors thought that she wouldn't live much longer than a few weeks. With the supportive hospice therapy she received, she had already lived for a year.

Related Characters: Dr. Atul Gawande (speaker), Lee Cox, Sarah Creed

Related Themes:

Page Number: 160-161

Explanation and Analysis

When Gawande accompanies Sarah Creed on her rounds with the hospice service, she explains to him the difference between hospice and traditional medicine. This helps clarify some of Gawande's—and likely readers'—misconceptions about what hospice means. Hospice is not the absence of medicine. On the contrary, medicine is crucial to helping people alleviate pain and ensuring a much higher quality of life in their final days, as Creed explains here. Traditional medicine, by contrast, often focuses on the possibility of greater survival instead. But, as Gawande notes throughout the book, the pursuit of this possibility can often come at a huge cost to a person's short-term health and well-being, and for people with little time to live, that can make a huge difference.

Gawande sees hospice as a major improvement over traditional medicine for people with terminal illnesses because hospice workers help people identify their priorities in the final phase of their life, like the kinds of things that Sarah lists here. And armed with that knowledge, hospice workers can then help people achieve those goals. Additionally, as Gawande hints at here and affirms with data later in the chapter, hospice can ironically sometimes help people live longer than they would have were they treated with traditional medicine, only proving further how medical institutions should move away from focusing on survival and instead focus on well-being.

It's worth pausing to consider what had just happened. Step by step, Sara ended up on a fourth round of chemotherapy, one with a minuscule likelihood of altering the course of her disease and a great likelihood of causing debilitating side effects. An opportunity to prepare for the inevitable was forgone. And it all happened because of an assuredly normal circumstance: a patient and family unready to confront the reality of her disease.

I asked Marcoux what he hopes to accomplish for terminal lung cancer patients when they first come to see him. "I'm thinking, can I get them a pretty good year or two out of this?" he said. "Those are my expectations. For me, the long tail for a patient like her is three to four years." But this is not what people want to hear. "They're thinking ten to twenty years. You hear that time and time again. And I'd be the same way if I were in their shoes."

Related Characters: Dr. Atul Gawande (speaker), Dr. Paul Marcoux, Laura Carstensen, Sara Monopoli

Related Themes:

Related Symbols:

Page Number: 167

Explanation and Analysis

In this passage, Gawande documents how Sara Monopoli ends up on a fourth round of chemotherapy despite limited possible benefits. In doing so, Gawande highlights the problems of people trying to avoid confronting their mortality. While Gawande notes that this instinct to avoid the topic of death is understandable, it creates an inherent miscommunication between Sara and her oncologist, Paul Marcoux. He acknowledges that while she thinks she can get ten or twenty years of her life back, he is thinking one to two at most. Because she isn't in that same mindset, she isn't able to contemplate her priorities in the same way. As Laura Carstensen's studies proved earlier in the book, people's priorities shift drastically when they know how much time they have left. Sara doesn't have that opportunity to evaluate her priorities, and it's because neither she nor her doctor is able to confront the inevitable.

And so this is what creates a fundamental problem for Sara. Because without knowing her priorities, Marcoux can only try to give her greater survival. But, as Gawande has shown time and again, sometimes there are more important things than survival, particularly well-being. Sara has expressed several times that she doesn't want to die in the hospital. But these treatments, while giving her some hope of living longer, ultimately end up worsening her life and causing her to die in the hospital. Thus, Gawande illustrates the real consequences of patients avoiding death and doctors who only focus on well-being.

The result: those who saw a palliative care specialist stopped chemotherapy sooner, entered hospice far earlier, experienced less suffering at the end of their lives—*and they lived 25 percent longer*. In other words, our decision making in medicine has failed so spectacularly that we have reached the point of actively inflicting harm on patients rather than confronting the subject of mortality. If end-of-life discussions were an experimental drug, the FDA would approve it.

Related Characters: Dr. Atul Gawande (speaker), Sara Monopoli

Related Themes:

Page Number: 178

Explanation and Analysis

Gawande discusses the dilemma between continuing traditional medical treatments like chemotherapy or surgery and choosing hospice care, which usually entails forgoing these traditional treatments. But in citing a study where half of a group saw palliative care specialists and the other half did not, Gawande illustrates that this choosing palliative care can have counterintuitive results. Not only does hospice allow people to experience less suffering, but as a result, they also actually live longer. This proves how care that is focused on well-being rather than simple survival time can actually improve overall health even more than traditional treatments do.

Gawande emphasizes this irony in his metaphor. In putting the treatments into medical terms, he shows that doctors should consider palliative care in terms of the effectiveness of any other treatment—and they should understand that it works better than most. This study not only emphasizes the effectiveness of palliative care, but also the benefits of confronting one's mortality in general. The medical field has issues because it does not help people fully confront their deaths, and as a result, they often sacrifice their well-being and their priorities. This scathing critique that medicine has "failed so spectacularly" emphasizes the importance of ensuring these discussions among doctors and patients to avoid the harm that evasion currently causes.

"If I had not had that conversation with him," she told me, "my instinct would have been to let him go at that moment because it just seemed so awful. And I would have beaten myself up. Did I let him go too soon?" Or she might have gone ahead and sent him to surgery, only to find—as occurred—that he was faced with a year of "very horrible rehab" and disability. "I would have felt so guilty that I condemned him to that," she said. "But there was no decision for me to make." He had decided.

Related Characters: Dr. Atul Gawande, Susan Block (speaker), Jack

Related Themes:

Page Number: 184

Explanation and Analysis

When Susan Block's father Jack experiences complications in his surgery, she expresses how lucky she feels to have had a conversation with him about what he wanted beforehand. This episode illustrates the value of having end-of-life discussions before people reach crises. This is true not only for people like Jack, whose lives are in question, but also for people like Block herself, who can feel more comfortable with the decision-making because she knows she is doing what her father would want. Only by identifying his priorities—being able to eat ice cream and watch TV—is Susan able to then make sure that he can have a life that is worthwhile for him.

Ultimately, Jack has a serious period of recovery and major disabilities. But through therapy, he is able to write two books in the last years of his life. This was an acceptable level of being alive to him, and only by discussing the difficult topic of death and disability was Block able to ensure that she made the decision he wanted. In highlighting this example, Gawande advocates for all people to take the time to have similar conversations when a loved one's health is flagging or they are undergoing a risky treatment.

Chapter 7 Quotes

> In truth, neither type is quite what people desire. We want information and control, but we also want guidance. The Emanuels described a third type of doctor-patient relationship, which they called "interpretive." Here the doctor's role is to help patients determine what they want. Interpretive doctors ask, "What is most important to you? What are your worries?" Then, when they know your answers, they tell you about the red pill and the blue pill and which one would most help you achieve your priorities.

Related Characters: Dr. Edward Benzel, Dr. Atul Gawande (speaker), Sara Monopoli, Gawande's Father

Related Themes:

Page Number: 201

Explanation and Analysis

As Gawande recounts how his father's surgeon, Benzel, discussed the potential treatment options for his father's spinal cord tumor, he references an essay by Ezekiel and Linda Emanuel, two bioethicists, called "Four Models of the Physician-Patient Relationship." Their description of the kind of relationship that people most want from their doctors aligns perfectly with Gawande's arguments throughout the book. A doctor should not simply tell patients what to do, as in the paternalistic model, since this takes away all autonomy from the patients. Nor should doctors simply give a list of potential treatments, allowing patients to work out what they want alone. Gawande criticizes this approach in himself when he worked with Sara Monopoli.

Instead, doctors should help initiate a conversation about terminally ill patients' priorities so that both patient and doctor can be on the same page about the reality of the disease. Doctors can impress upon patients the severity of what they are facing, giving them an accurate frame of reference, while patients can help give doctors an idea of what is most important to them. This allows both parties to not just prioritize a patient's survival; it helps them uncover the most fulfilling path forward.

> I realized then that my father had already told us what to do, just as Susan Block's father had. My dad was more afraid of becoming quadriplegic than of dying. I therefore asked Benzel which posed the greater risk of his becoming quadriplegic in the next couple months: stopping or proceeding? Stopping, he said. We told him to proceed.

Related Characters: Dr. Edward Benzel, Dr. Atul Gawande (speaker), Jack, Susan Block, Gawande's Mother, Gawande's Father

Related Themes:

Page Number: 213-213

Explanation and Analysis

When complications arise during Gawande's father's surgery, Gawande expresses his relief that he had a conversation about his father's priorities prior to the surgery. As such, Gawande is able to make an informed decision about the surgery based on that conversation, highlighting the importance of being able to confront difficult topics *before* crises occur. Only then can people like Gawande's father live out his final days and die in the way that he wishes. This is made even more evident after the surgery—because of Gawande's decision, his father survives and he doesn't lose any motor function, as they feared. Although not every story has this kind of happy ending, his father's happiness was only possible through having the conversation.

As Gawande notes, this echoes the incident with Susan Block and her father Jack, who also has complications arise during a life-threatening surgery. Because Block had a conversation with her father, she, too, was able to guide the doctors. Like Gawande's father, Jack relieved her of the burden of the decision (as it was Jack's to make) and helped Jack live out his remaining days in the way he wanted. Both of these cases emphasize the importance of facing mortality and discussing it with loved ones.

> We witnessed for ourselves the consequences of living for the best possible day today instead of sacrificing time now for time later. He'd become all but wheelchair bound. But his slide into complete quadriplegia halted. He became more able to manage short distances with a walker. His control of his hands and his arm strength improved. He had less trouble calling people on the phone and using his laptop. The greater predictability of his day let him have more visitors over. Soon he even began hosting parties at our house again. He found that in the narrow space of possibility that his awful tumor had left for him there was still room to live.

Related Characters: Dr. Atul Gawande (speaker), Gawande's Father

Related Themes:

Page Number: 229

Explanation and Analysis

After Gawande's father begins hospice care, Gawande is amazed to see him markedly improve. This is another ringing endorsement of hospice care and other palliative care that acknowledges suffering and death rather than trying to avoid unpleasant inevitabilities. Such care can actually give people more liberty, well-being, and even more time. Because Gawande's father was able to identify the things that mattered most to him, he was then able to accomplish his goals—things like having visitors and entertaining in the last few months of his life. His care also helped him avoid becoming more paralyzed and gave him greater clarity of mind.

The alternative to this care would have been chemotherapy or continuing to try to adjust his medications himself and likely continuing to have dangerous falls. Having hospice care workers who are solely focused on well-being helps him avoid the negative consequences of all of those actions. The final sentence in this passage shows that living isn't just about surviving, as traditional medicine often prioritizes. It's also about one's emotional and mental well-being, and hospice care helps Gawande's father recover that.

Chapter 8 Quotes

> When our time is limited and we are uncertain about how best to serve our priorities, we are forced to deal with the fact that both the experiencing self and the remembering self matter. We do not want to endure long pain and short pleasure. Yet certain pleasures can make enduring suffering worthwhile. The peaks are important, and so is the ending.

Related Characters: Dr. Atul Gawande (speaker), Gawande's Father, Jewel Douglass, Sara Monopoli

Related Themes:

Page Number: 239

Explanation and Analysis

Gawande recognizes that decisions at the end of one's life can be difficult to grapple with, particularly as people face a great deal of suffering. He references Daniel Kahneman's *Thinking, Fast and Slow*, which posits that even if we endure suffering over long periods of time, when we remember experiences, how we rate the experience in our memory depends on the peak amount of suffering and the end amount. This is another implicit argument for the value of hospice care. While Gawande acknowledges that sometimes traditional medicine can give people greater survival time, hospice is usually better at alleviating suffering and creating a more meaningful ending for people.

Good contrasts can be found in Sara Monopoli, who died in the hospital on a ventilator and didn't have a real opportunity to say goodbye to her family, as she was largely in denial about the severity of her condition until the very end of her life. By contrast, Jewel Douglass and Gawande's father die in this chapter surrounded by family in their homes, having had the opportunity to say goodbye and do things like take walks together or look at pictures of the memories that are most important to them. While facing mortality is difficult to do, it reduces suffering at the peaks and the ends. Jewel's daughter writes later to Gawande that she appreciates the time that she had with her mother and calls her death the "perfect ending." Thus, understanding the importance of the peaks and the ends not only helps alleviate the suffering of those who are dying, but also of the loved ones, who will live beyond those who have died and remember the time that they had with their family members.

> Certainly, suffering at the end of life is sometimes unavoidable and unbearable, and helping people end their misery may be necessary. Given the opportunity I would support laws to provide these kinds of prescriptions to people. About half don't even use their prescription. They are reassured just to know they have this control if they need it. But we damage entire societies if we let providing this capability divert us from improving the lives of the ill. Assisted living is far harder than assisted death, but its possibilities are far greater, as well.

Related Characters: Dr. Atul Gawande (speaker)

Related Themes:

Page Number: 245

Explanation and Analysis

In this quote, Gawande explores the complex issue of assisted suicide (also called death with dignity), wherein doctors prescribe terminally ill and suffering patients lethal drugs to help them end their lives. Here he explicitly supports enabling terminally ill patients to end their own suffering, viewing it as an important way to give people autonomy over their own lives. This is also in line with much of his argument in the rest of the book, as doctors and medical institutions should not put survival over a patient's well-being. Thus, when well-being is no longer possible, it does not make sense to prolong a person's life simply for the sake of survival.

However, Gawande offers an important caveat to this idea. While he supports making these prescriptions available to people, this should not be the focus or the primary way in which people die by any means. The point is to improve care even more, so that people have a good quality of life until they die, not to simply help people end their lives because the possibility of a good life no longer exists. Again, this ties back to the idea that medicine has enabled us to live longer, but progress is still necessary to improve the quality of life in old age.

Epilogue Quotes

❝ If to be human is to be limited, then the role of caring professions and institutions—from surgeons to nursing homes—ought to be aiding people in their struggle with those limits. Sometimes we can offer a cure, sometimes only a salve, sometimes not even that. But whatever we can offer, our interventions, and the risks and sacrifices they entail, are justified only if they serve the larger aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it, the good we do can be breathtaking.

Related Characters: Dr. Atul Gawande (speaker)

Related Themes:

Related Symbols:

Page Number: 260

Explanation and Analysis

Gawande's conclusion touches on all of *Being Mortal*'s themes. He again returns to the idea that medical progress and the institutions springing from that progress have allowed people to live much longer lives. But, he argues, living longer should not be the end-all, be-all. The point is not simply to enable survival for its own sake; even in our final phase of life, people should be able to have well-being, purpose, and meaning. His references to surgeons and nursing homes reiterate his points that medicine should be concerned with well-being, and nursing homes should work to provide autonomy to their residents to make sure they have fulfilling lives.

Gawande acknowledges that the care that hospitals, nursing homes, and surgeons can provide is very powerful. It often provides hope where in previous decades people would have been resigned to death. But as he has argued, these institutions and professionals also have to be realistic with that hope and help patients understand their reality. When medicine has limits—and at one point or another, it always does—it is important for doctors to acknowledge those limits so that patients can identify their priorities and live (and die) in a way that feels most meaningful to them. The final two sentences in this quote emphasize both the good and bad possibilities of medicine: the capacity to inflict suffering and the capacity to alleviate that suffering. *Being Mortal* asks doctors to ensure that they are helping more than harming.

❝ When I was a child, the lessons my father taught me had been about perseverance: never to accept limitations that stood in my way. As an adult watching him in his final years, I also saw how to come to terms with limits that couldn't simply be wished away. When to shift from pushing against limits to making the best of them is not often readily apparent. But it is clear that there are times when the cost of pushing exceeds its value. Helping my father through the struggle to define that moment was simultaneously among the most painful and most privileged experiences of my life.

Related Characters: Dr. Atul Gawande (speaker), Gawande's Father

Related Themes:

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Explanation and Analysis

As Gawande spreads his father's ashes in the Ganges River, which is sacred to all Hindus, he reflects on how he watched his father grapple with his mortality. This passage shows one of the most difficult things about a child confronting their parent's death: while his father took care of him and taught him never to accept limitations, now they have experienced a reversal of roles. Gawande was the one caring for his father, and he watched as limitations became a greater and greater part of his father's life. Gawande acknowledges that this shift is an uncomfortable one, because it requires acknowledging that he is going to die.

