By KEN MURRAY
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Arthur Giron
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Charlie, 68 years old, was uninterested. He went home the next day, closed his practice and never set foot in a hospital again. He focused on spending time with his family. Several months later, he died at home. He got no chemotherapy, radiation or surgical treatment. Medicare didn't spend much on him.
It's not something that we like to talk about, but doctors die, too. What's unusual about them is not how much treatment they get compared with most Americans, but how little. They know exactly what is going to happen, they know the choices, and they generally have access to any sort of medical care that they could want. But they tend to go serenely and gently.
Doctors don't want to die any more than anyone else does. But they usually have talked about the limits of modern medicine with their families. They want to make sure that, when the time comes, no heroic measures are taken. During their last moments, they know, for instance, that they don't want someone breaking their ribs by performing cardiopulmonary resuscitation (which is what happens when CPR is done right).
In a 2003 article, Joseph J. Gallo and others looked at what physicians want when it comes to end-of-life decisions. In a survey of 765 doctors, they found that 64% had created an advanced directive—specifying what steps should and should not be taken to save their lives should they become incapacitated. That compares to only about 20% for the general public. (As one might expect, older doctors are more likely than younger doctors to have made "arrangements," as shown in a study by Paula Lester and others.)
Why such a large gap between the decisions of doctors and patients? The case of CPR is instructive. A study by Susan Diem and others of how CPR is portrayed on TV found that it was successful in 75% of the cases and that 67% of the TV patients went home. In reality, a 2010 study of more than 95,000 cases of CPR found that only 8% of patients survived for more than one month. Of these, only about 3% could lead a mostly normal life.
Unlike previous eras, when doctors simply did what they thought was best, our system is now based on what patients choose. Physicians really try to honor their patients' wishes, but when patients ask "What would you do?," we often avoid answering. We don't want to impose our views on the vulnerable.
The result is that more people receive futile "lifesaving" care, and fewer people die at home than did, say, 60 years ago. Nursing professor Karen Kehl, in an article called

"Moving Toward Peace: An Analysis of the Concept of a Good Death," ranked the attributes of a graceful death, among them: being comfortable and in control, having a sense of closure, making the most of relationships and having family involved in care. Hospitals today provide few of these qualities.

Written directives can give patients far more control over how their lives end. But while most of us accept that taxes are inescapable, death is a much harder pill to swallow, which keeps the vast majority of Americans from making proper arrangements.

It doesn't have to be that way. Several years ago, at age 60, my older cousin Torch (born at home by the light of a flashlight, or torch) had a seizure. It turned out to be the result of lung cancer that had gone to his brain. We learned that with aggressive treatment, including three to five hospital visits a week for chemotherapy, he would live perhaps four months.

Torch was no doctor, but he knew that he wanted a life of quality, not just quantity. Ultimately, he decided against any treatment and simply took pills for brain swelling. He moved in with me.

We spent the next eight months having fun together like we hadn't had in decades. We went to Disneyland, his first time, and we hung out at home. Torch was a sports nut, and he was very happy to watch sports and eat my cooking. He had no serious pain, and he remained high-spirited.

One day, he didn't wake up. He spent the next three days in a coma-like sleep and then died. The cost of his medical care for those eight months, for the one drug he was taking, was about $20.

As for me, my doctor has my choices on record. They were easy to make, as they are for most physicians. There will be no heroics, and I will go gentle into that good night. Like my mentor Charlie. Like my cousin Torch. Like so many of my fellow doctors.

—Dr. Murray is retired clinical assistant professor of family medicine at the University of Southern California. Adapted from an article originally published on Zocalo Public Square.

A version of this article appeared Feb. 25, 2012, on page C2 in some U.S. editions of The Wall Street Journal, with the headline: Why Doctors Die Differently.

1. Costs for health care have tripled while access and quality remains poor. For 18 years I have been part of a prototype medical practice providing better service at a lower cost, but no one will listen. Why?

2. The hospital emergency room at a minimum cost of $1000 per visit has become the default primary care system. No one has been able to stop the growth of ER visits. Despite claims to the contrary, people are making profit from ER over use and fragmentation of care.

3. Part of this is due to the loss of alternative sources of care. Independent family medicine offices can do a better job than government clinics. But, regulations, academic opposition, and political resistance have driven most of us out of business. The high touch, lower cost family medicine +OB solution has been lost in a gerrymandered system of generic primary care.

4. Medical schools are DNA factories for doctors. These factories are funded and controlled by special interests who lobby for regulations requiring purchase of their products. Medical schools have repeatedly sidestepped all attempts to change their

current production pattern; ie, less than 15% of medical students become general community care physicians--superdocs. Academic factories are not accountable in producing an all purpose physician who can care for children, counsel a single parent, manage a simple fracture, deliver a baby, perform simple office surgery, coordinate care unrestricted by age, gender, pregnancy, and location of service, etc
5. Technology has made many diagnostic, xray, and minor surgery services safe in the community health center. Regulations have restricted independent medical practice while simultaneously creating profits through the  formation of economic monopolies and training cartels of the academic hospitals.
6. Under the banner of "quality" medical schools and tertiary care hospitals have partnered to create a monopoly on accreditation.