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# End-of-life issues in elderly patients

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BENJAMIN LIPTZIN, M.D.

Department of Psychiatry, Baystate Medical Center, Springfield, Massachusetts, and Department of Psychiatry, Tufts University School of Medicine, Boston, Massachusetts

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## ABSTRACT

*Objective:* To describe elderly-specific issues in end-of-life care.

*Methods:* Literature review and case examples.

*Results:* There is great heterogeneity in elderly patients' responses to end-of-life care.

*Significance of results:* Developmental and individual issues need to be considered in end-of-life discussions.

**KEYWORDS:** Aging, Elderly, End-of-life, Care planning

There has been a great deal of discussion in the last several years about end-of-life care as people in developed countries have confronted questions raised by the availability of life-prolonging technologies. The Terri Schiavo case has highlighted questions about who should be the decision maker when a patient is no longer competent to decide for him/herself. The question this article addresses is whether the issues around life-prolonging treatments look different from the perspective of an elderly patient.

The first point to make is that the very definition of who is "elderly" needs to be confronted. From a societal point of view, at age 50 one can sign up as a member of the American Association of Retired Persons, the powerful lobbying group that represents the interests of "older" people. One becomes eligible for Social Security and Medicare sometime after age 62 or 65. Yet, a recent 99-year-old patient refused to go to "senior citizen" activities because "that's for old people." There is considerable heterogeneity among older people from the 80-year-old who is CEO of a Fortune 500 company to the 102-year-old patient in a nursing home with dementia and multiple medical problems to the 60-year-old who has suffered a serious stroke and now has metastatic can-

cer. There is also great variation in the life circumstances of elderly persons from a 90-year-old single woman with no family to a 70-year-old man with two young children from a second marriage and grandchildren from a first marriage. These variations support the belief that the individual should have the primary responsibility for deciding what he/she wishes with respect to end-of-life care.

Health Care Proxies or Living Wills have been developed to allow individuals to state their wishes as to end-of-life care. However, those written instructions do not always account for changes in life situations. For example, a 79-year-old widow was receiving chemotherapy for metastatic ovarian cancer. She developed a hypercoagulable state and collapsed at home. She was hospitalized and found to have suffered a stroke. Because the patient was comatose, the attending physician met with the family to discuss whether to do a neurosurgical procedure to relieve the increased intracranial pressure but indicated that her neurological function would be quite compromised after any surgery. The family discussed it at great length and declined the surgery on the basis of their mother's strongly expressed preference to not be kept alive with severe impairments. They also signed "do not resuscitate" (DNR) papers. They went home, reminisced, cried, and began to make plans for funeral arrangements. The next day when they came to the hospital they found their mother sitting up in the Intensive Care Unit reading the newspaper and eating breakfast.

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Corresponding author: Benjamin Liptzin, M.D., Baystate Medical Center, 759 Chestnut Street, Springfield, MA 01199. E-mail: benjamin.liptzin@bhs.org

When her doctor came by on rounds and asked her whether she agreed with the decision for DNR she said “Absolutely not! Doctors give up too easily on older patients.” What had seemed like a pretty clear decision when she was 75 and healthy looked quite different under the condition she now found herself in. She fully recovered her cognitive abilities but was left with difficulty walking, which limited her activities. She was, however, able to fly to another city to attend the wedding of her granddaughter. Three months later she was faced with other decisions about end-of-life care. Her ovarian cancer recurred and spread quickly. The oncologist offered her an additional course of chemotherapy but indicated he was not optimistic that it would lead to a prolonged recovery. The implicit message was that treatment could prolong her death but not her life. Faced with those new circumstances she opted for comfort measures only. Over the next few weeks she slowly declined but had a chance to leave recorded messages for and talk with most members of her extended family to say goodbye. She lapsed into coma and died a peaceful death, one that most would classify as a “good” or even “very good” death” (Cohen, 2004).

Those who have studied psychological development across the life cycle have informed our understanding of how older people think about death. Erikson (1982) usefully points out that the developmental psychological crisis of old age also represents “the last stage” of human development. Clearly, death is the end point of this last stage. The theme of this last crisis is the struggle between integrity and despair. According to Erikson (1963, pp. 268–269), integrity is “the acceptance of one’s own and only life cycle and of the people who have become significant to it as something that had to be and that, by necessity, permitted of no substitutions. . . . The lack or loss of this accrued ego integration is signified by despair and an often unconscious fear of death: the one and only life cycle is not accepted as the ultimate of life. Despair expresses the feeling that the time is short, too short for the attempt to start another life and to try out alternate roads to integrity.”

Colarusso and Nemiroff (1987) described the psychological tasks that need to be dealt with in middle and late adult life. These include the aging process in the body and increased awareness of time limitation and one’s own death, illnesses, or death of parents, friends, relatives. This usefully reminds us that as people age they have more experience with death in those around them and with their own mortality and thus may be better prepared to confront end-of-life issues.