And yet, Gawande also emphasizes how crucial it is to confront mortality, because there are times when "the cost of pushing exceeds its value." The goal is not to ensure survival forever, because everyone knows that that is impossible. Instead, the goal is to ensure well-being as long as possible. In writing that helping his father through the end of his life is among his "most painful and most privileged experiences," Gawande concedes that these moments are not easy. But he knows the immense amount of good he did for his father in helping him sort through his priorities and enabling those goals in the final days of his father's life.

SUMMARY AND ANALYSIS

The color-coded icons under each analysis entry make it easy to track where the themes occur most prominently throughout the work. Each icon corresponds to one of the themes explained in the Themes section of this LitChart.

INTRODUCTION

Dr. Atul Gawande recalls that, in medical school, he and his classmates rarely talked about mortality and how people experience death. The students and professors largely saw the purpose of medical school as teaching them how to save lives, not to tending to people's demise.

Gawande opens Being Mortal*—which is largely concerned with examining how people age and die—by showing how even students training to be doctors avoid the subjects of mortality and death.*

The only time Gawande discussed mortality was in a weekly seminar called "Patient-Doctor," in which they read Tolstoy's *The Death of Ivan Ilyich*. In the story, Ilyich is 45 years old, and one day, he falls off a stepladder and develops a pain in his side. The pain grows worse, and he becomes unable to work. Doctors aren't able to figure out exactly what's wrong, and their remedies do nothing. Tolstoy writes that what bothers Ivan Ilyich the most is that everyone believes he is ill, not that he is dying. But he wants to be comforted as someone at the end of his life.

Ivan Ilyich's example demonstrates the problem with many doctors' mindsets. They frame almost everything as an illness, unwilling to acknowledge that people can and likely will die from certain conditions. As a result, Ivan Ilyich doesn't receive the comfort he so desperately wants as a dying man—he doesn't get to live out his final days in the way that he wants.

The medical students in the class believed that the failure in Ivan Ilyich's case belonged to the doctors: they couldn't properly diagnose him, and if they could, honesty and kindness and comfort would have followed. The students were more worried about having the proper knowledge, not about sympathizing. And yet when Gawande went out into the world, he found himself completely unprepared to help patients confront the possibility of death.

Even as students, doctors are unwilling to acknowledge their limitations, viewing it as their job to cure or treat a person, not help them grapple with it if medicine can't save them. But as a result, Gawande felt that he had a knowledge gap in helping people understand their own mortality and confront their deaths.

Gawande flashes back to his time as a junior resident. At the time, he began writing essays, including one about Joseph Lazaroff—a city administrator in his 60s who is suffering from a metastatic prostate cancer. Lazaroff loses weight, his body fills with fluid, and one day he can't control his right leg or bowels. The doctors find that his cancer has spread to his spine. It can't be cured, but they hope it can be treated. They provide him with two options: comfort care or a relatively risky surgery.

Lazaroff's story is typical, in that he is given a choice between traditional treatment and "comfort care," likely meaning hospice care. Lazaroff chooses the surgery, but part of the problem is that he doesn't fully understand the gravity of his situation or what the two options truly entail. This is because the doctors aren't being fully clear about what the surgery will do for him and what its risks are—they simply want to try to fix his issues despite that this is highly improbable.

No matter what, Lazaroff probably has a few months to live. Recovery would be difficult, and the operation could worsen and shorten his life. But Lazaroff still wants the operation. Lazaroff's wife died on a ventilator in intensive care a few years earlier, and at the time he told his son he didn't want anything like that to happen to him. But now he doesn't want to feel like he is giving up.

Lazaroff's belief that he is "giving up" plays into the common idea that people must fight death at any cost. But Gawande shows how this misconception comes at the risk of Lazaroff's well-being. Death is natural, but because Lazaroff is unable to confront this fact, he makes a decision that goes against his desire not to die in the hospital on intensive care.

Gawande believes Lazaroff's choice is a bad one, not because of the dangers of the operation, but because the operation cannot give Lazaroff the life that he really wants. The operation is a technical success, but Lazaroff never recovers from the procedure: he develops respiratory failure, an infection, and blood clots. Two weeks later, Gawande takes Lazaroff off the ventilator at Lazaroff's son's request.

Gawande introduces the idea that people often pursue the scant hope of survival or a better life at the expense of their well-being. And because Lazaroff didn't fully comprehend that the operation couldn't give him a better life, he wasn't able to have closure or the kind of death that he wanted.

A decade later, reviewing the story, Gawande is amazed at how much the doctors avoided talking about the choice honestly. They explained the dangers of the treatment options, but they never communicated the reality of the disease: it could not be cured, and Lazaroff would never return to the life he used to have. In this way, they didn't do much better (and may have done worse) than the doctors in Ivan Ilyich.

Gawande doesn't shy away from blaming himself and the other doctors who were treating Lazaroff. While they did offer him choices, they didn't give him actual guidance on what would give him the greatest well-being. Instead, they focused on what would give him hope for longer survival. Gawande regards this as a failure because it gave Lazaroff a misunderstanding of the reality of his disease. This emphasizes the need for honest discussions about death.

Modern science allows people to live longer and better than at any other time, but it also turns aging and dying into medical processes. In 1945, most deaths occurred in the home. But by the 1980s, only 17 percent did. The experience of aging and death has shifted to **hospitals** and nursing homes. When Gawande became a doctor, he did so to explore how medicine could pull people through difficult illnesses and injuries. He wasn't prepared to see medicine's limits.

Gawande touches on how progress in medicine has given people longer lifespans and better access to hospitals. But as a result, the process of dying has become extremely medicalized, and doctors—including Gawande—have a difficult time acknowledging that medicine has limitations.

Death is not a failure: death is normal and inevitable. It's sometimes difficult for doctors to comprehend this, particularly because they are in a profession meant to fix problems. But with unfixable problems, doctors rarely know what to do, and this has caused "extraordinary suffering."

Gawande emphasizes how death is normal, attempting to destigmatize it not only for readers and patients, but for doctors as well. Understanding that death is inevitable is crucial for doctors to fully grasp. That way, they can prioritize people's well-being over the constant pursuit of treatments that may make their lives worse, as in Lazaroff's case.

The book is about the modern experience of mortality in the United States, and how the current medical systems are failing. The last days of people's lives are given over to treatments that addle their brains and sap their energies for the smallest hope of a benefit. They are spent in nursing homes, where people are cut off from all the things that mattered to them in life. Gawande aims to explore how the experience of dying has changed and how it might be improved.

Gawande explicitly states his aim here: to provide some historical context for the process of aging and dying, to critique medical institutions for how they prioritize survival over well-being, and to destigmatize death and provide a starting point for people's own considerations of their final phase of life.

CHAPTER 1

When Gawande was in college, he began dating a girl named Kathleen and met her 77-year-old grandmother Alice Hobson. Alice was spirited and independent: her husband died in 1965 of a heart attack, when Alice was 56. She was able to live off his pension and keep her home. Her son, Jim, lived nearby, but she remained completely autonomous. She even mowed her own lawn and fixed her own plumbing.

In introducing Alice, Gawande establishes how, in the modern era, independence even into old age is a crucial part of people's well-being. Alice enjoys being able to live alone and take care of her own home.

Gawande eventually married Kathleen, and as the years passed, he started to wonder how long Alice would be able to live independently. She became arthritic and lost weight. When Gawande's father met Alice, he was surprised to learn she lived alone. Coming from India, Gawande's father felt it was the family's responsibility to take care of the aged and give them company.

Alice's living situation affords her autonomy, but Gawande's father's attitude comes from his own preconceived notions about elder care. Where he is from in India, living with children is considered more appropriate because it is safer for the parent, setting up a tension between safety and autonomy.

Gawande's grandfather, Sitaram, had a traditional old age that seems idyllic. He was a farmer in a rural village in India. Gawande met him on a visit to India when Sitaram was over 100 years old. Sitaram walked with a cane, was hard of hearing, and was very weak. But he was surrounded and supported by family at all times, and he was revered for his wisdom. The family consulted him on all important matters.

The picture of Sitaram's old age in India illustrates how different cultures treat the process of aging and dying. In the modern U.S., this situation is growing rarer. But in India, it is still the family's role to care for the elderly.

In America, Sitaram would likely have lived in a nursing home. If a person can't use the toilet, eat, dress, bathe, groom, get out of bed, get out of a chair, or walk, then they lack the capacity for physical independence. If a person cannot prepare food, shop, do laundry, manage medications, travel alone, and handle finances, then they lack the capacity to live safely alone. Sitaram could only perform some of the basic measures and a few of the complex ones.

This passage establishes the guidelines in the United States for ensuring that someone can live autonomously, again positioning autonomy in old age as a threat to safety. If a person cannot perform these basic actions, they are considered to be unable to ensure their own safety.

Living with family allowed Sitaram to manage his farm, which he built up from nothing to become one of the richest landowners in the village. Every day he rose before sunrise, and each night he inspected every acre of field on horseback—even at 100. Had he lived in the West, doctors would insist he live in a nursing home, but in Sitaram's world, he lived how he wanted to live and the family was meant to make that possible. He died at almost 110: he hit his head falling off a bus while he was going to a courthouse in a nearby town on business.

Because Sitaram lived with family, he was able to maintain the parts of his life that were most meaningful to him. Yet those meaningful routines, such as maintaining his farm, were ultimately what put him in danger and ended his life. It's difficult for an aging person to have both safety and autonomy, and this passage suggests that it's crucial to consider their own desires for their quality of life when making decisions about how they live.

For most of history, Sitaram's experience was the norm. Elders were cared for in multigenerational systems. One child, often the youngest daughter, remained in their family's home—this is what happened to Emily Dickinson, who lived in her parents' house until they died. It was understood in both these cases that parents would keep living in their home, assisted by the children they'd raised.

History confirms the traditional pattern of parents living with children through their old age. But Emily Dickinson's example is emblematic of the fact that sometimes it is the children who lack autonomy as a result of taking care of their parents.

Now, old age has changed. In the past, surviving into old age was uncommon. In 1790, people 65 or older were less than 2 percent of the population; now they are 14 percent. And thanks to technology and modernity, old age and wisdom isn't as revered—teenagers have just as much access to certain information as the elderly. As a result, traditional family systems have become more strained, as young people lost freedom about how to live their lives and battles emerged over land and money.

Gawande illustrates how society's perspective on aging is changing thanks to modern technology. Technology allows people to live longer and makes old age more common. In addition, technology means that wisdom is more equally distributed; older people no longer have disproportionate access to wisdom simply because they've experienced more.

Meanwhile, global economic development has put pressure on young people to move in search of greater opportunity—like Gawande's parents, who left India for professional opportunity in the United States. Gawande's father sent money home to help his family in India, but he never went back. Sitaram's situation was only possible because Gawande's aunts and uncles did not leave home. And even then, tension emerged between Sitaram and Gawande's uncles, who didn't always agree on how to run the farm.

The contrast of Gawande's father with his siblings shows how children risk losing some of their own autonomy in caring for their parents. The siblings had to give up some aspect of independence in remaining at home with their father, and even as they became middle-aged and older, they could not make their own decisions about their home and their business.

While many believe that they might want the old age Sitaram had, in reality, the historical pattern shows that people generally don't want this kind of living situation. Elderly parents discovered economic benefits to children leaving as well: they could rent or sell their land instead of handing it down. Rising incomes and pensions enabled people to accumulate savings and maintain economic independence. Retirement began to take shape.

When given financial independence, the elderly did not want to remain with their children. This fact suggests that they also found some cost to their autonomy in living with their children for their entire adult lives. In addition, greater financial independence, combined with greater longevity, allowed modern retirement to take shape.

Life expectancy, which was under 50 in 1900, climbed to 60 by the 1930s. Family sizes fell and women stopped having children at a younger age. As a result, more people now see all of their children live to adulthood. With new economic opportunity and fewer children, many aging parents found freedom in separation from their children—a worldwide pattern.

It isn't just medical advancements that change the way people live out the final phase of their lives. The changes to the traditional family structure also contributed to retirement homes' advent and the desire for greater independence among aging people.

The fact that the elderly and the young both have more choices and independence is a sign of progress. The elderly can choose a retirement community or remain independent in their own homes, like Alice Hobson. But there is one problem with this way of living. Even though people can be independent longer, sooner or later, independence becomes impossible.

The changing demographics and family structures are a sign of progress, as Gawande notes. But as he also suggests that this progress has created its own problems surrounding what to when elderly people can no longer remain independent—problems with which society is still grappling.

In 1992, Alice turned 84. She was in striking health, going to the gym, doing her own shopping, and taking care of her house. Soon, things began to change, however. On a mountain vacation with the family, Alice became confused and went into the wrong cabin. Then the family noticed bruises on Alice's legs when they visited her—she fell going down the stairs. Soon, she had more falls and a doctor found that she had thinning bones. He gave her medications, but in reality, he didn't know what to do: Alice was simply getting old, unsteady, and her memory was slipping. Her independence wasn't sustainable, and it was not a fixable problem.

Here Gawande shows how end-of-life care is often medicalized. It's hard for doctors to know how to treat the elderly, because they don't necessarily have discrete, fixable problems—often they are simply facing the danger of living alone as an old person. But there is often a breaking point between allowing people to maintain their independence and creating a safer environment for them.

CHAPTER 2

For most of history, death was a common, ever-present possibility. For most people, life would continue nicely until illness hit and people would deteriorate quickly—like Gawande's grandmother Gopikabai Gawande, who died of malaria before she was 30. But now, public health measures and advances in science have reduced the mortality of infection, traumatic injuries, childbirth, heart attacks, strokes, and many other conditions.

One of the primary ways that medicine and public health have changed the way we live and die is by remedying many illnesses and injuries that once were fatal. Because of this, death is no longer a "common, ever-present danger," it is one that we don't have to consider for most of our lives.

Even people with incurable cancers can undergo treatment, bringing symptoms under control for much longer. Although people still deteriorate rapidly, the point at which the bottom drops out occurs much later. Even if doctors can't stave off damage, they can stave off death. When people enter **hospitals** looking terrible, doctors can provide them with care that allows them to recover some ground. On the whole, however, medical progress has allowed large numbers of people to get a full life span and die essentially of old age, as people's bodily systems fail over time.

This passage emphasizes how amazing medical advancement has become, and how it has allowed even people with illness to live much fuller, healthier lives. But it also raises the issue that now it is much more difficult to know when someone with a terminal illness may die, leading people to cling to hope that they may live much longer than they actually will.

While medicine and public health have allowed for great progress, they have changed the way we think about old age. When people need help, they see this as weakness rather than a normal state of affairs. While one 97-year-old may be able to run a marathon, this is not the norm, and it is unrealistic to believe in this fantasy. This progress also makes it difficult for doctors to know how to treat people in old age unless there is a discrete problem to fix.

Because of medicine, people often maintain false hopes about what their own end of life might look like. They look at fit 97-year-olds rather than confronting the much more likely scenarios of disability and illness. And doctors are just as guilty about avoiding the reality of death as average people are.

Teeth are a good example of the natural way in which people age. While dental care can help avert tooth loss, old age gets in the way: the gums become enflamed, the roots of the teeth atrophy, and problems like arthritis make it difficult to brush and floss. The ability to chew food declines, and people shift to soft food, which are higher in carbs and more likely to cause cavities. By 85, almost 40 percent of people have no teeth.

Here the book provides some examples of the different ways in which people age to show how aging is both a natural and inevitable process. Acknowledging that it can't be stopped is a crucial part of helping people face mortality, even though they don't want to think about these issues. Even though people can take care of their teeth and body, doing so cannot prevent this decay.

While bones and teeth soften, the rest of the body hardens. Blood vessels, joints, and muscles pick up calcium deposits as bones wear away, and they stiffen. To maintain the same volume of blood flow through these blood vessels, the heart generates increased pressure, and more than half of people develop hypertension by 65. The heart muscle thickens, and muscle elsewhere thins and deteriorates.

Gawande then provides even more examples of how the body breaks down on a large scale. These aren't appealing prospects, but it is important to acknowledge them as a part of ultimately confronting mortality.

All of these processes are normal. While they can be slowed, they cannot be stopped. Lung capacity decreases, bowels slow, brains shrink—losing particularly the areas devoted to memory, judgment, and planning. Why we age is a subject of debate: the classical view is that aging happens because of wear and tear, but the newest view suggests that aging is genetically programmed, which is why most people prior to the past few hundred years died before 30. Thus, aging today is a very unnatural process.

