MY TIME

Abigail Trafford

A Mid-Marriage Change in the Rules May Make Sense

A friend telephones me with the news: She and her husband are back together. Both are academics, and they've had a rocky few years. She came to Washington to pursue a dream of working on health-care policy. He was left in his university town. Her one-year fellowship turned into a five-year sabbatical. A commuter marriage, she said. Abandonment, he said. They were inching toward the edge of the divorce cliff.

Now they are starting over. They've settled their arguments over money. They've divided up some of their assets. They are maintaining two households but agree to try to spend no more than 10 days apart in a month. They are about to celebrate their 40th wedding anniversary. "Deep down we really do love each other," she says. "If you once loved in a passionate way, you can reclaim that."

The news is the tool this 60-something couple used to reclaim their marriage: the post-nuptial agreement.

The post-nup is a contract signed during marriage to manage financial affairs and divide income and assets in the event of death or divorce. Unheard of 25 years ago, this mid-marriage document is gaining a foothold in American matrimonial culture. It was even featured on the television program "Boston Legal." In a recent survey of members of the American Academy of Matrimonial Lawyers, 49 percent said they had seen an increase in post-nuptial agreements in the past five years.

Like its better-known cousin, the prenuptial agreement, the post-nup is responding to two demographic trends: the overall aging of the population and the increasingly common pattern of marriage, divorce and remarriage along with its complicated legacy of children from different relationships.

One purpose of the post-nup is estate planning. "That is a perfectly good reason to do it," says Jeff Atkinson, principal author of "The American Bar Association Guide to Marriage, Divorce & Families" (Random House, 2006). It is a way to direct retirement benefits to children of a previous marriage, or to an adult child with special needs. Or to make sure a beloved summer cabin stays in the family by making it separate from the couple's community property.

For my friends, the post-nup removed money as an issue in their marriage and allowed them to focus on their relationship.

To be sure, many couples fight about money — one is a spendthrift, the other a saver. He buys a new car without consulting her. She resents the money going to college tuition for his children. And in late-life marriages, what's fair when one spouse earns more money than the other? A post-nup can give couples predictability and a sense of security about their financial future.

But using a post-nup to heal a troubled marriage is controversial.

"There are cases where that's advisable," says Gregg Herman, a family law attorney in Milwaukee. "But I only recommend it where there is an equal desire to stay married and work on the marriage." These are committed couples with "soft" problems of incompatibility, from struggling with retirement issues to coping with boredom. "Counseling and joint therapy are critical to these people," Herman says.

The post-nup is not recommended for couples who are confronting the "hard" problems: physical or mental abuse, infidelity, substance abuse. Nor for people who are really planning to break up and want to use the post-nup as a Trojan horse settlement in any future divorce battle.

Partners are rarely in the same place in a troubled relationship, and one spouse is often more committed to the marriage. The temptation is to use the post-nup as leverage to change behavior. For example, if one has a drinking problem or has had an affair but wants to preserve the marriage, the other makes staying together conditional on signing an agreement that says in effect: If you slip up again, you give up your rights — you have to pay me a lot of money in support and I get the house, too! This kind of post-nup is really an ultimatum. Money becomes the glue of the marriage. As Herman says: "Money is rarely a good bond for keeping people together. People stay together because they love each other, not because of financial reasons."

States vary in how they view the legality of post-nup agreements. Spouses must fully disclose their income, assets and debts. They should each have legal representation — and plenty of time to think about the terms so that neither is pressured to sign. And most important, the agreement has to be fair to both. Post-nups are held to a very high standard of fairness in financial matters, lawyers say, perhaps an even higher standard than are pre-nups.

These agreements are not about love. They can help couples deal with financial issues. But by itself, a post-nup cannot save a marriage.

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More Women Are Choosing Mastectomies

• More and more women are choosing to have a breast surgically removed after a breast cancer diagnosis instead of having a less-radical lumpectomy. So finds a Mayo Clinic study to be released at this week's American Society of Clinical Oncology meeting.

The trend goes against many experts' general preference for the more conservative surgery plus radiation — a recommendation that has held since 1990, when the National Cancer Institute found that treatment as effective as mastectomy for most women with early-stage breast cancer.

The new study, involving more than 5,000 women with early-stage breast cancer, found that the rate of mastectomy at Mayo was 43 percent in 2006, up from 30 percent in 2003 and almost reaching the 1997 high of 44 percent.

Why the uptick? Lead author Matthew Goetz, an assistant professor of oncology at Mayo, suspects several factors, including:

■ Increased genetic testing. Knowing the risk of a second cancer can make women want to remove as much breast tissue as possible, said Susan Brown, director of health education at the Susan G. Komen Foundation.

■ A rise in post-diagnosis MRIs. During the study period, the percentage of women who had breast MRIs more than doubled, from 11 percent in 2003 to 23 percent in 2006. Because MRIs often detect noncancerous abnormalities, said Shawna C. Willey, director of the Breast Health Center at Georgetown University Hospital and president of the American Society of Breast Surgeons, she recommends patients have a biopsy before basing a mastectomy decision on MRI results.

■ Improvements in breast reconstruction surgery.

So which is best? The option that best fits each woman, barring instances in which there's a clear medical case for one surgery over the other, Willey and Brown said.

