Every life ends with death. For the elderly, death is the end of a long life that has been shaped by personal history and world events, various relationships, well-set personality characteristics and, of course, happenstance. Each of these, in addition to the specific circumstances that herald death, shapes the experience of dying in old age.

_Death is more universal than life: everyone dies but not everyone lives._

A. Sachs

Every life ends with death. For the elderly, death is the end of a long life that has been shaped by personal history and world events, various relationships, well-set personality characteristics and, of course, happenstance. Each of these, in addition to the specific circumstances that herald death, shapes the experience of dying in old age. Unfortunately, the particularities of end-of-life care for the elderly are often overlooked. The specific challenges they face, the losses they incur, and the transitions they encounter can be difficult to address and often go unrecognized. As a consequence, their sense of dignity and quality of life may be undermined, and suffering mounts as life draws to a close.

**CASE VIGNETTE**

Professor M is a 78-year-old man with end-stage lung cancer. He had been a prominent university professor. His career had been marked by many successes and with the acknowledgments that often accompany outstanding achievement. As his illness progressed and he became more disabled, he found himself increasingly unable to maintain his usual work routine. His children had long since grown, and a close friend and colleague had recently passed away. In spite of his wife's unwavering support and encouragement, he had become more and more despondent and withdrawn. While fully aware of the gravity of his medical condition, he found himself preoccupied with a lack of sense of purpose or meaning. In the face of such “emptiness,” while he was not actively suicidal, he indicated that life was beginning to feel rather pointless.

**The principles of palliative care**

Palliative care is an approach that “improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other physical, psychosocial, and spiritual problems.”

The core principles of palliative care include a focus on the patient and the family; active management of distressing symptoms; total, individualized care of the patient; an interdisciplinary team approach; integration of the physical, psychological, and spiritual aspects of care; supporting family members throughout the patient’s illness and in their own bereavement; and offering support to the patient so that he or she may live as actively as possible until death.

There is growing recognition that a palliative approach should be initiated as early as possible. This approach is meant to become more dominant as cure or life-sustaining options become less viable. For the elderly, palliation and therapeutic nihilism are not to be mistaken for one another. This can be problematic for vulnerable patients, including the elderly (Figure). Findings from the Study to
Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), for example, indicate that older age is associated with lower resource intensity and less aggressive treatment, including more decisions to withhold life-sustaining treatment. There is also evidence that older adults are less likely to receive adequate pain management and are less likely to be referred for palliative care services. For marginalized populations, comfort measures are sometimes misconstrued as a substitute for other health care options. Palliative care is not about giving up; rather, palliative care is about never shirking responsibility to assuage patient distress and suffering. As such, it should be integrated in a seamless way with all treatment services for the elderly. It should be an integral part of geriatric medicine, which strives to provide the best possible quality of life for, and to meet the unique needs of, older adults and their families.

End-of-life care for the elderly requires an understanding of not only the inherent physical changes that occur with aging but also the influence of social conditions, culture, and individual life experiences and personality. Attempting to understand the experience of dying outside the context of the wholeness of life is equivalent to trying to comprehend the essence of life while excluding notions of vulnerability and mortality.

To understand the impact of dying on the elderly, one must consider their history and the emotional, social, and spiritual context in which they live. Age provides experience, which is perhaps why some studies have reported that older adults have a different outlook on life and death, display better mental well-being, and have adaptive strengths developed over a long life. Furthermore, multiple losses may have profound impact on a person’s identity, sense of self, and quality of life. These losses may touch all aspects of an individual’s end-of-life experience.

**CASE VIGNETTE**
Professor M’s cancer was predated by several years of functional deterioration and debility, secondary to COPD. The cancer diagnosis, along with the recent death of a good friend and colleague, resulted in feelings of grief, periods of despondency, and mounting frustration with his perceived lack of productive living. On examination, which took place a few weeks before his death, he was bedridden and expressed feelings of helplessness and hopelessness and a wish for death to come quickly. He denied any intent to take his own life, and while his physical comfort was relatively good, his emotional and existential suffering were considerable. Although he still appreciated his wife’s company, he was worried that he would become a burden to her and his other health care providers.