Aging is so natural that it is even genetically programmed into us. So while death may seem like a "failure," as Gawande noted before, it is just as inherent in our DNA as our other traits. This passage also emphasizes how it is medical progress, not our natural bodies, that has enabled people to live as long as they do.

Nonetheless, genetic inheritance has little influence on longevity, and so wear and tear may explain more than expected. Leonid Gavrilov, a researcher at the University of Chicago, argues that human beings fail the way complex systems fail: randomly and gradually. Humans are designed with many backup systems and redundancies, allowing us to function even as damage accumulates. But as defects increase, there is a point in time where one more defect is enough to impair the whole system.

This further peek into how we die becomes another way to destigmatize death and explore what causes it. It shows how ultimately, death just comes as an accumulation of defects. This also makes it difficult for doctors to know how to treat aging, because there is no one cause specifically; aging consists instead of many issues that build up.

People choose to avoid the subject of aging and death, and as a result, few societies have come to terms with the increasing number of old people. While the retirement age is still 65, people over this age approach close to 20 percent of the population, and few people give thought to how they will live in these later years. Additionally, these days people are putting aside less in savings for old age than they have at any time since the Great Depression.

This passage touches on why avoiding the topics of death and aging are problematic. More and more people are reaching old age, but without giving any thought as to how they want to live during this period. Part of Gawande's intention in writing the book is to remedy this fact.

At the same time, there is a shortage of geriatricians in the medical profession, because it pays less compared to other jobs in medicine. Additionally, many people dislike taking care of the elderly, who often have a multitude of problems and can be difficult to treat. There's nothing glamorous about taking care of high blood pressure, diabetes, or arthritis. One cannot cure these things—but one can manage them.

Even though medicine has enabled people to live longer, the field hasn't adapted to these changing demographics. The lack of geriatricians necessitates some reform in this area, as Gawande explores later in the chapter.

One morning, Gawande sits in on some patient visits in the geriatric clinic in his **hospital** with the chief geriatrician, Juergen Bludau. The doctor's first patient, an 85-year-old woman named Jean Gavrilles, has lower back and leg pain. She also has bad arthritis, high blood pressure, and glaucoma. Lately, she's had trouble controlling her bowels, and she recently had surgery for colon cancer. Gavrilles lives alone, and she takes care of herself capably.

Sitting in on the geriatrics appointments, Gawande recognizes the vast array of problems that can befall someone in old age, and he identifies which conditions they can live with. This is what makes geriatricians so key, as they navigate all of these different conditions to figure out how to best improve someone's life.

Bludau asks about Jean's day in great detail before examining her. She is in good condition for her age, but she faces everything from arthritis and incontinence to what might be metastatic colon cancer. Gawande thinks that the doctor could focus on the most potentially life threatening problem (the cancer) or the problem that bothers Jean the most (the back pain). But instead, the doctor spends most of the time looking at her feet, because often older people cannot bend down to reach their feet, and this suggests real danger and neglect.

Gawande acknowledges that Bludau's training as a geriatrician specifically gives him insight that Gawande, even for all his experience, doesn't have. The aging population has made geriatricians extremely vital, because only these doctors have this specialized training, and as the population grows steadily older due to advances in medicine and technology, geriatricians prove more and more critical.

Bludau informs Jean that she's doing impressively well, and the most serious threat she faces is falling. The three primary risk factors for falling are poor balance, taking more than four prescription medications, and muscle weakness. Elderly people with all three have almost a 100 percent chance of falling in a given year, and Jean has at least two. She has poor balance, as indicated by her neglected feet. And she's on five medications, some of which have the side effect of dizziness. But she doesn't have muscle weakness, and Bludau wants her to preserve her strength.

While Gawande focuses on Jean's discrete ailments, Bludau knows instead to focus on her overall condition. This is what makes the geriatricians so important, as Gawande highlights how, by contrast, regular doctors overly focus on certain ailments at the expense of well-being.

Later, Bludau tells Gawande that his job is to support quality of life: both freedom from disease, and the retention of enough function for active engagement in the world. He switches some of Jean's medications to avoid dizziness, recommends a podiatrist for her feet, and also suggests that she eat a snack during the day to keep her muscles strong. Almost a year later, Gawande follows up with Jean: she is eating better and still lives comfortably, without a single fall.

Bludau's recommendations, and Jean's condition a year later, illustrate the importance of focusing on well-being. Even though Jean has some concerning conditions, Bludau is able to keep them in check enough so that she doesn't have a larger health problem—a fall—and can continue to live in the way that she wishes.

When Alice Hobson began to fall frequently, Gawande didn't understand how much of an alarm bell that was. She then got into a **car** accident, mistaking the brake for the accelerator. Soon after, two men scammed her out of $7,000 when they did yard work for her and cornered her in her house until she wrote them a check. The men were eventually caught and convicted, but the whole process indicated that Alice was growing increasingly vulnerable, and Jim suggested they look at retirement homes.

Alice's difficulties here return to the conflict of autonomy versus safety. She wants to be able to live independently, but her old age and deteriorating mental and physical capacities are making it unsafe for her to be alone—which is why Jim suggests a retirement home to try to improve her safety.

Medicine can determine whether a person's decline is steep or more gradual. One study at the University of Minnesota focused on men and women over 70 who were living independently but had a high risk of becoming disabled. Half of them were randomly assigned to a team of geriatricians, while the other half were simply asked to see their usual physician. Within 18 months, 10 percent of each group died. But the patients who saw the geriatrics team were a quarter less likely to become disabled and half as likely to develop depression. They were 40 percent less likely to require home health services.

This University of Minnesota study illustrates the importance of having geriatricians to treat the aging population. Recognizing what to look for in elderly care and knowing how to prioritize overall well-being over specific ailments provides significant benefits to those who receive that care.

The geriatrics team simplified medications, controlled arthritis, and promoted overall health. But a few months after the study was published, the university closed the geriatrics division, because the services were too costly. This is a pattern all over the United States, which is why many doctors are choosing not to go into geriatrics. But the financial problems are indicative of a deeper reality: society does not prioritize doctors who bolster resilience in old age.

Just as Gawande emphasizes the importance of geriatrics, he illustrates the problems that geriatricians are facing across the United States. This is part of the reason Gawande brings these issues up, because he recognizes the importance of instituting reforms in medicine that prioritize geriatrics and incentivize people and places to support geriatricians.

Gawande meets Felix Silverstone, a national leader in geriatrics for five decades, when the man is 87 years old. Felix can feel his own mind and body wearing down. He worked until he was 82, at which point he had to retire to take care of his wife, Bella, who became almost completely blind. They moved into a retirement community for people over 75, and when they needed to, they could upgrade to assisted living.

Felix's story illustrates his struggle for autonomy not only for himself, but also so that he can help take care of Bella. Felix recognizes the difficulty in being able to care for someone else when he is also aging, which is why he opts for a place that can provide greater safety.

The retirement community is expensive, which is true of retirement communities generally. More than half of the elderly living in long-term care facilities spend their entire savings and have to go on government assistance to afford it. Ultimately, many Americans go to nursing homes, which Felix hopes to avoid. He is most concerned about the changes in his brain, as he feels his cognitive ability slipping. Sometimes, he feels he is depressed.

Here the book highlights another important problem in the evolution of end-of-life care. While retirement communities have become commonplace, as more people live for longer periods of time, the financial aspect of long-term care is currently unsustainable and requires reform.

What buoys Felix is a sense of purpose. He improves the health care services at his retirement home and forms a journal-reading club for retirement physicians. Most importantly, he cares for Bella. He knows that he has to be honest with himself about his progress, because if his health fails, he won't be any help to her.

Even though Felix has sacrificed some autonomy by moving into a retirement home, he has been able to keep a good balance of independence by caring for Bella and remaining connected to his passions. This highlights the importance of purpose in making a person feel they have control over their lives.

One evening, Gawande goes to dinner with Felix and Bella. Felix helps Bella sit and orders for her, as she can't read the menu. When the food arrives, Felix tells Bella where the food is on her plate by the hands of a clock. She almost chokes on her food, and then he almost chokes as well. Gawande is amazed that Felix can still remain independent, care for Bella, and do his research.

Although Felix has a great degree of independence for his age, Gawande also notes that this clearly comes at the expense of safety for Felix and Bella, as both of them have some difficulty with simply eating.

Felix has managed his old age well—particularly in finding a skilled geriatrician to help him. While there won't be enough geriatricians to replace the retiring ones, geriatrics professor Chad Boult posits that the best strategy is to direct geriatricians to train primary care doctors and nurses to deal with the very old. This will help improve their care overall.

Here, Chad Boult highlights another way in which the medical fields could compensate for some of the issues that Gawande has raised—particularly the lack of doctors to care for the elderly. Directing geriatricians to train primary care doctors would help alleviate the doctors' lack of knowledge and would improve the care (and lives) of the elderly generally.

One day Gawande accompanies Felix on a drive to run an errand. Gawande is admittedly nervous to be in the **car**: the very old are the highest-risk drivers on the road. Felix is a capable driver, and he's happy to be on the road. But Gawande knows that someday soon, Felix will have to give up his keys.

Cars are a key recurring symbol throughout the book, as many elderly people express dismay at having to give up this aspect of their lives. As a symbol of freedom and mobility, cars demonstrate how people often wish to hold onto the idea that they can remain independent. But cars can also be dangerous for the elderly and the people around them, and so often they have to give up that independence for greater safety.

CHAPTER 3

The very old often say they don't fear death—they fear what happens just before death, like losing hearing, memory, friends, and a way of life. People can live and manage a long time, but eventually losses accumulate. For Felix, it isn't his own problems that accumulate, it is Bella's. She loses her vision completely, her hearing becomes poor, and her memory is impaired. Still, they are grateful to have each other and to care for each other.

Gawande's description of these fears plays back into his assessment of why autonomy is so important. Having control over one's life is crucial, and deteriorating health can feel like a loss of autonomy in and of itself because it rips people away from their sense of purpose and the things that matter most to them.

One day, Bella develops a cold, and her eardrum ruptures from fluid accumulating. As a result, she becomes totally deaf, severing all communication between her and Felix. Even the simplest things are confusing. Felix doesn't know what to do, but before they transfer to a nursing home floor, Bella's right eardrum mends, and they are able to communicate again. Felix doesn't know what would happen if it recurred.

This episode proves how uncontrollable old age can feel. Bella loses her sense of autonomy simply because of her ruptured eardrum, and this makes her both entirely dependent on Felix and very confused.

Then, one day, Bella falls and snaps her fibula in both legs—she has to move to the nursing home floor for round-the-clock care. The staff is professional and lifts some of their burdens, but they treat Bella more as a patient than a person, dressing her like a rag doll, for example. There are particular ways Felix knows to care for her, but the staff doesn't learn these ways.

Bella's fragile condition exposes the tension between autonomy and safety. While the staff can help Bella accomplish her tasks more safely, they also take away all of her agency and don't always treat her as a person.

Felix moves Bella back downstairs, though the staff continues to work in Felix and Bella's home. Felix feels more control there, and Bella is more comfortable. This makes a big difference, as four days after Bella's casts come off, she collapses at lunch. An ambulance comes to take her to the **hospital**, and she dies on the way there. When Gawande sees Felix three months later, he feels that a part of himself is missing. But Felix is glad that Bella didn't suffer and that she got to spend her last few weeks at home.

Felix recognizes that safety is not the only important thing in a person's life. And so even though they might be less safe in their home, it gives them greater control over their own lives. And this also reinforces how longer survival isn't the only important thing—well-being in one's final days is also vitally important, ensuring that Bella didn't suffer and that Felix could feel that she had good final days.

Alice Hobson felt the same dread of leaving her home. But after the scam incident, it was apparent that she wasn't safe living on her own anymore. Jim began a search for a retirement home, looking for a place within a reasonable driving distance and an affordable price range. He wanted a community with apartments for independent living and a floor with nursing capabilities should Alice need them someday.

Jim's search illustrates some of the problems with children looking for nursing homes for their parents. His priority is a place where he can visit her and a place that can provide her with eventual round-the-clock care. But he doesn't really consider if the place will make her happy or provide her with purpose.

Alice ultimately chose a complex Gawande calls Longwood House. She moved into a one-bedroom apartment there in the fall of 1992. It was spacious and homey, but after a few weeks, Alice became withdrawn. Gawande thinks that this is perhaps because on the very first day, she thought her **car** was stolen and notified the police, but she simply parked it in the wrong lot. Mortified, she gave up her car. She also ate little and avoided group activities. She was depressed, and medication didn't help.

This passage reinforces the car as a symbol of autonomy, just as it represented independence for Felix. Alice relinquishes the autonomy of having a car just as she enters the retirement home. Not only does the episode illustrate her slipping mental capacities, but also her loss of freedom. That loss of freedom proves very damaging, as Alice grows depressed as a result.

In the past, people might have been thrilled to live in a place like Longwood House. Before pensions and Social Security, the elderly worked until illness became debilitating. If they didn't have family and weren't independently wealthy, they had virtually no options except a poorhouse, which were filthy and dilapidated. The Great Depression sparked a new era, however. With the passage of Social Security in 1935, the United States created a system of national pensions, and retirement became a mass phenomenon. In developing countries, poorhouses remain common, but in the United States, even poor people can expect nursing homes with meals, health services, physical therapy, and activities.

Here Gawande illustrates how economic progress like pensions and Social Security have markedly improved end-of-life institutions. He draws a contrast between nursing homes and the alternatives prior to Franklin Delano Roosevelt's New Deal policies. Without wealth or family, the only options for the elderly were work or poorhouses, neither of which helped them maintain a good quality of life. With these vital economic policies, everyone can have a better final phase of life.

Longwood House had a lot going for it, but Alice never got used to being there. She only grew more miserable. Gawande asked her about this, but Alice couldn't put a finger on what made her unhappy. A few years earlier Gawande read about the case of Harry Truman, an 83-year-old man who refused to budge from his home at the foot of Mount Saint Helens in March 1980 when the volcano began to steam and rumble. He didn't believe the volcano would actually blow, and he didn't want to leave his home, thinking that losing it would kill him anyway. On May 18, 1980, the volcano erupted, and Truman was buried in his home. He became an icon, taking his chances and living life on his own terms.

The story of Harry Truman represents the opposite end of the autonomy/safety compromise. Truman was completely unwilling to give up his ability to live in his home. But, as a result, he gave up his safety and even lost his life. However, this was his choice—he lived and died on his own terms, and presumably he found fulfillment and comfort in it.

Alice wasn't facing a volcano, but her feeling was the same. The things that made Longwood House safer and more manageable were the things that made it hard for her. Aides and nurses monitored her diet and health. They observed her growing unsteadiness. They forced her to take her medication under their supervision. While it was a friendly place, she lost control of her life.

Alice felt that she was compromising her autonomy in the name of safety by giving up her home, just as Truman anticipated he would feel if he left home before the volcano erupted. This is particularly true for Alice because the staff monitor her so closely, as they again prove how doctors and other medical staff often focus on survival rather than on Alice's actual well-being at Longwood House.

The modern nursing home developed in the middle of the 20th century, when medicine underwent rapid and historic transformations. Before that time, if a person were ill, doctors mostly tended to them in their own bed. **Hospitals** were mainly custodial, providing warmth, shelter, food, and care from nurses, but they did little to alleviate disease. After World War II, antibiotics and other drugs became commonplace and surgical practices improved. As a result, hospitals transformed from symbols of illness to a place for cures. Hospitals exploded; in the two decades after 1946, more than 9,000 new facilities were built.

Gawande's explanation of the historical context of hospitals and nursing homes shows how crucial medical progress has been. Hospitals now represent the huge benefits of medicine, where people can go to be cured. But this foreshadows the idea that hospitals have become so focused on fixing problems and prolonging lives that they don't fully account for what they cannot cure.

At **hospitals**, people gave over nearly every part of their lives to doctors and nurses in exchange for these cures. And many of the people who spent a long time in hospitals were the ill and frail who used to live in poorhouses. But the hospitals did not have the capacity for these people, and so in 1954 lawmakers provided funding to enable them to build separate custodial units for patients needing care over an extended period of time. This created the modern nursing homes, which were meant to clear out hospital beds. This is the problem of how modern society deals with old age: the systems are designed to fix problems other than providing a place for elderly people to live meaningful lives.