Willey advises all breast cancer patients to seek a surgical second opinion. Lumpectomies carry a 5 to 10 percent risk of cancer recurrence. The odds of a recurrence with a mastectomy are lower.

Resources offering pros and cons for each choice include: the American Cancer Society and the Komen Foundation.

— Francesca Lunzer Kritz

A TRAINED EYE

The High Price of A Medical Miracle

If Health-Care Costs Are Trimmed, Who Will Be Deprived of Treatment?

By Darshak Sanghavi
Special to The Washington Post

A few weeks ago in central Massachusetts, a previously healthy 15-year-old named Alex Hall awoke in the middle of the night because his chest hurt. Initially Alex thought the feeling would pass, but when it continued, his worried parents drove him to a local emergency room. There a blood test suggested that — incredibly — he was having a heart attack. An ambulance quickly took Alex to a tertiary care center staffed by pediatric specialists, and as the on-call pediatric cardiologist, I was paged to help out.

Alex's heart probably had been attacked by a virus, making him the latest victim of a small but worrisome epidemic in the area. Over the next two hours, the inflammation spread like wildfire through his heart, and the orderly spikes on Alex's cardiac monitor soon became disorderly seismic waves. "I'm scared," he whispered, looking at the monitor. Soon after, his lungs began filling with fluid and he started gasping for air.

Critically ill with a rare condition, Alex needed the kind of specialized but pricey care that is frequently blamed for busting health-care budgets.

The same week Alex came to the hospital, a team of researchers led by John E. Wennberg at Dartmouth Medical School reported massive state-by-state variations in Medicare spending, with New York and New Jersey spending almost 50 percent more per person than North Dakota and Iowa without, on average, having people live longer as a result. A lot of the discrepancy was chalked up to more intensive inpatient care in high-cost states. Wennberg argues that because health care is paid for in a piecemeal fashion (the more doctors that people, the more ■ they earn), states with lots of specialists and hospital beds are rewarded for overusing them. Health care, he concludes, is perversely "supply-sensitive."

To some, the Dartmouth data encourage the notion that if the supply of specialists and hospital beds were suddenly cut, doctors might reserve fancy care for patients who really needed it, and thus costs would fall. But as Alex's case suggests, these cost controls will require hard choices — and, inevitably, haphazard rationing of health care.

As the boy's heart continued to fail, our team realized that the only hope for survival was a machine that would bypass his heart and lungs entirely and deliver oxygen to Alex's brain and body. Called extra-corporeal membrane oxygenation, or ECMO, this technology required further escalation: We'd have to send him to another specialized center, at Children's Hospital in Boston.

The resources mobilized to save Alex were staggering. A specialized, fully staffed intensive-care truck from Boston arrived to transport him to the ECMO center, where a team of cardiac experts worked to surgically connect Alex to the device. For eight days, Alex lay connected to the artificial heart and lungs under general anesthesia to buy time for his real organs to recover.

ECMO is very expensive, available only in certain centers and not standard therapy, making it just the kind of care that causes geographic disparity in medical costs. But as reported last year in the journal Circulation, ECMO has been used worldwide in about 700 cases in which even the most advanced resuscitation had failed because of a child's severe heart failure, infection or lung disease. The lead author (who, incidentally, helped care for Alex) wrote that ECMO "rescued one-third of patients in whom death was otherwise certain." In short, the treatment snatched hundreds of children like Alex back from the dead. But no one could tell ahead of time exactly which ones would live.

Critics of American health care sometimes point out that high-cost regions have higher mortality rates and conclude that too much medicine is harmful. But that's like noting that obese people are on diets and deciding that low-calorie foods cause fatness. Centers that offer ECMO, for example, will have the highest costs and highest mortality since they attract the desperately ill. And while life expectancy in the United States supposedly places 42nd among developed countries, it's hard to imagine how a boy like Alex could have survived in such places as Guam or Jordan, which rank ahead.

Cuts will always be somewhat arbitrary, no matter who's making the decisions: In the end, some people won't get the treatment that may save them.

Of course, America lags behind many countries in providing a basic level of service for all citizens, since we lack universal health care. But for many, the system offers almost unlimited resources, which are often taken for granted. (In the March/April issue of Health Affairs, a former editor at the British Medical Journal whose daughter failed to get proper care in England writes how American health care "can replace a sense of resignation and futility with action and hope.")

Still, the estimated $2 trillion that Americans spend on health can't continue to grow. Indeed, health-care costs may need to come down. But these cuts will never be painless, since they can almost never be targeted only at useless expenditures. We've known this since the 1970s, when the Rand health insurance experiment found that patients cut back equally on both superfluous and necessary visits when asked for small co-payments.

It's unclear whether doctors given limited resources would be any better at rationing care. For now, they can't always tell when ECMO is necessary or futile. The same is true for many other expensive therapies, such as new cancer drugs, organ transplants and innovative psychiatric care. That's why cuts will always be somewhat arbitrary, no matter who's making the decisions: In the end, some people won't get the treatment that may save them.

Alex survived and continues to recover. Because of a minor paperwork error, however, his name remained on a heart transplant wait list, and a transplant coordinator called his home to check on him. You can take him off the list, his dad told the coordinator: Alex was one of the lucky ones.

Darshak Sanghavi is an assistant professor of pediatrics at the University of Massachusetts Medical School and the author of "A Map of the Child: A Pediatrician's Tour of the Body."