Another important concept in human development comes from the research of Neugarten (1970).

She suggests that a changing time perspective starts in middle age. Time becomes restructured in terms of time left to live instead of time since birth. Neugarten notes that most people cope well with major life changes (e.g., retirement or widowhood) when they occur “on time” in one’s life cycle. This suggests that older people should be better prepared to accept death than younger persons because they have done some psychological preparation and have been anticipating the possibility of their own death. She describes the issues that arise in old age as

adapting to losses of work, friends, and spouse; the yielding of a position of authority and the questioning of one’s former competences; the reconciliations with significant others and with one’s achievements and failures; the resolution of grief over the death of others and of the approaching death of self; the maintenance of a sense of integrity in terms of what one has been, rather than what one is; and the concern over legacy and how to leave traces of oneself. In old age there are also the triumphs of survivorship; the recognition that one has savored a wide range of experiences and therefore knows about life in ways no younger person can know; the knowledge that in having lived through physical and psychological pain, one recovers and can deal also with the contingencies that lie ahead; and a sense that one is now the possessor and conservator of the eternal truths. The preoccupation with time left to live loses some of its poignancy. Dependency and deterioration, not death itself, is the specter of old age. In the innermost parts of the mind the acceptance of one’s own death may be . . . impossible to contemplate, yet the old person seems relatively free to talk about death and to express concern not over the fact that death will come, but about the manner in which it will come. And there is, for many if not most, a sense of peace as much as protest.” (Neugarten, 1979, pp. 890–891)

For a small number of persons, the expectation that the end of life is approaching can lead to a “giving up” (Engel, 1962). An interview study of physicians in The Netherlands (Rurup et al., 2005) suggested that approximately 400 older people each year request euthanasia or assisted suicide because they are “weary of life” even though they have no severe disease. Of the 29 patients studied, 10 were assessed to be depressed or in physical pain and were provided analgesic medication or psychiatric treatment, including antidepressant medication or psychotherapy. The authors presented the following composite picture of such patients:

A woman, 81 years old, asked her GP if he had a pill for her to end her life. The GP had known her for a long time and the question did not really surprise him. Since her husband died 15 years ago, she had lived alone. Since then, people around her had died and she was the last one of her generation alive in her family. She had good relationships with her three sons, even though she often complained that they did not spend enough time with her. She had a visual and a hearing impairment and she had difficulty walking, but she was well taken care of in sheltered accommodation. When her GP asked why she wanted to end her life, she said that she was weary of life. She felt that she was physically declining and she did not want to live to see how she deteriorated further. She had seen members of her family developing dementia and she did not want that to happen to her. She had no prospects and felt lonely most of the time. She had drawn up the balance and decided that she was better off dead. When her GP explained why he could not provide a pill she seemed to accept the situation. After that they had several conversations concerning the subject. She seemed to accept her predicament, but she said regularly that she would rather be dead and that she hoped her GP would change his mind. (Rurup et al., 2005, pp. 669–670)

Another case in the author's experience illustrates the challenges in evaluating end-of-life care in older patients. A 78-year-old widower was being treated for depression after the death of his wife when he suffered a significant stroke that left him unable to speak, swallow, or walk. Acutely a decision was made for him to put in a feeding tube to keep him alive and determine how much recovery he would achieve. Gradually he recovered his ability to speak and to swallow and the feeding tube was removed. Because he could still not walk he was admitted to a nursing home for the last 2 years of his life. He repeatedly complained that he had been unfairly kept alive with the feeding tube instead of being allowed to die. He had no family or friends who visited him and could not enjoy any of his former interests in life. Antidepressant treatment and psychotherapy did not reverse his view that his life was over or get him to engage in additional activities.

In contrast, a 69-year-old woman had been treated for many years for chronic depression and abuse of prescribed opiates. She had made several suicide

attempts and had hidden a lethal supply of sleeping pills at home to reassure herself that if life became too painful she would have the control to end her life. After her husband died, however, she felt freed up to pursue various interests and began to feel emotionally better. Her children were pleasantly surprised by her ability to make a new and better life for herself as a widow. Unfortunately, she developed a highly malignant bladder cancer. Rather than resorting to suicide as she had tried earlier in life and had planned for many years, she became a model patient undergoing surgery and chemotherapy. She was an inspiration to her children and to the hospice nurses who cared for her prior to her death. It was remarkable how she was able to deal with the reality of death in contrast to the pain and suffering of her depression earlier in life.

## SUMMARY

There is great heterogeneity among older persons. Studies of human development suggest that aging confronts people with the death of friends and family, allowing for anticipation and preparation for one's own death. As with younger patients, the individual patient's wishes should be respected unless they are judged to be incompetent to make decisions for themselves. Each individual's personality, life experience, and current social support impacts on their decisions with respect to end-of-life care and need to be understood and appreciated by the health professionals caring for them.

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