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End-of-life decisions in geriatric medicine: risk of divergent opinions

Abstract

Two geriatric patients with an acute deterioration are described. The cases demonstrate the importance of planning discussions about end-of-life decisions early on. This is to avoid unnecessary consultations in acute situations. Nevertheless, sometimes it's impossible to bridge the gap between different perspectives.

Keywords: geriatric medicine, health care, metastases, morphine, hypertension

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Introduction

In recent decades, aging and geriatric medicine have become important topics in Western health care. In the Netherlands, a small, prosperous European country where I have worked as an internist throughout my life, the average ages for women and men are 83.3 and 80.5 years respectively. Moreover, a political party for the elderly has been established. The so-called 50PLUS party won 2 seats in parliament in the latest elections. There are many advantages to growing older. On a personal level, these include: enjoying your retirement and hoping for many disease-free years. Another advantage is the benefit of knowledge, wisdom, or other competencies, acquired. There are several opportunities to contribute to civil society. However, the disadvantages of growing older are increasingly attracting attention. In general terms: care needs and additional health care costs increase. Frailty and cognitive problems often play important roles in individuals. After retiring as an internist at the hospital, I still occasionally work as a consultant in local nursing and care homes. In addition to the usual topics of delirium, infections, and falls, acute medical events are important. This is particularly true in cases of complicated fractures, unexpected clinical deterioration or end-of-life decisions. The issues that arise are well-known: including patient's desires for resuscitation or emergency room care. These matters have often been discussed in advance, but sometimes a grey area remains. This occurs despite the excellent medical guidelines, that have been developed, including those for patients receiving frailty and palliative care.[1–3] Recently, despite my long experience, I realized once again that guidelines and medical advice are very useful tools. However, they cannot be used as practical cookbooks in challenging situations. On the same Friday evening, I came across two geriatric stories that illustrate this point, which I would like to share with the readers of this journal.

Cases

Patient A was a 91-year-old man living in a nursing home with Lewy body dementia. He had recently started immunotherapy for an inoperable melanoma of the scalp, with suspected neck lymph node metastases. With the help of this modern treatment, the tumor decreased in size, the patient's appetite returned to normal. After several discussions with the patient, his wife, and son, palliative treatment was considered. The patient indicated that he did not want to undergo any surgery in the future, and his family agreed. Early on Friday evening, the patient developed nausea, vomiting and low-grade fever. His bowel movements and appetite had been normal until the previous day. On physical examination, his abdomen was tender and very painful. As the patient had undergone abdominal surgery 15 years prior, his presentation was highly suggestive for mechanical ileus due to adhesions. This situation required extensive consultation, which took place with his wife and son. Purely medically, a CT scan of the abdomen and assessment by the surgeon were indicated. After careful consideration, everyone agreed not to send the patient to hospital. Following the initiation of palliative sedation with subcutaneous morphine and midazolam, the patient died peacefully the next day in his own room in the nursing home.

Patient B was a 90-year-old man. He had been in a nursing home for 10 years because of advanced Alzheimer's disease. His medical history included insulin-dependent diabetes mellitus, hypertension and atrial fibrillation. He received several medications, including insuline, cardiovascular pills and full dose anticoagulation (NOAC). He reported feeling restless. He also experienced regular falls, despite adjustments to his medication. Late on Friday evening, he fell again. On physical examination he reported pain on the left side of his face and nostrils . Although fractures could not be fully excluded clinically, there were no sings of dislocation of the altered anatomy. The situation appeared to be manageable with the help of pain relief and close observation. However, the discussion regarding the course of action was difficult. The family persistently demanded an assessment at the emergency department of the neighboring hospital. Adequate monitoring of the patient's condition at the nursing home was not possible, therefore, the patient was transferred tot he hospital. However, he returned to the nursing home within a few hours with a diagnosis of a stable fracture of the nose, that could be treated conservatively. The hospital doctor advised the nursing home staff to follow a no-referral policy in case of future problems. Thwe patient's family members were aware of this recommendation. However, the patient fell again two days later, before the no-referral plan could be discussed. Before this issue can be discussed. This time the patient hit the back of his head. And experienced loss of consciousness and nausea. A palliative care policy was proposed, but could not be implemented based on wishes of the patient's family. The family requested that the patient receive full treatment and not be made aware of his condition. the very last moment. Nor should the approaching death be discussed with the patient. At the hospital, a CT scan of the brain revealed a subdural hematoma with impingement. The patient died one day later in a busy hospital ward.

Discussion

End-of-life consultations require commitment and experience, in addition to medical expertise. These aspects refer to the professional qualities of the care providers. However, the skills of the patient and their family or legal representatives must also be considered. Good conversation has sometimes been compared to walking across a bridge. Each party starts on an opposite and meets in the middle above the water. Listening and understanding are essential. The two cases presented above describe a specific geriatric setting. Two very old men, known with advanced cognitive limitations, were struck by an acute misfortune. They were no longer eligible for admission to the hospital or for surgery, which was clear to the nurses and doctors, including myself that Friday evening. However, the second case illustrates the difficult part of the communicative bridge walk. Determining the course of the patient's medical care was challenging. Medical guidelines can be used to guide patients and their family members in making difficult decisions.[1–4] When applied here, the cautious advice for both patients is understandable. However, medical knowledge and experience did not bridge this gap. In my opinion, the deep conviction regarding the treatment of the second patient led to an uncomfortable hospital stay. In retrospect, the family was very satisfied that everything possible had been done.

Conclusion

The two cases demonstrate that the perspectives of healthcare professionals and families can differ widely. It is wise to start discussions early.[5] Nevertheless, it might happen that differing opinions and beliefs persist. Communication in geriatric medicine: sometimes a bridge too far.

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Conflicts of interest

None.

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