



The Who and Where of Care: Non-Oncologic Terminal Illness in the Elderly

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During the last few decades the face of medical departments in most hospitals has changed – a rising percentage of hospitalized elderly patients have advanced chronic illnesses. In a recent study in Jerusalem, 17% of admissions to medical departments were from institutions and 28% of all patients were defined as dependent prior to admission for an average of 2 years. In only three-quarters of patients was the cognitive state considered normal [1]. Furthermore, the mortality rate was 9% and a similar percentage was assigned a “do not resuscitate” order [2]. Thus, many of these patients show mental and functional decline. Gradually the medical departments are transforming into departments of geriatrics and hospice care in all but name.

Should elderly patients with advanced chronic illnesses be treated differently than otherwise healthy people with acute illness? Jaul and Rosin address some aspects of this topic in this issue of *IMAJ* [3]. Their foremost recommendation is that the care of the elderly patient with non-oncologic end-stage disease should be similar to that of patients with an oncologic end-stage disease. Therefore they suggest that these patients be treated in the community or in a hospice rather than in the hospital – with the aim of providing palliative rather than active “futile” treatment. Indeed, defining the point of “terminality” in the non-oncologic patient is no simple matter. Some would define terminality only when intractable organ failure threatens to directly cause death, e.g., heart failure unresponsive to full treatment with diuretics, vasodilators or vasopressors. Others would include end-stage dementia even where the imminent threat is a treatable infectious disease, e.g., a pneumonia requiring advanced generation antibiotics not to mention short-term respiratory support. Differences in defining “terminality” extend to implications as to when to deny further life-sustaining interventions. Lynn et al. [4] identified the cognitive state of patients as an independent criterion for the definition of a “point of no return” which, they assert, would justify withholding certain treatment modalities. However, Jewish *Halakha* (the body of Jewish law) maintains that demented persons should be afforded the same treatment as those with “intact” cognition [5].

Whereas in oncologic settings, palliative care of pain, as well as nutrition, hydration, and anxiety are less likely to be life-prolonging,

in non-oncologic terminal patients, palliative care of dyspnea with oxygen and diuretics and other medications as opposed to morphine for the “last breath” dyspnea may well extend life on the short term. Therefore the question of terminality includes not only when is treatment futile, but also what treatment is palliative and not life-prolonging.

Those who are accustomed to caring for elderly patients with any form of end-stage disease are familiar with the painfully difficult decisions that must be made on a daily basis. At what stage is the patient defined as terminally ill and medical treatment considered “futile”? If one accepts the concept of “futile” therapy, then administering it may cause needless suffering while neither improving nor prolonging life. At the same time, if one can know that a therapy is futile, how can we request that family members participate in choosing to forgo such a therapy, thereby imposing upon them needless potential guilt? In such circumstances some would therefore advocate that the physician decide unilaterally [6]. Others, opposing this view, ask: “who defines futility?” Although there has been a significant shift in attitude in Israel from paternalism of the medical staff towards the autonomy of the patient, the moral environment as regards full discussion about limited treatment varies between subgroups, and advanced directive orders are not yet common. Most often there is practically no legal authority to decide when and to what extent treatment can be withheld, which means that legally the staff appears to be liable to fully treat the patient even when staff or family members consider treatment as futile. Moreover, assuming we were able to unequivocally define from a medical-legal standpoint a “futile” state, significant segments of our population would be unlikely to accept such a concept. In a study conducted in Israel, attitudes and other factors affecting decision making by offspring of terminally ill patients were assessed regarding life-sustaining measures for their elderly parents [7]. Most of the patients were severely debilitated with advanced dementia. A significant minority of the offspring requested extraordinary life support and the majority requested continuation of nutrition and medication. The major factor influencing the request for aggressive treatment was religious outlook. The mental and physical quality of life of the parent prior

to hospitalization had no effect on the decisions of the offspring. On reevaluation after 6 years the offspring remained unchanged in their convictions [8]. Hence, at least in Israel, there is reason to believe that allocating "palliative only" care to terminally ill elderly might meet with considerable resistance.

The concept of "palliative" itself may be subject to misinterpretation and come to mean denying even simple but meaningful interventions. Beach and Morrison [9] showed that presence of a DNR order may affect physicians' willingness to order a variety of treatments not related to cardiopulmonary resuscitation. This is particularly germane considering that in the studies cited above [1,10], infections were the main reason for admission to a hospital in these patients. Here the question is which facility will provide better attention to the needs of terminal non-oncologic patients – the general hospital or a hospice?

It might be argued that a general hospital has 24 hour coverage by a wide variety of medical and surgical specialties and sophisticated diagnostic capabilities. Even in fairly moribund elderly patients, percutaneous drainage of an infected gallbladder, empyema, or diverticular abscess and prompt antibiotic treatment may be curative. Aspiration of a symptomatic pleural effusion is likely to be safer when ultrasound guidance and personnel experienced in chest-tube placement in the case of pneumothorax are present in the same facility. On the other hand, transfer to an unfamiliar environment may be traumatic for frail elderly patients. Also, no matter what documentation accompanies the patient, the hospital treatment team requires time to become acquainted with the patient and his or her mental, functional and social background. Moreover, too often, skills required for attending to dependent elderly patients are underemphasized in general medical wards. Finally, the very availability of diagnostic tests and equipment promotes a tendency to overuse of these – at considerable expense. For example, an unexpected laboratory finding may suggest performance of a debatable invasive procedure that may in turn result in iatrogenic complications. Now, suppose that the hospice team where the patient resides does not transfer the patient during an acute illness. The staff and surroundings remain familiar to the patient, and the staff is familiar with his/her medical condition and special needs. The lack of extensive diagnostic facilities would favor performance of only those procedures that have immediate practical implications for relief of symptoms and treatable life-threatening complications. Despite the lack of controlled studies, one might reason that provision of acute care in long-term care facilities might significantly reduce costs and contain antimicrobial resistant organisms. On the other hand, implementing this level of care may require considerable forethought and planning to allow adequate budgets, clear guidelines, monitored dissemination of advanced antibiotics, and to guarantee prompt diagnosis and

treatment of most common complications in this group of patients. Furthermore, even after implementation, the public may need to be educated on the merits of this approach.

In conclusion, the idea of treating non-oncologic terminal patients at a hospice-like sub-acute facility outside general hospitals may have some advantages, such as emphasizing the best palliative care rather than pursuing futile diagnostic procedures or treatments, and saving costs. Implementing this idea runs the risk of using this program for patients who for whatever personal, moral, religious or cultural beliefs desire more than palliative care. We recommend this idea only for long-term care patients whose condition is well known to the team in real time of an acute event. A similar event in terminally ill patients residing at home should be evaluated first at a hospital to allow fuller consideration of their current event. We further caution that the slippery slope paradigm threatens, with time, that this program may be applied much more extensively than for those it was conceived.

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DNR = do not resuscitate

Trust in Allah, but tie your camel

Moslem proverb