Here Gawande emphasizes how nursing homes sprang out of overflow problems in hospitals—they were not actually intended to cater to the emotional needs of the elderly living in them. This is why they are so often known as places where people have little autonomy: in a hospital, people recognize that they are supposed to do what doctors and nurses say. But when people spend years of their lives in nursing homes, safety should not be the only priority.

The next spur to nursing home growth came in 1965 when Medicare was enacted. The law specified that Medicare, the United States' health insurance system for the aged and disabled, would only pay for care in facilities that met basic health and safety standards. Many **hospitals** couldn't meet those standards, and so the Bureau of Health Insurance dictated that if a hospital came close to meeting those standards, it would be approved for Medicare. This gave an opening to nursing homes, which asserted that they were close to the standard as well, and their populations exploded. By 1970, 13,000 facilities were built. With time, regulations were tightened, but the core problem persists: they were never truly made for the people who lived in them.

Gawande's review of how nursing homes became popular reinforces that nursing homes are simply places to put elderly people and offer care—not places where they can truly live. *While the development of more hospitals and the ability for elderly and disabled people to get insurance through Medicare was crucial, it also created additional problems in nursing homes, and Gawande highlights those problems to demonstrate how society needs to reform institutions like nursing homes.*

One morning in late 1993, Alice fell while alone in her apartment. She had no serious injuries, but Longwood House encouraged her to move to the nursing floor. She refused, until she fell again and broke her hip. Alice was left with no choice but to move into the nursing home, and she needed help with all her daily activities. Her privacy and control were gone. She wore **hospital** clothes most of the time and stuck to a schedule of eating and bathing dictated to her by the staff. She lived with whomever they assigned, and she felt like she was in prison for being old.

Alice's feeling that she was "in prison for being old" provides personal insight into how little freedom and control people have in nursing homes. Alice was expected to live according to the convenience of the staff, not in a way that satisfies her own needs. Her safety has come at the expense of any autonomy.

Though the official aim of nursing homes is to care for people, being under this form of care doesn't bear any resemblance to living—people expect more from life than safety. This is why many nursing home residents resist standard practices. Some, like Alice, avoid group activities or medications. Some are feistier, like a resident who sneaks in cigarettes and alcohol. In bad places, staff will physically restrain people or subdue them with medications. This is the problem with a society that faces the final phase of life by not thinking about it. Institutions address goals like easing **hospital** beds or unburdening families, but they do not address the goals of the people inside them.

This passage hammers home the argument that safety cannot be the only priority in a person's life—but so often it becomes central to nursing homes at the cost of actual well-being. Physically restraining and subduing people in pursuit of "safety" is contradictory. Alice's experience provides a personal example of how crucial autonomy over one's life is, and how people are willing to give up a degree of safety to maintain independence because autonomy is what makes life meaningful.

One day when Jim visited Alice in winter 1994, she said that she was ready to die. Jim understood her desire, and not long afterward, they arranged for a Do Not Resuscitate order to be put on record at the nursing home. One day the following April, Alice developed abdominal pains and vomited blood, but she didn't tell anyone. The next day, they found that Alice passed away.

The end of Alice's life puts a fine point on the failures of these nursing homes: even though they provided safety, they did not provide a meaningful life. Alice felt this so viscerally that she didn't even want to continue living.

CHAPTER 4

Nursing homes still exist because people haven't found anything better—living with family still remains the primary other option. But greater longevity has coincided with more women joining the workforce alongside men, which creates problems for children (particularly daughters) of the elderly who try to juggle jobs and take care of parents. In one such case, Lou Sanders is 88 years old when he and his daughter Shelley face a difficult decision about his care.

This chapter explores the option of living with family in old age. But in contrast to the example with Sitaram in the first chapter, this section emphasizes that economic developments in the United States have made it even more difficult for children to take care of parents. While previously, women worked less and could take care of their parents, now women work more and there is greater difficulty juggling parental care with jobs.

Up until this point, Lou has managed well. He retired at 67, while his wife, Ruth, developed health issues. Three years after Lou retired, Ruth had a stroke that she never fully recovered from, and later she developed cancer and died in October 1994, when Lou was 76. For the next decade, Lou led a happy, satisfying life alone. He made friends with many people, including a young Iranian man named Bob who worked at a video store in town that Lou often visited.

Much like Alice Hobson, who spent decades living alone before moving into a nursing home, Lou also found great pleasure in independence—particularly because he could control where he went and how he spent his time.

Then, in 2003, at 85, Lou had a heart attack, but after a few weeks at a cardiac rehabilitation center, he recovered fully. Three years later, Lou had his first fall, and a neurologist diagnosed him with Parkinson's disease. He began having trouble with his memory. After another bad fall, he became frightened that he might die alone. While he refused to look at retirement homes, Shelley knew that she couldn't let him live on his own. Shelley and her husband Tom decide that Lou should move in with her.

Lou's refusal to look at retirement homes echoes many people's fears, which spring from the idea that he will lose some degree of autonomy. At the same time, Shelley's primary concern is his safety, which is why she suggests Lou move in with her. Their relationship reinforces the dynamic that children often care about their parents' safety over everything, while the parents themselves want to prioritize their autonomy.

Shelley and Tom have two teenage children and no obvious extra space, so they convert their living room into a bedroom for Lou. But Lou doesn't like not being the master of his house, and in their suburban home, he has nowhere to walk to and no company for most of the day. Gradually, though, he adapts. He becomes devoted to Tom and Shelley's dog and becomes friends with the mailman. Shelley also hires a young man named Dave to spend time with Lou, and they hit it off and play cribbage together.

Even though Lou tries to avoid the retirement home in order to maintain some autonomy, moving in with Shelley still curtails this autonomy somewhat. He no longer has control of his home, and he no longer has as much access to some of the friends and places that used to give his life meaning.

While Lou adjusts, Shelley finds the situation steadily more difficult. She is juggling working, taking care of her kids, looking after the home, and now taking care of her father. Lou's falls continue, and doctors aren't able to figure out how to fix his balance issues. Shelley arranges for an aide to come during the daytime and help Lou wash and perform other tasks, but Lou doesn't want to wash in the daytime, so Shelley has to do it.

Meanwhile, Shelley also loses some of her own autonomy in the interest of Lou's safety and in trying to give him some control over his life—like helping him bathe on his own time rather than having that schedule be dictated by someone else.

The burdens pile up: Lou doesn't like the food Shelley makes, so he doesn't eat and she has to start making separate meals. He blasts the television so he can hear it. Shelley becomes a round-the-clock concierge, chauffeur, medication troubleshooter, cook, maid, attendant, and income earner. To take any trips, she has to hire someone to stay with Lou. He also starts to have falls. She wants to be a good daughter, but she is getting overwhelmed. Reluctantly, Shelley and Lou start to look for a place despite his protests.

Lou and Shelley both continue to lose some of their autonomy in the name of Lou's safety. He loses control over the food he eats; she loses control over the TV volume and her ability to take trips with her family. She wants to keep him safe, but they have both lost so much freedom in their lives that they feel they have to resort to an assisted living facility.

Shelley and Lou look for an assisted living facility, which many believe is an intermediate stop between independent living and life in a nursing home. But Keren Brown Wilson, one of the originators of the concept, wanted to create a place that was an alternative to a nursing home. She wanted to create a place where people like Lou could live with freedom and autonomy despite their physical limitations.

Keren Brown Wilson's introduction illustrates her desire to solve exactly the problem that Shelley and Lou are experiencing: how to provide the elderly with an environment that is safe but still allows them freedom.

Wilson's father died when she was in grade school, and her mother, Jessie, suffered a stroke at 55 years old, leaving her permanently paralyzed on one side of her body. At the time, Wilson was a college student with no income, and there was nowhere for Jessie but a nursing home. But Jessie hated it. As a result, Wilson became interested in policy for the aged, getting a PhD in gerontology at Portland State University. She wanted to do something that would help people like her mother so that Jessie could have assistance, but also have privacy and autonomy.

Wilson understands from personal experience with her mother how dispiriting nursing homes can be, and she works to remedy the situation to help people like her mother. She acknowledges the tension between autonomy and safety, and she hopes to build a place that can afford both rather than sacrificing one for the other.

Wilson began to formulate a new kind of home for the elderly. She laid out plans with an architect and found a private investor. She cleared every safety and health obstacle, and in 1983, her facility, Park Place, opened in Portland. Her 112 units filled up almost immediately. None of the residents were treated as patients. They had private apartments with a front door that locked, they could have pets and choose their furniture, and they had control over temperature settings, food, and who came into their apartment. But they also had help with the basics: there was a nurse on-site and tenants had a button for urgent assistance.

The fact that Wilson's units filled up almost immediately shows the demand for places that provide people with greater freedom. The front door that locks is a concrete symbol of returning autonomy to the people living in the residence. At the same time, Wilson hopes not to sacrifice safety by making sure that people get the care they need.

The health care providers understood that they were entering someone's home, which changed the dynamics between them and the residents. The residents controlled the schedule and the rules. They could eat pizza and M&Ms and stay up all night if they wanted to. And if their mind faded to the point where they could no longer make rational decisions, their family could help negotiate risks that were acceptable.

Wilson acknowledges that even elderly people have a right to make choices about how they live, even if they may not always be the healthiest choices. Wilson's belief is that for older people, having the autonomy to determine things like what they eat and when they bathe ultimately does more for their health than strict safety precautions.

Many people attacked the concept immediately, questioning how people with physical and mental problems could lock doors, use knives, and care for pets. The state monitored the facility closely and published a study of the residents' health, cognitive capabilities, physical function, and life satisfaction. It found that residents' health was maintained and their satisfaction increased. Their physical and cognitive function actually improved. And the cost for those on government support was 20 percent lower than in a nursing home. The program was successful.

This study demonstrates how autonomy and safety are not necessary mutually exclusive, as some of the other residences' rules suggest. Instead, allowing people to maintain their autonomy actually makes them healthier and safer. Because it requires less intensive monitoring, this is also a more economically viable program than a nursing home, demonstrating its overall success.

At the center of Wilson's work is a central question: what makes life worth living when we are old and frail? Psychologist Abraham Maslow's famous hierarchy of needs shows that people's basic needs include food, water, and safety. Only after attaining these things can they attain the next level of needs, which includes love and belonging. Above that is the desire for growth: personal goals, knowledge and skills. At the top is self-actualization—self-fulfillment through pursuit of moral ideals and creativity.

Maslow's hierarchy of needs (often depicted as a pyramid) suggests that safety is a basic necessity—which is to say, people need to have safety before pursuing the next level of needs. This is perhaps the basis of some thinking surrounding nursing homes—that safety is the most important priority.

Reality is more complex: people will give up some degree of safety for the sake of something beyond themselves, such as family, country, or justice. And motivations in life change over time. Young people seek a life of growth and self-fulfillment, but in the latter half of adulthood, people prefer spending more time with family and established friends than new people. They focus on *being* rather than *doing* and on the present rather than the future.

Gawande quickly complicates some of the ideas in Maslow's hierarchy of needs. He acknowledges that people are willing to give up safety for certain concepts higher up on the hierarchy, and he shows that humans are not uniform in what motivates them. This suggests that safety isn't necessarily the most important thing in life.

Stanford psychologist Laura Carstensen studies why this change occurs. In one influential study, she and her team tracked the emotional experiences of 200 people over decades. Every five years, the subjects were given a beeper for a week and asked to report their emotions 35 times over the course of the week. While Maslow's hierarchy suggests that old people would be generally unhappier, as they are unable to achieve greater sources of fulfillment, Carstensen's research found the exact opposite. The elderly found living more emotionally satisfying and stable.

Carstensen's study also refutes Maslow's hierarchy of needs, illustrating not only that people's needs change over time, but also that older people are generally happier despite the fact that they might not be able to pursue more meaning and could have difficulty with safety.

Carstensen suggests that her findings are due to a difference in perspective: people's sense of how finite their time is in the world. Carstensen drew on her own experience for this idea. In 1974, she was 21, with an infant at home and a marriage in divorce proceedings, when she was in a car accident that nearly killed her. She had a serious head injury, internal bleeding, and multiple shattered bones. Prior to this accident, she often thought about what she wanted to do in her life. Now, she reevaluated what mattered to her: other people. And these new thoughts echoed the four other patients in her ward, all of whom were elderly women recovering from hip injuries.

Carstensen's personal perspective returns to people's awareness of mortality. Being more aware of the finiteness of her time, Carstensen then re-evaluated her priorities. This is not so different from Gawande's aim throughout the book: to make people more aware of death in order to help them understand their own priorities for the end of their lives, or at least highlight the need for those considerations

Bored in the **hospital**, Carstensen started taking an introduction to psychology class with the help of her father, who audiotaped lectures at a local college. Fifteen years later, when she became a scholar, she formulated a hypothesis: how we spend our time depends on how much time we think we have. As young people, we broaden horizons and delay gratification—willing to invest years for a bright future. As horizons contract, the focus shifts to the things and people closest in the present moment.

Carstensen's hypothesis again suggests that when people are aware of their own deaths, their priorities shift as they consider their finite time more concretely. It also shows that people want more than just safety when their time is finite: they want to be able to do the things and see the people that are most meaningful to them.

In another study, Carstensen interviewed a group of adult men, ages 23 to 66. Some of the men were healthy, but some were terminally ill with HIV/AIDS. In general, the younger the subjects, the less they valued time with the people they were emotionally close to, and the more they valued time with people who were sources of new information or friendship. Among the ill, the differences disappeared—the preferences of a young person with AIDS were the same as those of an elderly person.

Carstensen's study with those who have HIV/AIDS supports the idea that considering one's mortality makes people reevaluate or shift their priorities. Knowing that they may not have as much time to live, their priorities mirror others who also have limited time, like elderly people.

Carstensen tried to find holes in her theory, but she confirmed them even across cultures. When people believe life is fragile, their goals and motives shift completely. Tolstoy grasps this in Ivan Ilyich, as the dying man loses his ambition and vanity and simply wants comfort and companionship, particularly from his servant Gerasim, who understands him more than anyone in his family. Gerasim recognizes that Ilyich is dying and helps him have companionship, everyday comforts, and to achieve his modest goals. This is what Keren Brown Wilson also wanted to help people do in her assisted living facility.

Returning to Ivan Ilyich reinforces the importance of confronting one's own mortality and sharing that burden with others. Only Gerasim, who is able to acknowledge that Ilyich is dying while the doctors simply say he is ill, can understand Ilyich's needs. Only then can Gerasim help Ivan Ilyich pursue those priorities prior to his death.

Around 1990, due to Wilson's success, assisted living facilities became the fastest-growing form of senior housing in the country. By 2000, Wilson expanded her company from fewer than 100 employees to more than 3,000 in 184 residences in 18 states. But a distressing thing happened along the way: assisted living became so popular that developers used the title for almost anything. Wilson worried about the way the idea was evolving, as assisted living often became a stepping stone on the way to a nursing home, rather than an alternative. Concern about safety and lawsuits limited what people could have in their apartments, and many places defined stringent conditions that would trigger "discharge" to a nursing facility.

Even though assisted living began out of a desire to return more autonomy to the elderly, ultimately the concept bowed to economic forces. Worries about lawsuits and a desire to capitalize on Wilson's success meant that the idea of assisted living became somewhat corrupted and watered down. Ultimately, assisted living became just as concerned with safety over autonomy, and the rules constantly threatened that autonomy even more. The use of the word "discharge" also echoes language used in hospitals, reinforcing how assisted living can often now feel like a hospital as well.

Shelley finds an affordable assisted living facility for Lou just before his 92nd birthday. He is depressed to go, but he knows that his falls have made staying at home untenable. Lou is lost, as he doesn't know many people. There are very few men in the facility, and the activities often cater to women. He doesn't have his family, friends, or his dog, and the staff doesn't seem to care about Lou as a person.

Like Alice Hobson, Lou is forced to choose between safety and autonomy. In the assisted living facility, he isn't able to choose his own activities, and as a result he loses much of what is meaningful to him.

Because Lou is miserable, he and Shelley work out a compromise, where she will bring him home every Sunday through Tuesday so he can maintain some of the life he enjoyed. Gawande asks Wilson why assisted living often falls short. Wilson says that it's often easier and less aggravating for staff to do things themselves—like dress a person—than to give a person agency and let them do what they can. The tasks come to matter more than the people.

