



Hope. A Plan. And Peace of Mind

What makes life worth living?

What is the most important issue for a doctor to address when meeting a frail elder? Is it blood pressure or cholesterol? Their memory or weight? I have found that while these are important issues, the number-one issue is almost always something much simpler, and much more profound: For this person, what makes life worth living?

The answer to this one question directs ALL future care. It deserves a closer look.

As one ages, and inevitably becomes more frail, medical problems arise. Many of these can be worked up completely, and treated aggressively. However, Nature always balances her books. Proactively and intensely working up a condition exacts a price. The question for us in the medical field in these situations is, "What am I accomplishing by this workup? Am I making things better, or am I making them worse, according to what the patient wants? It's a very tricky question sometimes.

Here's an example: Anne is an 83 year-old woman with advanced dementia. She recognizes familiar people -- her family, the staff at her facility, and so on -- but has no idea of the time or place and needs help with all areas of her personal care. She has a diligent physician who has placed her on medications for her blood pressure and for high cholesterol.

What makes life worth living?

What would my loved one want?

How will proposed testing help mom now?

How will proposed medication help mom now?

What risks and side effect are involved with meds or interventions?

Have we had a family discussion about these issues, so everyone is in agreement?



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He also sends her for yearly mammograms. Because of her dizziness, he has ordered fairly invasive tests and an MRI and found she has clogged arteries to her brain. He is advising that she have a surgical procedure to unblock these arteries.

This approach sounds reasonable. However, in a frail population, particularly with dementia which itself is life-shortening, there may not be a benefit to these interventions -- and often they can cause harm. When it comes to the health of a loved one, particularly an elder, our natural instinct is to do all we can. But this is not always a good idea.

It may not be in Anne's case.

The mammogram. Dr. Louise Walter has shown that for many cancer screening tests, there is no survival benefit unless the person being examined has a high likelihood of living for at least another decade. In general, mammograms are advised until the age of 70-75 for otherwise healthy women. When dementia is diagnosed, on average women live for 7 more years. Men live 4 more years. Mammograms are uncomfortable. Many people with dementia do not even like bathing. For these patients, being undressed by someone, especially a stranger, then having their breast flattened in a vise is very alarming. And statistically, it's pointless.

The medications. These can be useful. Even if someone is frail or has dementia, preventing a stroke can improve daily quality of life. This is what the blood pressure medication is intended to do. However, elders over 85 are found to do better with slightly higher blood pressure. And as one loses weight, medications can decrease pressure below the desired 130/80 and lead to dizziness or low blood flow to the head and body. This should be watched closely.

Cholesterol lowering medications (statins) help decrease the risk of heart attack and stroke, but over the course of months. The number of strokes prevented per 1000 patients treated for 5 years in patients with CHD

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(coronary heart disease) is 9 for statins, compared with 17.3 for antiplatelet agents (such as aspirin). Statins have not yet been shown to reduce stroke risk in the typical general population without known CHD, nor have they been shown to prevent recurrent stroke in patients with prior stroke. They can have side effects, too, such as liver inflammation and muscle weakness.

If one is very frail, eating little or has very advanced dementia, with a life expectancy of months, these medications can cause symptoms that can make the patient feel worse. The bottom line: if one has coronary heart disease risk factors and is otherwise doing well, they should take statins (with their doctor's direction).

If one is frail, not eating well, not functioning well, and has a poor prognosis, statins may not help survival and may lead one to feeling more poorly.

The artery blockage. This is the most concerning. As things stand, Anne's condition is stable. Her arteries are blocked, but she is walking and interacting fairly well. If she goes into the hospital for a surgical procedure, she may have more complications and become sicker sooner than had she had no intervention. There are several ways this can happen.

First, simple bed rest itself can lead to problems. There is a 5% muscle mass loss daily in elders who stay in bed. In 10 days, Anne would lose 50% of her muscle mass and might not walk again.

Second, those with more advanced dementia are at higher risk for delirium from transfer from their familiar environment to the hospital, independent of the illness. Even if Anne does understand the purpose of the care in the hospital, the environment there may frighten her. Many perfectly lucid patients of all ages fear hospitals. In an elder suffering from dementia, this fear can lead to serious trouble.



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If the hospital frightens Anne, she is likely to pull out tubes, monitors, and thus be restrained (hands tied down) and given sedating medications.

These can lead to infections, pressure ulcers, aspiration, and blood clots from her immobility. Simple admissions for bladder infections, when one is demented and at higher risk for delirium, can lead to death within 3 weeks or less for this reason.

Third, as with any medical procedure, there is always a risk of medical complications such as infections from the hospital or complications of the procedure itself, that can lead to decline. This can happen to patients of any age, but because of their increased frailty, elders are more susceptible to problems than younger patients.

In short, for any intervention for a frail or demented person, the first question is: How will this make their lives better now? Given their shorter life expectancies, the long-term effect of many procedures and conditions may be of lesser importance. Weighing the various risks against equally various benefits is never easy, and typically, the decision is guided by an understanding of the patient's priorities, values and beliefs. If the family knew that Anne hated hospitals and never wanted invasive treatments, it would be clear that she would not respond well to those interventions now. If she became sicker, having hospice care for her in her familiar environment with her familiar caregivers would be less frightening than being in a hospital.

What makes life worth living is a question for all of us. Each patient's answers will be different – and critically important. We owe it to our family and loved ones to tell them what matters to us in advance. Make your wishes known. It is much less heart-wrenching to do what you *know* your father would have wanted, than to have to make life-and-death decisions in a crisis with no guidance.