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Values at the End of Life: The Logic of Palliative Care. By Roi Livne.
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We have come a long way in the decade since Sarah Palin's rhetoric around "death panels" made discussions of palliative care a political third rail. More recently, we have seen a renewed engagement around end-of-life issues in popular culture with bestsellers such as Atul Gawande's *Being Mortal* and Paul Kalinithi's *When Breath Becomes Air*, as well as countless articles in the lay press and Oscar nominated documentaries. Roi Livne's *Values at the End of Life: The Logic of Palliative Care*, explores the development of what he calls the "new economy of dying" and how the specialty of palliative care medicine successfully counteracted the prevailing curative culture of medicine to create and legitimate an industry that "focuses on facilitating a 'good death' and minimizing suffering" (p. 4).

Embedded within the tradition of economic sociology, Livne centers his argument around the "economizing gaze" of palliative care, which he defines as "embracing a prudent disposition towards abundance" as well as a "relationship between ends and scarce means" (p.11). He argues that this new economy of dying takes on both economic and moral valances, providing a "rationale to economizing dying" (p.13). Fundamentally, Livne uses the economization of palliative care to argue that understanding economization more broadly necessarily includes moral and economic rationalities.

Using historical documents, ethnographic observations, interviews, and ethics committee archives, he weaves together a narrative that includes players as wide ranging as clinicians, economists, administrators, policy makers, patients, families, and the lay public. In this historical narrative, he highlights the intentionality with which divergent stakeholders were brought into line to collectively champion and internalize a morality of economized end-of-life care. He notes the concerted efforts of early philanthropic efforts such as the Program on Death in America and the seminal Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT), both of which continue to have a dramatic influence on the field to this day.

The SUPPORT study also revealed a great dissonance that "despite experiencing tortuous dying trajectories, patients and their families were still happy with the care they received" (p.53). Livne highlights the contradictions between palliative care advocates' aspirations and societal reality through the bold statement that "the patients were part of the problem as well as its victims" (p.45). As such, palliative care advocates "aimed to engage the wider US public in end of life discourse" by "stimulating an 'impassioned consumer movement'...that would pressure the medical profession, health care institutions, and policymakers to economize dying" (p.53). To take this a step further, researchers conducted a multitude of studies to characterize patient preferences and attitudes around what is called a "good death" (e.g., (Steinhauser, Karen, *In Search of a Good Death: Observations of Patients*,

Families, and Providers, Annals of Internal Medicine, 2000). In some ways, these studies served as both a way to measure the movement's success as well as provide a justification for its continued existence.

In Chapter 2, Livne delves into the symbiotic relationship between palliative care and corporate healthcare interests. He argued that "the very moral hospice and palliative care protagonists championed facilitated financialization because they made cost savings at the end of life appear virtuous, legitimate, and necessary" (p.81). The two movements depended upon each other; the financial argument was what some advocates felt they had to embrace to make the case for their expansion. By doing so, financially motivated organizations were able to create a moral and ethical problem around end-of-life overspending and the promotion of counteracting palliative care strategies.

Chapter 3 grapples with the quandary that "economizing remained difficult because it required the consent of the patients themselves" (p.19). He describes in subsequent chapters how the broader economizing gaze is enacted and physicians' strategies to align the economizing gaze with patient and family preferences. The economizing gaze is embodied "through the ways patients articulated and defined themselves" (p.153) as opposed to an external force imposed upon them by doctors. Doctors build a trusting, therapeutic relationship with patients and families through listening, eliciting wishes, and asking about the patients' *lifeworld* experiences to bring alignment between their goals and values and what clinicians believe is in the patients' best interest around the de-escalation of aggressive treatments. Strategies include bridging between these goals and values into concrete and feasible medical end-of-life goals, framing of questions to avoid menus of choices or requests to "do everything" and emphasizing that palliative care was not less care but rather an active form of comfort-oriented care. He also hypothesizes how this economizing gaze is inculcated, particularly to trainees through direct feedback and debriefing.

I however would argue that more attention should be directed towards issues of moral distress, especially amongst nurses and trainees. This speaks to a more inherent moral dilemma over providing non-beneficial treatments that motivates clinicians distinct from the palliative care hidden curriculum argument. His field sites appeared to be hospitals where there is a strong palliative care presence, and with that, strong acculturation around the palliative care gaze. Livne states that "the movement is now an established medical field, in which economizing dying is the rule" (p.149). However, the Center to Advance Palliative Care's (CAPC) state-by-state report card on access to palliative care reveals that access is extremely variable. I suspect that regional variations in institutional culture would demonstrate significant differences in the palliative care gaze overall and subsequently less inculcation of trainees. In regions and hospitals where the palliative care presence is weak, I surmise that there would for example be fewer clinicians with a pervasive palliative care gaze (p.59) and fewer formal and informal disciplining of clinicians who did not economize dying properly (p.79).

Overall, *Values at the End of Life* offers a sweeping and cohesive narrative of how economic and moral values were brought into alignment through public pressure, professional advocacy, and financial incentives to create both a supply and demand for an economizing palliative care gaze. This book is a worthwhile read for a broad audience and provides fascinating insight into the moral, ethical, and financial roots of a burgeoning field.