**Physical issues**
The physical consequences of aging provide a necessary backdrop to understanding the psychosocial dimensions of end-of-life care. The elderly often experience a variety of physical conditions of varying severity. In one study, elderly patients with advanced cancer reported a median of 11 distressing symptoms. In another study, older adults (65 or older) with cancer reported 3 or more comorbid conditions. Thus, while different illnesses are associated with their unique disease trajectories, the elderly may be plagued by long-term frailty, either predating or accompanying a life-threatening condition. Long-term disability and dependency can diminish functional capacity and set the stage for emotional, spiritual, and existential distress.

**Psychological issues**
There is a great deal of evidence that shows the consequences of unrelieved symptoms and loss of dignity, poor quality of life, and suffering.\textsuperscript{14-16} Similarly, the association between unmet physical, spiritual, and existential needs and psychological distress has been well articulated.\textsuperscript{17,18} Distress can become so overwhelming as to engender a genuine desire for early death. People who covet death, even toward the end of life, often report significant pain, lack of social support and, most significantly, major depression.\textsuperscript{14,19} Nearly 60% of patients who express an ardent wish to die meet diagnostic criteria for major depression.\textsuperscript{14} Approximately 10% to 25% of adults experience depression within the context of palliative care.\textsuperscript{19,20}

Diagnosing depression in the elderly is fraught with additional challenges, including the lack of somatic symptom specificity, along with a frequent reticence to volunteer their feelings of depression as readily as younger patients.\textsuperscript{21,22} It is little wonder that depression in older patients, particularly patients near the end of life, often goes unrecognized and undertreated. Anxiety among the elderly may derive from a variety of sources. On the one hand, it may be a manifestation of other conditions such as depression, delirium, dementia, or underlying medical complications.\textsuperscript{23} With regard to the latter, in the palliative care setting, anxiety can signal impending cardiac or respiratory decompensation, pulmonary embolism, an electrolyte imbalance, or dehydration. On the other hand, anxiety may result from psychological or existential challenges, such as fear of isolation or abandonment, dependency, disability, and death itself.\textsuperscript{24} Some studies suggest that death anxiety may decrease with age. Others report that although the elderly are more accepting of the finiteness of life and are able to put it into the context of the wholeness of life, fear of dying may actually increase with age.\textsuperscript{25-27} Information that demystifies the experience of dying and addresses anticipated concerns that may arise during a terminal course of illness has been found to alleviate distress toward the end of life.

**Existential and spiritual issues**

Gerontological theorists have identified finding purpose and meaning in life as key developmental tasks facing the elderly.\textsuperscript{28} Both of these are facets of spirituality and are important issues for the elderly facing death. In fact, the ability to find or sustain a meaningful life is considered to be a strong buffer against despair at the end of life.\textsuperscript{29} The results from a study by Moadel and colleagues\textsuperscript{30} show that patients with cancer expressed a need for help in overcoming fear, finding hope and meaning in life, finding spiritual resources, and having someone to talk with about the meaning of life and death. However, 25% to 51% of the participants indicated that their spiritual needs were not being met.

Spiritual and existential distress has been shown to correlate with loneliness, depression, and anxiety.\textsuperscript{31,32} The connections between spirituality, meaning, and dignity have been examined within the context of aging. For older adults, notions of dignity are intimately tied to being able to serve a purpose, feel important, feel involved, and have a sense of belonging.\textsuperscript{33} Our study group has examined the issue of dignity from the vantage point of patients approaching death. On the basis on these studies, we have developed an empirical model of dignity for patients at the end of life (Table).\textsuperscript{34} The Dignity Model suggests that a person’s perception of dignity is related to and influenced by 3 major areas:

- Illness-related concerns derive from or are related to the illness itself, and either threaten to or actually do impinge on a patient’s sense of dignity.
- The dignity-conserving repertoire consists of those internally held and socially mediated approaches a person uses to maintain a sense of dignity.
- The social dignity inventory refers to external environmental factors that can strengthen or undermine the quality of interactions with others and, thereby, a sense of dignity.