Shelley tries to return some autonomy to Lou by having him stay at her home for a few days a week. Additionally, Wilson's explanation illustrates just how much people lose their autonomy in assisted living facilities. The staff's jobs are easier when they dress someone or bathe the residents, but it dehumanizes the people whom the staff looks after.

In addition, there aren't very good metrics for a facility's success other than health and safety—none deal with resident satisfaction. And assisted living is often geared towards the children's wants, not the parents. Places tout their computer labs, their exercise centers, their trips to concerts and museums—but this fits what the children want for their parents, not what parents actually want. Wilson explains that "we want autonomy for ourselves and safety for those we love," and that many things children subject their parents to, they would never want for themselves.

Wilson explicitly summarizes the tension between parents and children: that children want safety for their parents, while parents want to maintain autonomy. And because children are often making decisions for their parents (a loss of autonomy in the first place), the assisted living facilities then start to cater to the children and tout their safety and cleanliness rather than illustrating quality of life for residents.

Lou lives in the assisted living home for a year, but one day at a cribbage night after drinking, he passes out and hits his head. Afterwards, he starts to pass out more frequently, and things get to a point where he can't manage walking, even though he refuses a walker. He doesn't eat properly, his memory worsens, and he often stays alone in his room. Shelley feels that Lou is getting too frail not to have 24-hour care. And so, even though she knows he wouldn't want this, she feels that she has to put him in a nursing home. When Gawande presses Shelley on why she does this, she doesn't know how to answer, saying that she worries he's not safe, even if he may become more unhappy.

Because Shelley feels that Lou is unsafe in his home, she makes the decision to send him to a nursing home, where he will have even less autonomy than at the assisted living facility. This again calls into question what Lou's priorities in life are. While Shelley prioritizes his safety, safety isn't the only thing that makes life meaningful. As the studies on assisted living suggest, autonomy, purpose, and happiness can be even more crucial to a person's well-being.

CHAPTER 5

In 1991, a man named Bill Thomas begins a job as medical director of Chase Memorial Nursing Home in New Berlin, New York. Until then Thomas worked as an emergency physician at a nearby **hospital**, and he took the job as a chance to do something different. With fresh eyes, Thomas sees how depressing the nursing home is. At first, he tries to find a doctor's solution, examining the residents and investigating their medications to bolster their spirits.

Thomas's first approach reinforces doctors' initial impulses to use medicine to fix everything. He doesn't yet realize that, in reality, he needs to give people greater purpose and meaning in their lives outside of simply keeping them alive and safe.

Soon, Thomas realizes that he needs to try something totally different. He knows the value of an independent and self-sufficient life. He wants to put more life into the home by adding plants, animals, and children to the residents' lives. He lays out a plan to apply for a small New York State grant for innovations. He wants to attack the "Three Plagues of nursing home" life: boredom, loneliness, and helplessness. He suggests two dogs, four cats, and 100 birds. They win the grant and all the regulatory waivers needed to follow through on it.

By bringing in a garden, plants, animals, and children, Thomas hopes to give a greater degree of meaning and freedom to the people within the nursing home. Referencing the three plagues shows how necessary it is to combat the most crucial problems in the nursing home. Ironically, none of these "plagues" are health- or safety-related. Instead, the biggest problems have to do with well-being.

Thomas and others bring in the animals and the garden, and staff members bring in their children. Seeing the animals, the residents offer to help care for them. They establish feeding shifts for the animals and walking schedules for the dogs. The residents' engagement with the animals not only makes them happier, but it also helps the staff monitor their sharpness as residents give daily reports on the animals.

Thomas's plan shows that bringing in plants and animals is crucial for the residents' well-being. Even though it makes the place a little more chaotic, it brings energy and purpose back into their lives, illustrating that there are more important things in life than safety. Implementing these changes even helps the staff watch over the residents, benefitting everyone.

Researchers study the effects of this experiment over two years and find that the number of prescriptions required per resident fell to half of that of a control nursing home—particularly drugs for agitation. Thomas posits that this is because of the fundamental human need for a reason to live. Even something as small as a plant to take care of makes people more active and alert.

As Thomas's statement implies, safety is not a reason to live—it is a means, but not an end. People need something in addition to safety, and the animals provide that purpose and even give the residents a little more independence and control.

Thomas recalls meeting a man named Mr. L., who was admitted to the nursing home after a suspected suicide attempt. He gave up walking and refused to eat. But when he accepted a pair of parakeets, he started to perk up, giving him something to watch, companionship, and the chance to take care of something. He began eating, dressing, and getting out. He took the dog for a walk. Three months later, he moved out and back to his home—Thomas is convinced the program saved his life.

Thomas even shows how something as simple as an animal can give people a reason to live. In the case of Mr. L., he regained so much control over his own life that he even felt independent enough to leave the nursing home, providing him with even more autonomy. This shows how empowering these kinds of changes can be in nursing homes.

In 1908, Harvard philosopher Josiah Royce wrote a book questioning why being merely housed and fed and safe and alive seems empty and meaningless. He concluded that we all seek a cause (big or small) beyond ourselves: family, country, a building project, or the care of a pet. Royce calls this "loyalty," the opposite of "individualism." The individualist puts his own interest first, and loyalty to something other than themselves seems strange. But he argues that human beings need loyalty, because our own desires are fleeting and often difficult to fully satisfy.

Royce's philosophy illustrates why nursing homes are often so unsatisfying. Prioritizing safety does not provide people with meaning because it is entirely self-focused and there's no purpose in it besides remaining alive, in line with Royce's theory of individualism. Having loyalty means giving people the control to pursue something outside themselves.

Gawande supports Royce's philosophy, noting that people care deeply what happens to the world after they die. As people's time winds down, they become less ambitious but more concerned about legacy and the need to identify purposes outside themselves that make living meaningful. The problem with medicine and its institutions is that they have no view about what makes life significant. They concentrate on health and safety, but not "sustenance of the soul." And yet these institutions define people's last days. Both Bill Thomas and Keren Wilson wanted to help people in a state of dependence pursue meaningful existence.

Gawande uses Royce's philosophy to illustrate medicine's shortcomings. While medical institutions focus on health and safety, "sustenance of the soul" is just as—if not more—important. This requires people to have both purpose and enough autonomy over their lives to be able to pursue that purpose. Both Thomas and Wilson recognize this need and try to restore that autonomy and purpose in the elderly's lives.

Gawande explores other places that have tried to change the model, like NewBridge, a residence in the Boston suburbs. It is built not with shared apartments along endless corridors, but as houses for sixteen people, with private rooms built around common living areas. Research has found that units with fewer than 20 people have less anxiety and depression, more socializing and friendship, greater safety, and more interaction with staff. And it avoids the feel of a clinical setting, helping people bond and join in each other's activities.

NewBridge also attempts to restore greater autonomy to people by making them feel like they live in a home with friends, rather than making them feel as though they live in a hospital. Through this home structure, they have a greater purpose, and as Gawande notes, better overall health and safety as a result.

One day, Gawande interviews one NewBridge resident, Rhoda Makover. At 99, she has frequent falls and is nearly blind from retinal degeneration. But the staff understands how important walking is to her health and her mental well-being, so they allow her to continue. A few years earlier she lived alone and was happy. But then when she started falling, she moved into a nursing home. She was there for a year before moving to NewBridge and said there was no comparison. NewBridge also shares its grounds with a private school for kindergarten through eighth grade, and residents can work as tutors and librarians.

Rhoda's experience at NewBridge echoes Gawande's thoughts on what makes the place so meaningful, because it provides people with a variety of outlets to live for something outside themselves. NewBridge gives them the ability to have control over their lives and engage with the world outside of the nursing home.

Another place, Peter Sanborn Place, was built in 1983 and had 73 units for independent, low-income elderly people. As residents aged, Jacquie Carson, the director, knew she needed more accommodations for them. She brought in physical therapists and organized nurses. But officially, it's still just a low-income housing unit. Carson often battles the medical system, working with ambulance services and **hospitals** so that the place is consulted about care for residents. But to her, it's most important to help the residents stay in their homes.

Jacquie's difficulty facing medical institutions despite her accommodations for the people in her units demonstrates the constant conflict for anyone who is not conforming to the standard nursing home structure. But Gawande commends those who are trying to reform end-of-life care to cater more to the people who live in the residences.

Making lives meaningful in old age is new, and there aren't any standard solutions yet. Gawande interviews Ruth Beckett, a Sanborn resident. She explained that her son Wayne has cerebral palsy; he can handle basic aspects of life, but he needs structure and supervision. When Sanborn opened, he became his first resident. Three decades later, when a fall put Ruth in a nursing home, Carson worked out how to take Ruth in so she could be with her son. Jacquie hopes to build more units, but she faces lack of funding and bureaucracy.

Ruth's case shows just how important these kinds of reforms can be. Without Sanborn Place, Ruth would never be able to see her son Wayne. But by taking her needs into account, Sanborn Place helps her regain control over her own life and help her take care of her son as well.

Gawande finds many places trying to change the traditional nursing home model. While these places often look extremely different from one another, the people in charge of them are committed to a single goal—maintaining people's autonomy. There are different kinds of autonomy: one is living completely independently and free of limitation. But this is only a means to an end, as freedom is not a measure of worth in a person's life. There is a second sense of autonomy: the freedom to be the author one's own life. The battle of being mortal is the battle to maintain a connection to who you are or who you want to be. Professionals and institutions should not make this battle harder in the name of safety.

Gawande makes a crucial distinction about autonomy: he knows that his first definition, living independently, doesn't make for a meaningful life, just as safety doesn't make for a meaningful life. Instead, the more important definition of autonomy is having the freedom to choose how to live one's life, even under certain kinds of limitations. And he explicitly states that this kind of autonomy is not worth risking simply for the purpose of safety.

Lou is soon to go to a nursing home when Shelley hears about a new place opening: the Leonard Florence Center. Lou is impressed from the first tour, as all the rooms are single—something normally unheard of in nursing homes. It also looks like a home, rather than a **hospital**. This is in part thanks to Bill Thomas, who wanted to build a home for the elderly from the ground up—one that looked like a nursing home to the government, but which felt like a home to the residents. He called it a "Green House." Not long afterward, a foundation he worked with launched the National Green House Replication Initiative, which constructed more than 150 Green Houses—including the Leonard Florence Center.

In contrast to their search for an assisted living facility, in which Shelley was impressed by the cleanliness and the activities available, here Lou focuses on his day-to-day quality of life and the things that will be most meaningful to him. Additionally, it shows the value of people like Bill Thomas, who are working to reform assisted living and nursing home facilities to return autonomy and purpose to the residents' lives.

All Green Houses are small and communal, with no more than 12 people. The residences are warm and homey, and the residents determine their own schedules. Residents like Lou work together with the caregivers, each of whom focuses on just a few residents. Each caregiver cooks, cleans, and most importantly, provides companionship. Lou connects with the other residents, but he also values his time alone. Sitting with Lou and talking in the Green House, Gawande thinks that this is the first time that he does not fear reaching this phase of life. While Lou's mind and body are slowly deteriorating, he is still able to live in a way that makes him feel he has a place in the world.

The relationship between the residents and caregivers is a crucial one, and this is a big difference between what Lou experienced at the assisted living facility and even when living at Shelley's. The center acknowledges that he needs help doing certain tasks safely, but it prioritizes his schedule and desires rather than the staff's. And he is able to determine what he wants to do at all times, in all aspects of his life. This is also an important contrast with Alice Hobson, who did not have that control, and as a result, did not feel that she still had a place in the world, as Lou does.

CHAPTER 6

Understanding the transformation of elder care helps Gawande think about some of its implications for medicine. Making people's lives better in old age or ill health may not always mean fixing and controlling them. But it begs the question of when doctors should try to fix people and when they should not.

The dichotomy of autonomy versus safety isn't that different from the questions that Gawande poses about medicine. While he recognizes the value of medicine to promoting health and survival, sometimes this comes at the expense of overall well-being, and like the question of autonomy vs. safety, sometimes compromises between the two are necessary.

Sara Monopoli is 34 years old and pregnant when doctors discover that she has lung cancer, though she never smoked or lived with anyone who had. Doctors want to start treatment right away, so they induce her labor at 39 weeks so they can start. Luckily, the baby is born in perfect health. The next day, her oncologist Paul Marcoux explains that Sara's lung cancer is very advanced. It is inoperable, but there are chemotherapy options that might allow for a period of recovery. This puts a gloss on a dire reality: the median survival for lung cancer is about a year. But Sara and her husband Rich don't want to focus on survival statistics; they want to manage her diagnosis.

Sara's case illustrates the difficulty of terminal illnesses. It is easy to pursue treatment in the hopes of gaining more time. But often this comes without fully understanding the grim realities of a disease. By not looking realistically at her situation and by avoiding the topic of death, Sara pursues treatment that could ultimately harm her while not understanding her goals in this final phase of her life. This is similar to Joseph Lazaroff's case in the book's introduction.

Sara starts chemotherapy and doctors put a tube into her chest to drain fluid that interferes with her breathing. Three weeks later, Sara returns to the **hospital** with a pulmonary embolism and starts on blood thinners. But then doctors discover that she doesn't have the genetic mutation that the chemotherapy targets. Marcoux recommends more standard chemotherapy, but Sara has an allergic response to it, so they change drugs yet again. By October, the tumors have grown substantially. Sara takes the setbacks in stride, but by November, she doesn't have the lung capacity to walk, and the cancer continues to spread. This poses the difficult question of what to do next.

In relentlessly pursuing treatment and not confronting the reality of her lung cancer, Sara undergoes several difficult rounds of chemotherapy, none of which help her get better and in some ways cause greater suffering. This calls into question whether medicine should be so singularly focused on treating diseases at all costs. Instead, Gawande implies that doctors should help patients adequately weigh the costs and benefits of the treatments to focus both on survival and on well-being.

The issue of treatment has gotten attention because of the rising cost of health care on incurable conditions where expensive surgeries and drugs often have little benefit. With most cancers, there are high initial costs, and if all goes well, it tapers off. But for terminal cancer patients, the cost curve is U-shaped, with an average cost of $94,000 during the last year of life with metastatic breast cancer, for example. Doctors are good at prescribing treatments but not at knowing when to stop.

Gawande illustrates how treating a patient no matter what also has a great cost outside of the suffering inflicted on the patients. The system of paying $94,000 for little benefit is unsustainable for the United States' health insurance system, and it provides another perspective on why it is important to examine how patients and doctors make decisions about treatment.

Gawande speaks with an intensive care unit physician in his **hospital**. The physician says that of the 10 patients in her unit, only 2 are likely to leave. Many are elderly and tethered to pumps keeping them alive, drifting in and out of consciousness. Though they all knew that they had a terminal condition, they and their families were usually unprepared for this final stage and didn't know how to prevent them from landing in the ICU.

Gawande's colleague highlights what happens when medicine fails and people do not consider their wishes for end-of-life care: people are left clinging to life via machines with very little hope for leaving the hospital.

In 2008, the Coping with Cancer project published a study that showed that terminally ill cancer patients who were admitted, near death, to intensive care had a substantially worse quality of life in their last week than those who did not go to intensive care. People with serious illnesses have priorities besides prolonging their lives, like avoiding suffering, strengthening relationships, being aware, and not being a burden. The United States' system of medical care fails to meet these needs.

Gawande emphasizes how studies have even shown that medicine might be focused on trying to help people survive, but it gives little consideration to the quality of life that they have in the hospital. Gawande views this oversight as a critical failure.

In the past, the interval between recognizing one had a life-threatening ailment and dying was a matter of days or weeks. For example, George Washington developed a throat infection on December 13, 1799, and died the next day. There were guides published on the "art of dying." In this short period, people attempted to reaffirm their faith, repent sins, and let go of worldly possessions and desires. Now, swift illness is the exception. For most, death only comes after a long medical struggle with an unstoppable condition, or the accumulating debilities of old age.

The fact that people do not often die of swift illness is a testament to medicine's progress and clear benefits. At the same time, it has created a problem: depriving people of the ability to die as they want, surrounded by family and after coming to terms with their death. Using the term "art of dying" also suggest that dying is more of a philosophical act than a medical one.

