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Some Thoughts on Intensive Care for Elderly Patients at the End of Their Lives



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Over the last decades, increasingly more elderly and often chronically ill patients are being cared for in hospitals during the last weeks or months of their lives. "Elderly patients" in this article refers to patients above 65 years of age. There are other cutoff ages used, yet with regards to treatment options and prognoses, the numerical age of elderly patients is less influential than their biological condition – as mirrored by their previous health as well as their mental and functional status. The elderly are the fastest growing age-group worldwide, and the increase in hospital treatment of elderly is due, amongst others, to this global demographic change towards ageing societies, the implementation of public health policies, for instance regarding certain vaccination programmes, improved sanitation and better availability of adequate nutrition, as well as medical and technological progress (World Health Organisation). Furthermore, there is also a societal trend towards transferring birth and death from the home environment to institutional environments. Allegedly, the majority of elderly would prefer to die at home, however, a minority really does.

When elderly patients are being treated in hospitals, the predominant and primary intention of the healthcare team is to improve or at least maintain their quality of life. This is often achievable by comparatively small measures, such as exchanging one drug for another to minimise side effects, prescribing an antibiotic to overcome an acute infection or supporting daily activities through the help of medical home care services. If their vital functions are threatened or compromised, however, elderly patients usually need to be treated invasively in specialised units, such as cardiac care or intensive care units (ICUs).

The primary task of intensive care medicine is to temporarily treat patients whose vital functions are compromised with the intent to stabilise or restore those functions, so that the patients can continue their lives at their prior level of independence. Owing to the achievements of medicine and medical technology, disrupted vital functions can be sustained for a comparatively long time these days by invasive measures, especially in ICUs.

The fundamental question regarding an intended invasive treatment is, whether the respective individual patient can thereby expect mitigation of or even cure his/her ailments and whether subsequently a restitution to his/her prior health status or at least to a quality of life acceptable for him/her can be achieved (Michalsen 2008). In the elderly, prognostication of the medical course often is more difficult than in other age groups; also, age-specific benefits and burdens of treatment need to be taken into account. If there is a realistic chance of restitution for the individual patient under the circumstances prevailing, then intensive care treatment appears warranted – provided that the patient gives his/her informed consent. Unfortunately, knowing an elderly patient's own preferences and choices can be very difficult (Nelson and Nierman 2001). Perhaps treatment is also justifiable, if a decision cannot be deferred due to urgency, even though there is insufficient information about the patient at that time. But if there is no realistic chance for benefit, then the indication for intensive care therapy needs to be reviewed. The pure availability of intensive care treatment modalities does not justify their general usage – they must benefit the individual patient in question (Michalsen 2008; Strätling and Schmucker 2005).

In daily practice, this rather puristic directive of treatment application is not always implemented for several more or less comprehensible reasons. For instance, there is insufficient clarity as to whether the patient has given or is able to give informed consent; there is variable interpretation of his/her living will; there is insufficient clarity as to the potential benefit of the intended invasive measures; there are conflicts amongst staff or between staff and family as to the goals and the extent of treatment; there is fear of litigation; there is insufficient knowledge of the respective legal stipulations amongst the treating physicians; there is a variability of values and beliefs amongst the healthcare team and/or the family; and there is insufficient knowledge about widely accepted ethical principles and ethical reasoning amongst staff (Michalsen 2008; 2007; Nelson and Nierman 2001; Sprung et al. 2003; Beauchamp and Childress 2001).

Each of these reasons to implement or continue non-beneficial life-sustaining therapies would merit a more comprehensive discussion beyond the scope of this article. Based on the four well-established ethical principles – non-maleficence, beneficence, respect of the patient's autonomy, and justice (Beauchamp and Childress 2001) – the following general approach regarding decisions on intensive care treatment for elderly at the

end of their lives can be recommended to healthcare teams:

1. If a patient is capable of decision-making and does not give his/her informed consent, then treatment is not justified.
2. If a patient is incapacitated and if his/her wishes and choices cannot be ascertained otherwise, for instance through a living will, then a statement by a legal representative of the patient must be sought (according to the prevailing legal stipulations).
3. If there is insufficient information on the patient's medical history, present health status or prognosis and if treatment is urgent, then treatment may well be justified – at least, until more information is available.
4. Numerical age alone generally does not preclude treatment (Nelson and Nierman 2001).
5. If treatment is warranted, then it needs to be implemented timely and appropriately. If treatment is not warranted or if treatment does not prove beneficial after implementation, withholding or withdrawing treatment are acceptable alternatives (Michalsen 2008; Strätling and Schmucker).
6. Concurring with the principles of shared decision-making and family-centred care, the patient and his/her family need to be informed about and involved in the treatment process as comprehensively as possible (Michalsen 2008; Fassier and Azoulay 2007; Evans et al 2009).
7. Conflicts amongst the healthcare team or between the team and the family need to be acknowledged and dealt with pro-actively. An open communication strategy especially with regards to the patients' values and wishes as well as to truthful prognostication is a very important means to solve conflicts and move forward – as is the willingness to build consensus. If a conflict appears to be insurmountable for the healthcare team, then it may be helpful to ask an ethics committee for advice (Michalsen 2008; Fassier and Azoulay 2007).

In the future, many more elderly will seek and require intensive care therapy. It does not appear justified to preclude them from invasive treatment at the end of their lives on the mere basis of their numerical age. But it does not appear justified either, to apply or continue life-sustaining technology without a realistic chance of benefit. Therefore, after weighing age-specific benefits and burdens of the proposed intensive care treatment for each patient individually, in some patients it will not be implemented, and in others it will fail. In both scenarios, the treatment goal will have to be changed from curative to palliative care. It needs to be remembered, though, that patients do not die from withholding or withdrawing non-beneficial treatment – they die from the underlying diseases. And perhaps, some can still die at home.

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