On the basis of the empirical Dignity Model, our research group has developed a brief, individual therapeutic intervention that we call dignity therapy.\textsuperscript{35} Dignity therapy invites patients to address issues, recall memories, and share reflections, which they may wish to offer those they are about to leave behind. Typically, patients share life stories; highlight their values; speak about how they wish to be remembered, their most important accomplishments, hopes, and dreams for loved ones; and provide advice or guidance for important people in their lives. These sessions are tape-recorded verbatim and then edited to create a cohesive narrative. The patient receives this “generativity document,” which in most instances is bequeathed to a loved one.

In an initial pilot study of 100 terminally ill, mostly elderly patients, 91% reported feeling satisfied
with the experience, 81% found it helpful for their family, 76% said that it heightened their own sense of dignity, 68% reported an increased sense of purpose, and 67% reported a improved sense of meaning. Symptoms of depression and suffering were also reduced.\textsuperscript{35}

\textbf{CASE VIGNETTE}

Based on Professor M’s predominant depressed mood and loss of interest in most activities, along with a certain element of self-deprecation, a trial of psychostimulant medication was initiated. These medications have a fast onset of action and are often energizing, making them particularly appropriate in the context of end-of-life care.\textsuperscript{36} The patient, in consultation with his family, was also offered a trial of dignity therapy. This gave him the opportunity to speak about his previous scholarly passions and life achievements and to engage, to a lesser extent, in some life review. For the time he was well enough to participate, this approach seemed to engender a sense of meaning and purpose. When the final “generativity document” was read in its entirety (a standard part the dignity therapy protocol), he and his wife thought that it had “captured his essence.”

\textbf{Dignity-conserving care}

Patients approaching death anticipate the loss of all they know and love. For the elderly, this can be marked by a shattered sense of self. The “ABCDs” of dignity-conserving care, namely attitude, behaviors, compassion, and dialogue, provide a framework that embraces core values of medical professionalism, such as humanity, kindness, and respect.\textsuperscript{37} For all patients, particularly the frail elderly, the application of this framework as a means of staving off end-of-life distress can complement any treatment.

\textit{Attitude} emphasizes the notion that our view of the patient influences the way he sees himself. Patients look to their care provider for affirmation or acknowledgment of continued worth. People near the end of life, the young as well as the old, maintain the wish to be seen in terms of who they are or who they once were.

\textit{Behaviors} refers to how health care providers interact with patients. Even small cues, such as not being fully attentive or assuming one knows how the patient wishes to be addressed, can further assault a patient’s sense of self. All behavior toward the elderly patient should be predicated on understanding that patients need to feel accepted as human beings and individuals, not just as objects of medical interventions.

\textit{Compassion} refers to a deep awareness of the suffering of another, coupled with the wish to relieve it. Compassion begins with the humble realization that each and every one of us is vulnerable. In caring for the elderly, it is especially important not to lose touch with the fact that, death notwithstanding, aging and disability are inevitable. A not-so-subtle reminder of this comes from the disability community, where the term “TAB” is often used to refer to the Temporarily Able-Bodied.

\textit{Dialogue} underscores the importance of conversations that acknowledge personhood. It can be as simple as finding out who the patient is, or asking what needs to be known to deliver the best care possible.

In palliative care, novel psychotherapeutic approaches based on existential themes such as meaning, purpose, and dignity are showing great promise in their ability to diminish suffering and enhance the will to live. Perhaps being mindful of these issues in the context of providing care to the elderly could yield similar results.

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Evidence-Based References

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