One morning, Gawande goes on patient rounds with Sarah Creed, who works with the hospice service. Hospice care is given to patients who have a life expectancy of less than six months, and patients who choose hospice care indicate that they are forgoing regular medical care like surgeries and other treatments.

In this section, Gawande introduces the topic of hospice care. On its surface, it seems like hospice care's goals are the opposite of traditional treatments and surgeries: instead of focusing on long-term survival, the priority is maintaining short-term well-being.

First Creed visits Lee Cox, a 72-year-old woman with heart failure and pulmonary fibrosis, a lung disease. She is dependent on oxygen and unable to do ordinary tasks. Creed asks about Cox's condition, and Cox admits that she now has trouble catching her breath while walking and has chest pains. Creed sees that Cox is out of heart medication and one of her inhaler parts is broken, so Creed makes calls to remedy these things. Cox's spirits are low. She lives with her niece, but she feels that she's in the way. Creed assures her that everything's going to be okay and reminds her of a good day she had recently shopping with her niece.

Accompanying Creed on her rounds with the hospice service, Gawande observes as Creed tries to make Cox as comfortable and cared for as possible. This not only includes medical care, but it also emphasizes emotional well-being.

Outside, Gawande asks why Creed is still trying to extend Cox's life. Creed says that the goal of hospice is for people with a fatal illness to have the fullest lives possible in that moment. That means focusing on freedom from pain and maintaining mental awareness, not on life span.

Creed corrects Gawande's misconception that hospice simply means acknowledging death's inevitability. On the contrary, hospice shows how important medical care can be. The difference is that hospice care is palliative—focused on increasing well-being and decreasing suffering.

Creed says when she meets patients, many haven't fully accepted their fates. She says that her goal is simply to communicate what she can offer them to make their lives better. One patient, Dave Galloway, starts to experience unmanageable pain during his fight with pancreatic cancer. The whole lower half of his body swells with fluid. Hospice workers set up a pain pump, knowing he only has a few days to live. They give him a "comfort pack" of drugs and instruct his wife on how to care for him.

Dave's ability to acknowledge that he only has a few days to live, and getting him hospice care, allows him to have a much more comfortable and fulfilling final set of days than he would have had in the hospital. This is part of the important service that Creed provides to all hospice patients.

Dave and his wife Sharon are able to sleep through the night at home, and after a few days, they even go out to a restaurant (though Dave doesn't eat). Hospice staff explain that Sharon shouldn't give him intravenous feedings because of the swelling. As a result, Dave's condition gets markedly better, but Sharon worries she is starving Dave. Dave also avoids using the pain pump because it feels like defeat. Creed tells him that no one can manage his amount pain without medication, and he needs to take it to be able to enjoy time with his wife and daughter. Hearing this, Dave uses the medication.

Creed also helps destigmatize death and suffering for Dave. As Gawande discussed in the book's opening chapters, to many people, illness, pain, and death feel like failures. Hospice care helps people recognize that these things are inevitable, and in turn it helps people combat them with crucial medication so that they can have worthwhile time with their families as they die.

A week later, Dave dies—at home, at peace, and surrounded by family. A week after that, Lee Cox dies, too, of cardiac arrest. Hospice is a new kind of guide to the art of dying, but it is a struggle—against suffering but also against medical treatment.

Hospice both helps people confront death and allows them to consider what meaningful final days might look like. Both Dave and Lee are able to achieve that, finding comfort in family or meaningful days before passing.

When Sara Monopoli meets with her oncologist, Paul Marcoux, to discuss treatment in November, Sara understands that her disease is incurable. She leaves instructions about her wishes for her newborn daughter's upbringing after she is gone, and on several occasions, she tells her family that she does not want to die in the **hospital**. But she avoids the prospect that the time might be coming soon and she pursues treatment.

Sara highlights the difficulty of knowing what to do with a terminal illness, because there are always treatments available that might help her live slightly longer. But this comes at the cost of her truly confronting aspects of her disease, like how she might want to live out her final days. She knows she doesn't want to die in the hospital, and yet she continues to try different treatments that have a likelihood of landing her there.

Marcoux tries to reassure Sara and Rich. Marcoux knows that most of his patients will die, but he also wants to maintain hope. He talks to them about the option of supportive care, but also about some experimental drugs. To enroll in one, Sara would need to wait two months to get past her pulmonary embolism, and in the meantime, she can go back to chemotherapy. Gawande points out that with little thought, Sara is now on a fourth round of chemotherapy with a miniscule likelihood of extending her life and a great likelihood of causing debilitating side effects.

Sara continues to turn to treatments for hope because she is unwilling to fully come to terms with the fact that she is going to die. But Gawande foreshadows how this will be to her detriment, as he points out that the chemotherapy has a small likelihood of helping her and a great likelihood of worsening her quality of life.

Gawande asks Marcoux what he hopes to accomplish for terminal lung cancer patients: Marcoux says he wants to gain them a good year or two—though he knows Sara and Rich are hoping for much longer. But Gawande notes that doctors often overestimate their patient's survival time (the average is 530 percent too high) and don't voice their prognoses, even when pressed. Doctors offer treatment options they believe aren't likely to work, and they are hesitant to trample on a patient's expectations.

Here Gawande highlights how even doctors are hesitant to confront death and be realistic with their patients. But avoiding the topic of death only prevents people from making informed choices about the care that they want. This is a key failure, as doctors try to focus on survival time but don't recognize how much this can hurt patients' well-being as they die.

Gawande recognizes this problem of not confronting reality in himself. In addition to lung cancer, Sara has a second unrelated thyroid cancer which is operable, and Gawande is called in to decide whether to operate. He knows that Sara will not likely survive her lung cancer, but he doesn't want to let her thyroid cancer go untreated if she does survive. He avoids talking about this reality though, telling her that the priority is lung cancer, and they shouldn't hold up that treatment for now.

Gawande criticizes himself as well, as he also knows how little time Sara has to live but avoids this reality. Still, even though he avoids the topic, he knows that it's not worth it to put her through the pain of thyroid cancer treatment, knowing that she will likely die from lung cancer. He still tries to put her well-being over trying to fix the problem.

Over the next months, Sara becomes steadily sicker, with the lung cancer spreading through her spine, liver, and lungs. She begins to need oxygen at home to breathe. The cancer spreads to her brain, meaning her experimental drug will no longer work. She completes five days of radiation treatment and eats almost nothing afterward. She confesses that she has double vision and can't feel her hands, but she didn't want to tell anyone for fear that they would stop treatments. Her chances are rapidly dwindling.

Sara shows how she, too, is willing to risk her well-being for a sliver's chance of greater survival time—to the point where she sees double and can't move her hands, but she didn't tell anyone because she wanted to continue pursue the hope of living longer.

Gawande notes that for any terminal illness, there is almost always a possibility that patients could defy doctors' expectations and live much longer. He notes that there's nothing wrong with aiming for this goal, unless it means failing to prepare for the much more likely scenario: death.

Gawande understands Sara's dilemma, knowing that it is worth holding out hope that people could get better. However, hope often comes at the expense of acknowledging reality and openly discussing the likely possibility of death.

For Sara, the end approaches, and she is unprepared. Three days before she starts another round of chemo, she wakes up and has extreme trouble breathing. Rich has no hospice number to call, so he dials 911. At the **hospital**, Sara is diagnosed with pneumonia. They give her intravenous antibiotics and high-flow oxygen. She begins to drift out of consciousness, and so they put her on a ventilator.

Gawande highlights the difference between Dave Galloway and Sara. Because Dave chose hospice care, he had intense pain medications and specific nurses to help him. But because Sara and her doctors haven't fully prepared for her death, she doesn't have the same options, and so she winds up exactly where she said she did not want to die—the hospital.

The natural impulse is to fight against our diseases, imagining that we have much more time than we do. We imagine that we can wait until doctors tell us that there is nothing more they can do. But rarely is there *nothing* more that doctors can do. The impulse is to fix, to do something.

Again, Gawande acknowledges the doctors' failure in this situation. While their impulse is to try to fix their patients, he highlights how it is important for them to acknowledge how they can and cannot help and guide their patients accordingly.

In the 1990s, insurance companies attempted to challenge these treatment decisions in terminally ill patients, but the strategy backfired. Nelene Fox was diagnosed with metastatic breast cancer in 1991, when she was 38. The cancer spread to her bone marrow and the disease became terminal. Fox had one chance: a new treatment of high-dose chemotherapy and bone marrow transplant. Her insurer, Health Net, denied her coverage for the cost. She raised $212,000 through charitable donations, but the therapy was delayed, and she died eight months after treatment. Her husband sued Health Net for bad faith, breach of contract, and punitive damages, and he won $89 million.

Gawande covers the historical context that has enabled doctors and patients to pursue many rounds of expensive treatments, even if they have little possibility of benefitting patients. Because the insurance company lost so much money and the industry does not want to repeat this kind of incident and lose money, they are much more willing to allow doctors to pursue these treatments.

Paradoxically, Health Net was right. Research ultimately showed the treatment had no benefit and actually worsened the patients' lives, but the jury verdict shook the insurance industry. In 2004, Aetna tried a different approach, increasing hospice options. The company allowed patients like Sara to continue medical treatment as well as having hospice care. People who used hospice jumped from 26% to 70%. Surprisingly, patients visited emergency rooms half as often and used **hospitals** and ICUs more than two-thirds less. Overall costs fell by almost a quarter.

The irony of the story is that even though patients want to focus on survival at any cost, this incident is emblematic of the fact that the endless pursuit of treatment is actually harmful to well-being. By contrast, encouraging people to go on hospice care—even though it means confronting a grim reality that they are likely to die—both helps people live better lives before their death and is more financially sustainable.

Aetna ultimately finds that hospice's benefit lies in patients' ability to talk to someone knowledgeable about their daily concerns, and that was enough. Evidence for this theory has grown in recent years. Those who enroll in hospice and have discussions about end-of-life care suffer less, are physically more capable, and are better able to interact with others. Their family members are also less likely to experience persistent depression after their deaths.

This passage explicitly lays out the benefit of discussing one's end of life, as Gawande hopes to spur more of these conversations, even though it means grappling with a difficult topic and confronting mortality. It not only helps those who are dying, but it also helps buffer their loved ones against depression.

A 2010 study followed two groups of people: one group who received oncology care and another group which received the same care plus visits with a palliative care specialist, who specializes in preventing and relieving suffering. Those who saw a palliative care specialist stopped chemotherapy sooner, entered hospice earlier, experienced less suffering, and lived 25 percent longer. "If end-of-life discussions were a drug, the FDA would approve it." Multiple studies show that hospice care actually extends survival, showing the failure of current decision making in medicine.

This study illustrates concretely how important end-of-life discussions can be. The actions people take after discussing their wishes for the end of their lives can both lessen suffering and help them actually live longer. Comparing these discussions to a drug reinforces the idea that they can actually be more beneficial than more traditional medical treatments.

In La Crosse, Wisconsin, elderly residents have unusually low end-of-life **hospital** costs and an average lifespan of more than a year longer than the national average. During their last six months, they spend half as many days in the hospital as the national average. Their ICU has no patients with terminal diseases like heart failure or cancer. The difference can be traced to 1991, when local medical leaders began a campaign to get doctors and patients to discuss end-of-life wishes. It became routine for all patients in hospitals, nursing homes, or assisted living facilities to be asked four questions about severe medical interventions to keep people alive (e.g., intubation and mechanical ventilation).

The residents in La Crosse reinforce the idea that discussing end-of-life wishes before people reach crises can markedly improve how people die. Simply by thinking through questions about the kinds of medical interventions people would want enables patients to have experiences that align with their wishes, leading people to spend less time in hospitals at the end of their lives and actually live longer lives.

By 1996, 85 percent of La Crosse residents who died had a written advanced directive like this, and doctors knew the instructions and followed them, making their jobs vastly easier. Sometimes patients' answers change, but it means that people are far more likely to have talked about what they want or don't want before crises. The discussion is what matters most.

Although the answers to these questions are mutable, simply asking helps people think about their priorities in death. Again, the study indicates that confronting mortality, though uncomfortable, helps people make more fulfilling decisions surrounding their deaths.

One winter morning, Gawande meets with a patient he operated on the night before. She was having an ovarian cyst removed when the gynecologist discovered she had metastatic colon cancer. He removed a section of her colon, but the cancer spread widely. Gawande doesn't want to beat around the bush, remembering how timid he was with Sara Monopoli. He explains how much the cancer spread, but also minimizes it and says that chemotherapy can be very effective. When she asks if she's going to die, he assures her no. He says that they don't have a cure, but treatment can "prolong your life."

Gawande again shows how difficult it can be for doctors to initiate these realistic conversations with their patients. As much as Gawande wants to avoid a repeat of what happened with Sara Monopoli, he still tends to minimize the risk of this woman's cancer and pushes treatment, rather than trying to guide her through the disease and weigh the options alongside her.

Years later, the woman continues to do well with treatment. Gawande asks the woman how she remembered their initial conversations. She says that "prolong your life" sounded harsh, like Gawande was dropping her off a cliff. Susan Block, a palliative care specialist, explains that doctors often make mistakes in these conversations: for them, the primary purpose of the discussion is to determine what patients want—facts and options. But the goal is actually to try to learn what is most important to patients under the circumstances, so that doctors can provide the information and advice on the best approach.

Just as patients have to identify their priorities in these conversations, the goal for doctors should not simply be to submit different treatment options for review. Instead, as Susan Block argues, doctors should be trying to navigate patients' priorities alongside them to help them find treatments that will align with those goals.

Block's 74-year-old father Jack was admitted to a **hospital** 10 years earlier with a mass growing in the spinal cord of his neck. The neurosurgeon said that the procedure to remove the mass carried a 20 percent chance of leaving him quadriplegic, but without it he had a 100 percent chance of becoming quadriplegic. The evening before surgery, Block realized that she had no idea what her father wanted in dire scenarios, and so she asked him what quality of life would be tolerable for him. He said that if he can eat chocolate ice cream and watch football, then he's willing to stay alive. Block would never have expected him to say that.

Susan Block and her father's conversation shows just how critical confronting mortality can be. Even though the conversation is difficult, it proves really important—particularly because Block is surprised by her father's wishes. This revelation shows why it is most important for the person whose life is at risk to discuss death, because sometimes they haven't fully thought through or expressed exactly what would make life worth living to them.

The conversation proved critical, because after surgery Jack developed bleeding in his spinal cord. Doctors could save his life, but the bleeding would likely leave him disabled forever. When Block learned that he would still be able to eat ice cream and watch football, she told them to save his life. Without their conversation, she would not have known what to do. Over the next two years, Jack regained the ability to walk short distances and still had partial use of his hands—enough to write two books. Eventually, though, he had too much difficulty swallowing. He cycled through **hospitals** and rehabs until he decided to start hospice care. He died five days later.

Block's conversation with Jack proves just as critical for Block as for her father. Without his guidance, she might have made the wrong decision by letting him go too soon, or by saving his life and condemning him to a life of misery. But because they were able to talk about the potential outcomes together, Jack was able to have a final two years that were worthwhile for him.

Block and Jack had the necessary conversation to figure out when to switch from fighting for time to fighting for other priorities. Few people have these conversations, but they are necessary. In another case, an oncologist tells Gawande about a 29-year-old patient she had with an inoperable brain tumor that continued to grow through two rounds of chemotherapy. They had hours-long conversations about how treatments likely wouldn't work. The patient opted for hospice and spent a month with his family before his death. Later, his parents thanked the oncologist, glad that they were able to focus on being together in his final weeks.

This is a rare example Gawande provides of a doctor being realistic with her patient. Only by helping him confront his mortality, rather than simply focusing on extending his survival time, is he able to have a meaningful end-of-life. And while it is difficult to acknowledge a loved one's impending death, the family also ultimately realizes how valuable it was to have a meaningful final month with their son. In this way, the doctor focused on the patient's well-being, not just health.

Medicine exists to fight death, but eventually death wins. In a war you cannot win, you want a general who knows how to fight for territory that can be won and how to surrender when it can't—not to fight to the point of total annihilation. Often, doctors are neither. They march soldiers onward while asking the patients when to stop. But patients aren't able to make rational decisions—they have no experience to draw on. They need doctors willing to have hard discussions.

Gawande's metaphor offers another critique of how doctors fail to guide patients. The metaphor of war provides imagery of armies surrendering with dignity rather than the devastation of wrecking one's body and well-being while fighting against death. Gawande calls on physicians to be willing to have these conversations rather than deferring the experience solely to the patients, who often have no point of reference.

