Letter to the editor

Dare to care for the elderly: Five insights

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Care is often limited by patient age due to societal forces concerning expense and successful outcome. A mother's critical illness yields insights into care that worked despite advanced age. The five subsequent insights are viewed against data from randomized clinical trials illustrating how we know what we think we know. From this a healthcare model is proposed that insures a healthier elderly population.

Keywords: Limiting care, Elderly, Risk, Age cutoff, Clinical knowledge

Increasing age is associated with vascular outcomes such as stroke and heart disease as well as cancer and degenerative illnesses. In the United Kingdom, access to hemodialysis for renal failure was initially restricted based upon age (Levinsky, 1993). Intensive care unit admission for older patients occurs less frequently than guidelines suggest and these patients receive less intense treatment (Nguyen et al., 2011). Age cutoffs for care are a response to studies showing that lifetime medical expense is highest near the end of life in an attempt to reduce healthcare expense (Lubitz, Beebe, and Baker, 1995; Spillman and Lubitz, 2000).

In the United States lacking age-specific benchmarks, other factors inform care-limiting discussions. Most commonly such discussions are with family members rather than the patient and driven by specialists who have an inpatient experience with the ill loved one rather than a

longitudinal outpatient relationship. The central theme of these discussions is often whether the patient would want to continue life in their current circumstance as a bridge to a life of greater impairment.

When my mother was critically ill at the age of 83 years with *c. difficile* colitis, fluid resuscitation had produced marked volume overload. With legs the same diameter as her swollen thighs, there was also progressive dyspnea. I was advised that intubation as a bridge to dialysis for fluid management was not recommended. Specialists told me that if she survived then recovery would be prolonged and she might have to go to rehabilitation if she were to ever walk again. Previously, they had advised against oral vancomycin as treatment since the white count exceeded 59,000. I was even told that because of dementia, this might be the time to stop or limit care.

While a pulmonary specialist was telling me these things, another attending

intensivist had reported that when the pulmonologist asked for my phone number, my mother had told him all ten digits through the re-breathing mask. Since my mother's prehospital mental state had been one of an affective disorder, I was surprised to hear it characterized as a degenerative illness.

My mother was intubated and mechanically ventilated for 4 days. Fluid management was successful with dialysis. Afterwards, she went to rehab and was walking within 30 days. This was 6 years ago, now thyroid replacement is the only medication she takes.

I believe that my mother's illness and my experience of her care provide five insights that other physicians might consider useful in similar situations.

First, old people are healthy, that is why they lived to be old. Most individuals are not healthy and die early or prematurely. I wish it was the case that care helped most become old, but that is not the case with care in America.

Second, when old people become acutely ill, then do the simple things. Oral vancomycin is not very difficult to provide and is an accepted therapy for *C. difficile* colitis. Why withhold simple things? If they work, then you do not have to provide more aggressive therapies, and if they do not, then you can have the care-limiting discussion.

Third, do not give up. Since those who lived to be old have been healthy, if they can survive then perhaps those same forces can permit a return of function. Not every old person who is acutely ill is like Humpty Dumpty—never to be put back together again.

Fourth, do not be too certain about how things will turn out. While we read about the natural history of diseases, our experience is shaped by the results of our own care. It is possible that negative outcomes are due to restriction of care or its early withdrawal. What we know is what we have done and its outcome, not truly

the natural history of disease(s). In short our experience becomes our expectation which could have a negative bias.

Fifth, a portion of what we think we know consists of information from other eras or different times. For example, over the past 10 plus years, cardiovascular risk has changed. In 1995 placebo patients in a study of intravenous thrombolysis for acute ischemic stroke had a death rate of 21 percent (NINDS Study Group, 1995). By 2008 in a study to extend the time window for such therapy from 3 hours to 4.5 hours, the placebo group had a death rate of 8.2 percent (Hacke et al., 2008). The highest risk subjects have died in the interval years and the surviving population has lower risk. Part of the current lower risk is Darwinian and some may be care. At least I hope for the latter. As death has become less frequent in clinical trials, it is no longer an examinable endpoint.

Rather than finding a way to justify limiting care because of its expense, an alternative programme focuses on the value proposition in medicine: to save lives cheaply. Prevalent preventable conditions are identified and treated in younger populations. When coupled with stewardship programmes that increase social capital, programs of lifetime care should insure a healthier aging population. I am not persuaded that there is any other way forward.

REFERENCES

- Hacke, W., M. Kaste, E. Bluhm, M. Brozman, A. Dávalos, D. Guidetti, V. Larrue, K.R. Lees, Z. Medeghri, T. Machnig, D. Schneider, R. von Kummer, N. Wahlgren, and D. Toni. 2008. Thrombolysis with alteplase 3 to 4.5 hours after ischemic stroke. *New England Journal of Medicine* 359: 1317–29.
- Levinson, N. 1993. The organization of medical care. *New England Journal of Medicine* 329(9): 1395–9.

- Lubitz, J., J. Beebe, and C. Baker. 1995. Longevity and medicare expenditures. *New England Journal of Medicine* 332: 999–1003.
- Nguyen, Y.-L., D.C. Angus, A. Boumendil, and B. Guidet. 2011. The challenge of admitting the very elderly to intensive care. *Annals of Intensive Care* 1: 29.
- NINDS Study Group. 1995. Tissue plasminogen activator for acute ischemic stroke. *New England Journal of Medicine* 333: 1581–7.
- Spillman, B., and J. Lubitz. 2000. The effect of longevity on spending for acute and longer-term care. *New England Journal of Medicine* 342: 1409–15.

BIOGRAPHICAL NOTE

A. S. Callahan III was born in Columbus, GA. He received his SB degree from MIT

in 1971. At Vanderbilt Medical School he was a Justin Potter Scholar, member of AOA and graduated in 1975. After training in internal medicine at Vanderbilt, he completed his neurology residency at Massachusetts General Hospital and fellowship at Harvard Medical School. His research interests include stroke prevention and treatment, integrated vascular medicine and care of vulnerable populations. He is a member of the steering committee of the SPARCL trial (secondary stroke prevention). These efforts have resulted in eighty publications in peer reviewed journals. He and his wife Helen have been married for forty-four years with two children and four grandchildren. His main avocational interest is sailing. His email address is stealthasc@earthlink.net