Sara Monopoli had discussions with her family and told them that she did not want to spend her dying days in **hospitals** or ICUs, but she didn't know how to achieve that goal. That's when her primary care physician, Chuck Morris, stepped in. The morning she was admitted to the hospital in February with pneumonia, he explained that this was likely the end. Even the oncologist was rattled by her condition.

Calling back to the metaphor of the war, Sara is the soldier who keeps marching, unsure when to stop. But critically, her primary care physician steps in as a voice of reason to help her family focus on her well-being in these last few hours of her life.

Morris, Sara, and her family had a discussion. They instructed the medical team to continue antibiotics, but not to put her on a breathing machine if things got worse. They gave her palliative care and morphine, but they stopped the medical team from putting a catheter in or doing more lab tests. In the previous three months, none of the scans or radiation had achieved anything—they may actually have worsened her condition. But at the very end, Sara was spared from greater discomfort. That day, Sara fell into unconsciousness as her body failed and she passed away.

Sara's death illustrates the tragic consequences of someone desperately avoiding the reality of their death and doctors (including Gawande) who enable that avoidance. While doctors wanted to focus on her survival, in reality they only made her condition worse. And as a result, she wasn't able to die at home, in the way that she wanted.

CHAPTER 7

Traveling abroad, Gawande discusses Sara's case with two doctors from Uganda and a writer from South Africa. They say that most people with terminal illness in their countries would not go to the **hospital**, and the health system wouldn't have money for it. But their stories still sound familiar: a grandparent on life support against his wishes or a relative who died in the hospital on an experimental treatment. This reflects the fact that 5 of the 10 fastest-growing economies are in Africa, and better medical care is becoming widely available.

Gawande's discussions with colleagues from Uganda and South Africa illustrate how the problems besetting terminal illness, end-of-life decisions, and health care are not isolated to the United States: they are occurring worldwide.

There are three stages of medical development in any country: first, when a country is in extreme poverty, most deaths occur at home. In the second stage, as countries grow economically, people turn to health care systems when they are ill. At the end of life, they die in **hospitals**. In the third stage, when a country's income climbs to the highest level, people become concerned about quality of life in sickness, and deaths at home rise. This pattern is occurring in the United States: in 1917, a majority of deaths occurred in the home, but only 17 percent did in the 1980s. In 2010, 45 percent of Americans died in hospice care—either at home or at a hospice facility or nursing home.

Despite Gawande's critiques, his context illustrates how the United States is making improvements, allowing people to focus on their quality of life during their final days. This has been enabled by a combination of the country's economic and medicinal progress over the past century.

But the United States is still in a transitional phase of how to face mortality and preserve a meaningful life, and Gawande faces this question with his father. Gawande's father always had tremendous energy, but in his 70s, he started to experience neck pain and tingling fingertips. Over the next few years, the neck pain progressed, and numbness spread through his left hand. He began having trouble tying sutures in his surgery practice. In the spring of 2006, he got an MRI, and doctors found a tumor growing in his spinal cord.

In this passage, Gawande introduces his most personal case study—going through the process of determining end-of-life care with his own father. Here Gawande examines the issue not from the perspective of a doctor, as he has thus far, but from the perspective of the patients and their families.

In that moment, Gawande and his father begin their own journey to confront mortality. The tumor mass fills the entire spinal canal, from the base of his father's brain to his shoulder blades. Gawande is amazed that he isn't completely paralyzed. They try to talk about what they can do, as two surgeons, but they have difficulty discussing the severity of the issue. Spinal cord tumors are rare, and few neurosurgeons have experience with them. They decide to see two experienced neurosurgeons: one at Cleveland Clinic, and one at Gawande's **hospital** in Boston.

Here Gawande recognizes how difficult it is to discuss the prospect of his father's death, even though as surgeons they know that his condition is quite severe. It shows that even when people understand the reality of a disease, it is still difficult to have conversations about death with a person's loved ones.

Both doctors offer surgery to remove part of the tumor and to make more room for the rest of it so it doesn't crush the spinal cord. The neurosurgeon in Boston suggests operating right away, as the situation is dangerous. The surgery has risks, but he is more concerned about Gawande's father's tumor. The surgeon at the Cleveland Clinic, Edward Benzel, doesn't push to operate right away, as he said some spinal cord tumors take years to progress and often do so in stages. The operation also carries a 25 percent chance of causing quadriplegia or death.

The prognoses of the two different surgeons highlights Gawande's argument about prioritizing survival over well-being. While the first surgeon simply pushes to operate—to fix Gawande's father's ailments—Benzel is more realistic about the drawbacks, acknowledging the possibility that the surgery could actually make Gawande's father worse.

Gawande's father fears both the tumor and the surgery. He asks the surgeons questions about how the operation would be done. The Boston neurosurgeon grows exasperated with the questions, and Gawande's father realizes that this isn't the surgeon for him. Benzel, however, recognizes that Gawande's father's questions come from fear, and he takes the time to answer them. Benzel also realizes that Gawande's father seems more afraid of surgery than the tumor. Gawande's father agrees, explaining that he doesn't want to lose the ability to do surgery for the sake of an uncertain treatment. He elects not to have the surgery yet.

Gawande illustrates the importance of having these more realistic conversations. First, Benzel asks his own questions to try to assess what Gawande's father's priorities are, and he realizes how important Gawande's father's career is to him. Understanding these priorities then allows Benzel to counsel Gawande's father about the best way to achieve his goals—in this case, by not going through with the surgery.

In the end, Benzel's assessment proves correct. Gawande's father notices no change in symptoms for a year, when a repeat MRI shows the tumor has grown. But a physical examination finds no changes in Gawande's father's strength, sensation, or mobility, so they go by how he feels. He keeps driving his **car**, playing tennis, and doing surgery. His neurosurgeons know what matters to him and let him live his life.

Gawande's father's progress shows how positive this kind of understanding from a surgeon can be. He is able to live his life in the way he wants for much longer, instead of risking both his physical and mental well-being by opting for surgery too soon. Additionally, the car symbolizes the fact that his father is able to maintain autonomy even while he is growing ill.

During medical school, Gawande read a short paper by Ezekiel and Linda Emanuel on the different kinds of relationships that doctors can have with patients. The most traditional relationship is paternalistic: doctors instruct patients what to do and tell patients only what they think patients need to know. It is a doctor-knows-best model, and though it is often denounced, it remains common for doctors who deal with the frail, poor, and elderly.

Gawande makes evident why the paternalistic model is largely denounced: because it takes all power and choice away from patients as to how to live their lives. It returns to the conflict between safety versus autonomy—particularly for the old and frail. While doctors will always choose safety, patients should be given the freedom to control their own lives.

The second type of relationship is "informative." Doctors explain the facts and figures of different treatments, then ask what the patient wants. This is increasingly common for doctors, and it works well when choices are clear and trade-offs are straightforward. But the reality is that people want information and control, but they also want guidance. This is the third type: "interpretive." Benzel was exactly that kind of doctor: he helped provide information *and* guided Gawande's father's decision.

While the paternalistic model doesn't give enough choice to patients, the informative model perhaps gives too much—so much that they aren't able to navigate what might be best for them. This is particularly crucial because doctors also rarely give the option of no treatment, when often that might be what gives patients the greatest sense of well-being. The best doctors, like Benzel, help people recognize their priorities and advise them on the best option—including the option to do nothing.

Gawande has always been most comfortable as Dr. Informative, but this was not sufficient to help Sara Monopoli. Around the time of his father's visits with Benzel, Gawande started seeing a 72-year-old patient named Jewel Douglass who had metastatic ovarian cancer. Douglass had been in treatment for two years, and most patients at her stage survive two years, but about 20% of patients become cured. After three rounds of chemotherapy, her tumors shrank, but her side effects were very bad, including terrible nausea and fatigue. Then she developed pains in her stomach and began vomiting up everything she ate, which led doctors to discover a blockage in her bowel.

Seeing Benzel's success with his father, Gawande wants to implement this strategy with his own patients. He acknowledges his failures with Sara Monopoli, simply giving her treatment options without fully helping her acknowledge the reality of her disease. As Gawande introduces Jewel Douglass, he hopes to be able to implement Benzel's strategies instead.

Gawande reviewed the scan of the blockage, but he couldn't make out exactly how the cancer was causing it. It is a problem that could potentially resolve itself, but it might only resolve with surgery. In either case, it indicated a troubling sign of cancer growth. Gawande presented Douglass with the fact that the blockage could resolve itself, but if not, they'd have to talk about surgery. Still, he avoided the more difficult issue: her cancer's severity. A day later, Douglass's situation grew much better, and she stopped vomiting up her food. But before leaving, Gawande decided it was important to talk about the larger issue.

Again Gawande acknowledges that it could be much easier to simply let Douglass go on her way without having a difficult conversation. But after what he's seen with Benzel and knowing the importance of these conversations, he decides to help Douglass be more realistic about what she's facing.

Bob Arnold, a palliative care physician, explained to Gawande that the mistake clinicians make in these situations is to supply facts and descriptions; instead, they should explain what the information means using three words: "I am worried." Gawande explained to Douglass that her tumor was still there, and the blockage was likely to come back. This communicated the seriousness of the situation, the fact that Gawande was on her side, and that there was still cause for hope.

Using the words "I am worried" helps doctors open up a serious discussion. At the same time, it shows that they care deeply about their patients' health on a personal level. Gawande knows that this is a difficult thing to hear, but it helps patients be more considerate about their situation and avoid some of the mistakes of constantly pursuing treatments for things like the bowel blockage while avoiding the larger problem of severe cancer.

A few months later, Gawande asked Douglass about this conversation. She said she was horrified, but recognized that he was trying to be gentle, and she was glad they spoke. The day after her discharge from the **hospital**, she was readmitted for more vomiting. This second episode also subsided quickly, but it helped her realize that her tumor was closing in and medicine could only provide brief rescue. She decided to take a vacation with her family, and when she returned, she took a break from chemotherapy, refusing to be weighed down by the side effects. She wanted to take advantage of the time she had left, just like Gawande's father.

Gawande's conversations with Douglass help her become more aware of her situation, knowing that even when her temporary symptoms subside, they are indicative of a larger problem. This enables Douglass to weigh her priorities. Instead of chemotherapy, she goes on vacation to spend time with her family. She prioritizes her well-being over living longer, and Gawande helps her achieve this goal.

After his diagnosis, Gawande's father continues life as he always has. But he visits his grandchildren more often and puts in an extra trip to family in India. As time goes on without his symptoms worsening, his ambitions return once again—he runs for district governor of Rotary for southern Ohio and wins. Then, two and a half years after his diagnosis, his symptoms change—he develops more numbness in his right hand. He retires, but still waits to get the surgery. He throws himself into his work as Rotary district governor, determined to control his life and adapt after losing his work, something that mattered so much to him.

The fact that Gawande's father both has a good understanding of his condition and a grasp on his priorities allows him to accomplish those priorities in the time that he has left. This means both having meaningful personal experiences, like time with family, and the ability to achieve professional accomplishments. Even though he has to give up his surgery practice, he still feels that he has more he wants to do before resigning his life to the various medical treatments he knows he will likely have to undergo, or the debilitating side effects that might result.

The following spring, Gawande's father loses strength and has trouble walking. He and Gawande then have a difficult conversation. Gawande's father explains that he doesn't want to be a burden and he worries about taking care of himself. In turn, Gawande asks what his father wants out of the end of his life. Gawande tells him about Jack (Susan Block's father), who said if he could still watch football on TV and eat ice cream, that would be good enough for him. Gawande's father disagrees, saying he wants to be in charge of his life. He doesn't want a ventilator or a feeding tube, and he is more afraid than anything of becoming paralyzed. Afterward, they are both relieved to have had the conversation.

Even though Gawande knows it is difficult, he recognizes the importance of confronting his father's mortality together. Like Susan Block, he wants to understand his father's priorities as they figure out how to move forward, knowing that his condition will only continue to grow worse. Only by understanding those priorities can Gawande help his father achieve them, and even though it is a difficult conversation, he shows how relieving it is for both of them to have the discussion.

Gawande's father decides it is time for the surgery, and Gawande and his mother go with him to the Cleveland Clinic. Two hours into the surgery, his father goes into an abnormal cardiac rhythm and his blood pressure drops. The doctors stabilize him, but there is uncertainty about proceeding, and Benzel comes out to consult Gawande and his mother about what to do. Gawande knows from their conversation that his father is more concerned about becoming quadriplegic than dying, and so he asks which carries the greater risk: stopping or proceeding. Benzel says stopping, and so they ask him to continue the operation.

This is why the conversation between Gawande and his father proves so critical. Knowing that his father is more concerned about becoming paralyzed than anything else, Gawande is then able to make an informed decision about how Benzel should proceed with the surgery. If they had not had the conversation, Gawande might not have made the right choice for his father.

Seven hours later, Benzel returns and explains that the rest of the operation went well, and when Gawande's father wakes up, he has no major loss of motor function. With his fingers, he communicates to them that he is "HAPPY." A day later he leaves the ICU and spends three weeks in a rehabilitation center. He returns home feeling stronger than ever, walking and experiencing little neck pain. He made the choices that mattered to him.

Not only is Gawande relieved to have had the conversation, but the outcome of the surgery shows how important it was for his father. Waking up after a successful surgery, his father explicitly communicates how "happy" he is with the outcome—an outcome that may not have occurred had he and Gawande not had their conversation.

The choices don’t stop, though. After Gawande’s father recovers, he sees a radiation oncologist for his tumor, who suggests radiation and chemotherapy. Gawande’s father is hesitant about sacrificing more of his life for treatments, but the doctor explains that the side effects will be minimal and he has much to gain from the treatments.

While Benzel was good at working with Gawande’s father to understand his priorities, the radiation oncologist fails to do so, returning to the impulse to simply fix Gawande’s father’s cancer and downplay potential risks.

Unfortunately, the doctors were not realistic about the radiation’s benefits and drawbacks. Over time, Gawande’s father experiences stabbing pains in his back and neck, nausea, throat pain, fatigue, and loss of his sense of taste. And in the end, nothing improved. He lost weight because he had no desire to eat. The numbness in his left hand spread, and he also gained numbness in his lower extremities. He gets vertigo and his neck and back spasms persist. After a six-month MRI, the tumor has expanded.

The radiation’s outcome illustrates the problem with the doctors’ approach and thinking. They were so focused on the possibility of greater survival that they ignored the potential drawbacks to Gawande’s father’s well-being, and in the end, his survival didn’t even improve.

Gawande and his father and mother see a different oncologist, but she, too, proceeds in information mode, laying out eight or nine chemotherapy options. She says that the likelihood of tumor response is 30 percent. She says Gawande’s father could be back on a tennis court that summer. Hearing this immediately tips off Gawande’s father, realizing the fantasy she is presenting to him. He asks if the drugs will make his side effects worse, and she allows that they might. She takes them through each of the drugs, but the conversation becomes confusing and data-driven.

With this oncologist, Gawande and his parents are able to see through the doctor’s optimism. They recognize that she, too, is focused on scant possibilities rather than honestly examining his father’s situation. This is why Gawande’s father presses her on the side effects: he doesn’t want to risk more of his well-being, as the radiation oncologist had.

Gawande’s father asks what would happen if the tumor progressed. The oncologist explains his upper and lower extremity weakness would increase, and difficulty getting oxygen would become the biggest problem. Gawande asks her straightforwardly about time frames for people with no treatment versus with treatment. She says without treatment, people live three months to three years. With treatment, people don’t usually live much longer than three years but the average is longer. This is a startling estimate, as the Gawandes were not thinking in a time frame this short. Gawande’s father takes time to think about his options, and in the meantime he experiences several painful falls. When Gawande visits after one of them, he notices that his father’s condition is growing much worse, and his mother can’t do much to help.

Instead of allowing himself to be pulled towards treatment by fantasies, Gawande’s father presses his doctor to have a real conversation about his likelihood of dying. And it is important for them to have this conversation because they had no sense of the time frame—they did not have this doctor’s experience to be able to make that call. But knowing this much shorter time frame, and the difference in time with or without treatment, allows Gawande’s father to have a much clearer picture with which to make his decisions about how to live.

Gawande searches around his parents' area for different end-of-life options for his father. He speaks to Margaret Cohn, a retired biologist whose husband has a severe form of arthritis. Together, they formed Athens Village, a program that created neighborhood support for the aged to stay in their home. The neighborhood has a handyman and a part-time director who checks up on people. A nurse agency provides a discount on nursing aide costs, and church organizations provide a transportation service and meals on wheels. This helps people like the Cohns stay at home even as they become more disabled.

Athens Village is another type of residence that aims to shake up the traditional nursing home model. By hiring staff as a neighborhood, it allows the residents to have extra assistance with things like meals, transportation, or help around the home, but still maintain their autonomy and live independently in their homes.

The Gawandes talk about joining Athens Village; the only other option is home hospice care. They meet with a hospice nurse, who impresses Gawande. She makes clear that she cares about Gawande's father and his pain, not about his disease or diagnosis. She asks Gawande's father what he thinks about hospice, and he says it may be best because he doesn't want chemotherapy. She says hospice is about managing his pain, giving him nursing visits and providing emergency support. He can also end the services at any time. She asks if he wants to start now or think about it, and he says start now.

In contrast to the doctors and oncologists that Gawande's father has been meeting with, the hospice nurse prioritizes Gawande's father's well-being over providing him with a litany of treatments. In addition, Gawande's father shows how much he has thought about his death and sorted through his priorities, as he has already come to the decision that he doesn't want chemotherapy and wants to start hospice right away.

The nurse asks Gawande's father about his biggest concerns: he says he wants to stay strong while he can and to be able to type. The nurse stays for two hours, examining him, inspecting the home, and giving the family instructions on how to help. She also discovers that Gawande's father has been adjusting his own medication doses, and she tells him to stick to a routine so they can sort out the best dosage. She also tells him not to attempt to get out of bed without help. He agrees.

The nurse illustrates how different the focus is in hospice care versus traditional medicine. The nurse actively asks about the most important things to Gawande's father, then sets about making sure to give him the best chance at achieving those things.

In the coming days, Gawande is amazed to see the difference from these two simple instructions. The nurses help his father smooth out his medication, and as a result, his father's pain control improves. In addition, he has no more falls, which had each set him back severely. His slide into quadriplegia halts completely, and his control of his hands and arms improves. He even starts hosting parties again.

While before, Gawande showed the differences between how hospice workers and regular doctors approached people's health, here he shows the outcome of those different strategies. Not only does Gawande's father gain greater strength and short-term health, but his emotional outlook improves and his long-term prospects do too.

Two months later, Gawande returns to visit him and give the graduation address at Ohio University. When the day comes, Gawande's father is able to walk the length of a basketball floor and up a flight of steps for the first time in half a year. This is the impact of a different kind of medicine and the ability to have hard conversations.

Here Gawande hammers home the importance of destigmatizing death and the value of hospice care. Only through these two things is Gawande's father able to make improvements, unlike the traditional medicine which was only making him worse.

CHAPTER 8

In 380 B.C., Plato wrote about courage, positing that courage is strength in the face of fears or hopes. In aging and sickness, there must be courage to confront the reality of mortality: to seek out the truth of people's fear or hope. But aging and sickness also require the courage to act, and to determine whether one's fears or one's hopes matter most.

In this reference to Plato, Gawande acknowledges that aging, sickness, and death are frightening prospects that require courage to face. But that courage is crucial to understanding our priorities and acting according to them.

When Gawande returns from Ohio, he gets a late-night page that Jewel Douglass is vomiting once more. In the **hospital**, he finds that her cancer has grown and multiplied, and her abdomen fills with fluid. But she still keeps a good attitude. Gawande realizes that he could suggest a whole new range of treatments and surgeries, or he could talk about hospice.

Gawande once more feels the temptation to talk about the various treatments alongside the option for hospice, placing the responsibility fully on Jewel Douglass and avoiding helping her through these discussions himself—the exact kind of doctor he critiques in the book.

Instead of overwhelming Douglass with her options, Gawande asks what her fears and goals are and what tradeoffs she's willing to make. She says she wants to be without pain, nausea, and vomiting; she wants to eat and get back on her feet; she wants to get back home and be with people she loves; and she wants most to go to a wedding taking place in two days. Gawande knows an operation would never let her get to the wedding, and chemotherapy would have a slim chance of improving her situation while providing major drawbacks. Gawande recommends this option: to drain the fluid in Douglass's abdomen, give her medication, and discharge her.

Gawande avoids his past mistakes and attempts to emulate Benzel once more. He tries to understand what Douglass's priorities are—like being able to eat and going to the wedding—and help her manage her disease in a way that allows her to do those things, rather than simply caring about the possibility of lengthening her life.

That same night, however, Douglass comes back to the **hospital**, as her vomiting returned. Surgery is now the best course of action to restore her ability to eat, but she's afraid of the tubes and the complications. Her greatest fear is greater suffering. Gawande estimates that he has a 75% chance of making her future better for a little while, with a 25% chance of making it worse.

Even as Douglass recognizes that she won't be able to attain all of her priorities, Gawande still tries to be realistic with her because he recognizes her fears about losing her well-being.

The brain gives two ways of evaluating suffering, as laid out by Nobel-Prize winning behavioral economist Daniel Kahneman in *Thinking, Fast and Slow*. He studied a group of patients undergoing colonoscopy and kidney stone procedures. They rated their pain both during and after the procedure. Patients typically had low to moderate pain punctuated by spikes of significant pain while they experienced it. But afterward, their ratings were predicted by an average of the pain at two moments: the worst moment, and the very end, not according to the total amount (the Peak-End rule).

Gawande's reference to Kahneman's book relates back to evaluating one's priorities during one's end of life. There are two ways of evaluating it: how one experiences suffering, and how one will remember the experience. It is worth considering both of these ways of evaluating suffering when considering medical choices. But it is notable that in both of these cases, the primary goal is to alleviate suffering.

Kahneman posits that there is an “experiencing self” that endures every moment equally and a “remembering self” that only remembers the peak and the end. When it comes to life, both matter: we don’t want to endure long pain and short pleasures, but certain pleasures can make enduring suffering worthwhile. The peaks and the ending are important, and this is the dilemma that Jewel Douglass faces. Should she focus on the worst things she might endure and the very end, or the overall amount of suffering.

Kahneman’s theory helps illuminate Douglass’s dilemma. She doesn’t know which is more crucial to her: enduring less suffering overall or finding a way to prioritize a good ending. In either case, Gawande highlights how this is an important part of establishing priorities: how much suffering she is willing to endure for certain additional advantages, like having more lucid time with her family.

Douglass tells Gawande that she wants to be able to spend time with her family but doesn’t want to be risky. With these instructions, Gawande tells her that he can look around at her intestines and unblock them only if he believes he can do it fairly easily without taking unnecessary risks. When Gawande performs the surgery, he realizes that her intestines are completely tethered by tumors, and trying to get them free would be too risky. So instead, they simply drain her stomach and abdomen and close her up.

Working with Douglass, Gawande avoids his past mistakes. Like Benzel did with Gawande’s father, Gawande helps Douglass understand what is most important to her. She wants to attempt a chance at greater survival, but if it looks like it could come at the cost of her well-being and time with her family, this is not a risk she’s willing to take. Gawande understands this and gives her medical advice and treatment according to her priorities.

When Douglass wakes, she thanks Gawande for trying, and for relieving her nausea and pain. Three days later, she leaves to go home with hospice to look after her. A few days later, Gawande visits her after work. She feels like she’s slipping, but she’s glad to see old friends and relatives all day. They talk about her memories, and she says that she is at peace. Gawande feels that Douglass’s ending is a good one. Two weeks later, her daughter sends Gawande a note that Douglass passed away, and that the family had a perfect ending with her.

Because Gawande didn’t just blindly treat Douglass, but instead acted according to her priorities, he was able to give her an incredibly satisfying ending. Knowing that they were fighting a losing battle, he prioritized her well-being over her survival and allowed her to die as she wanted.

The question arises as to how far our control should extend at the very end. “Assisted suicide” is the term, but advocates prefer “death with dignity.” We recognize some version of this right when we allow people to refuse food or water or medications. Cardiologists accept that patients have the right to have their doctors turn off their pacemaker if they want it. We recognize the necessity of drugs that reduce pain even if they speed death. We are running up against the philosophical distinction between giving people the right to stop artificial processes that prolong their lives and the right to stop natural processes that do so.

Here Gawande makes a concession in his overall argument, illustrating that sometimes there are ethical dilemmas in giving people too much autonomy. Opponents of assisted suicide or death with dignity argue that giving people relief from suffering shouldn’t extend to helping them die. Technology also complicates this question, as medicine often helps people live artificially anyway.

The debate is about what we fear most: the mistake of prolonging suffering or the mistake of shortening life. We stop the healthy from committing suicide because we recognize that their suffering is often temporary. Indeed, only a minority of people saved from suicide make a repeated attempt: the vast majority eventually report being glad to be alive. But this is not the case in terminally ill patients who face increasing suffering. In places that allow physicians to write lethal prescriptions (the Netherlands, Belgium, Oregon, Vermont), they can do so only for terminally ill adults who face unbearable suffering, make repeated requests, do not act out of depression or mental illness, and who have a second physician confirming that they meet the criteria.

Like many end-of-life decisions, Gawande illustrates that it's important to confront these difficult questions and understand what our priorities are surrounding assisted suicide—whether we prioritize extending people's lives or prioritize alleviating suffering. The regulations in place around assisted suicide help guard against the mistake of shortening life too soon.

Still, Gawande worries about actively assisting people with speeding death. By 2012, one in 35 Dutch people sought assisted suicide at their death, and this is not a measure of success. The goal is a good life to the very end. The Dutch have been slower to develop palliative care programs. But sometimes suffering is unavoidable, and helping people end that suffering may be necessary. Gawande supports laws to provide these prescriptions—particularly as about half the people given the drugs don't use them. But we should also focus on improving the *lives* of the ill, not just their deaths.

In this passage Gawande returns to his primary point: while the goal is to enable people to have more satisfactory deaths, the more important goal is to help them have good lives up until their deaths. He argues that assisted suicide should not take the place of important palliative care programs and hospice—society should focus on these programs before turning to shortening people's lives.

One day, Gawande gets a call from the husband of Peg Bachelder, his daughter's piano teacher. Peg has been undergoing cancer treatments for a rare soft-tissue cancer for over two years, but now she has run out of treatment options. She knows that she is going to die very soon, but she fears more pain, losing bodily control, and being unable to leave the **hospital**. Gawande knows that some in her position, offered death with dignity, might have taken it as the only chance for control. But Gawande convinces her to try hospice, which would at least get her home and might help her more than she thinks.

Gawande acknowledges that some might choose assisted suicide as a measure of maintaining autonomy over their lives, in the face of severe illness taking that autonomy away. And yet he again emphasizes hospice care's value in helping Peg combat her fears and give her more time with those she loves.

A few days later, Peg calls and wants to resume teaching Gawande's daughter. Hospice allowed her to manage her daily difficulties and regain the things she loves, which in turn reduces her anxieties. She lives a full six weeks, giving her the opportunity to host concerts with her students and say goodbye to dear friends. Peg gets to share memories, pass things on, settle relationships, establish legacies, and make peace with God. She gets to end her story on her own terms.

Hospice allows Peg to accomplish her most important priorities, and this in turn helps buoy her emotional and mental well-being. Thus, palliative care can create a positive feedback loop, wherein improving one's physical condition can improve one's mental state and vice versa. Again, when people aren't so focused on survival and instead on well-being, they can actually survive longer as a result.

Eventually, Gawande's father's story ends as well. After he starts hospice in the early spring, he has difficulty regaining a sense of normalcy as his body continues to break down, but he has good days and weeks as well. He still has dinner parties and watches movies and connects with friends. But his weight drops, and he sends some garbled emails.

As Gawande winds down his father's story, he again returns to the idea that death is inevitable. Even though it is uncomfortable, it is necessary to talk about it and confront it head on—something that he has experienced personally.

On Saturday, August 6, Gawande's mother calls, explaining that his father isn't waking up after taking a strong dose of pain medications. She calls the **hospital**, not the hospice agency, and they bring him to the emergency room. He has pneumonia and is at an unsurvivable oxygen level. They ask Gawande's mother whether they should intubate his father and move him to the ICU. But per Gawande's father's wishes, she tells them not to intubate him.

Again, having the difficult conversation with Gawande's father allows Gawande's mother to defer to his previous decision, rather than having to figure out what she should do in a time of crisis.

Gawande realizes that this is probably the end, but his mother and sister aren't certain. Gawande and his sister both book flights to Ohio, and later that afternoon, Gawande's father wakes up. He grows alert and unhappy about being in the **hospital** in deep pain—they fear he will lose consciousness again on the pain medications. But due to his protests, they give him an injection for the pain and send him home.

Even in the final days of Gawande's father's life, the hospital staff's instinct is to help him live longer—even at the cost of great suffering. Instead, Gawande's father wants to focus on his comfort rather than simply keeping him alive and suffering.

Gawande's father's greatest pain is his from the tumor. He starts to sleep for longer periods. But even in his last few days, he still eats well, sorts photos, and gives instructions about unfinished projects. Gawande gives him morphine every two hours, and the family sits by his bedside for long periods of time. On his second to last day, the family gets him into a wheelchair and he sits looking outside with them. But he decides that eating is prolonging his death, and that he'd rather sleep than be awake. During Gawande's father's final bout of wakefulness, Gawande shows him pictures of his grandchildren, and he smiles widely. Then he descends into unconsciousness again, and finally, his breathing stops.

Gawande's father's final days help to normalize death and show that it is inevitable. What is not inevitable is suffering. By choosing hospice, Gawande's father is able to fulfill some of his final priorities: spending time with family, recounting meaningful memories, and leaving a legacy for his children. This is not only a brave way to die, but it is one that focuses on well-being rather than fighting tooth and nail for survival when death is inevitable.

EPILOGUE

Being mortal is about the struggle to cope with the limits of our biology. Medicine helps push these limits, but the job of medicine is not just to ensure survival: it is to enable well-being. The important part of evaluating well-being is to understand one's hopes, fears, and trade-offs and choose the best course of action accordingly.

In his conclusion, Gawande underscores once more how medicine should focus on well-being rather than survival—and often that means confronting death and having difficult conversations about it.

Palliative care helps bring this kind of thinking to dying patients, but every doctor should help patients think in this way. Whatever risks and sacrifices that doctors offer are only justified if they serve the larger aims of a person's life. Otherwise the suffering can be immense. Gawande's most meaningful experiences came from helping others understand what medicine *cannot* do—like Jewel Douglass, Peg, or his father.

Gawande again illustrates how palliative care is crucial to helping people achieve the kinds of end of life that they want. While death never becomes comfortable, facing these difficult topics is part of Gawande's most meaningful work, and the book's project is to help other people be more prepared for death, illness, and aging as well.

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Gawande's father died without sacrificing his priorities, and he left clear instructions for what to do after his death. According to Hindu mythology, when a person's remains touch the Ganges River, they are assured eternal salvation, and so Gawande, his sister, and his mother took a boat and spread his ashes in the middle of the river according to Hindu customs. Gawande is grateful to have done this for his father, and that the rituals connect his father to something bigger than himself.

Recounting his experience spreading his father's ashes, Gawande acknowledges again the value of good endings, and the importance of honoring people's wishes about their own deaths. But acknowledging history also alludes to Gawande's own death, as he knows that he, too, will one day have to confront aging and death and become a part of that same history.

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Gawande's father taught Gawande not to accept limitations as a child. But in Gawande's father's final years, he had to shift from pushing against limits to making the best of them. Sometimes the cost of pushing exceeds its value. Gawande feels lucky to have helped his father through this struggle, and to have gotten to say goodbye. His father let his family know he was at peace, and this let his family be at peace, too. After Gawande finishes spreading his father's ashes in the Ganges, Gawande, his sister, and his mother return to shore.

Being able to confront death helps people have more peaceful deaths, as they are more ready to acknowledge when they should stop pushing against the inevitable. And in addition, it helps Gawande feel more at peace with how his father died. Additionally, the final image of the boat recalls the Greek myth of Charon, who ferried the souls of the dead across the River Styx. Similarly, Gawande makes it part of his own project to help ferry his patients through the process of aging and dying.

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