
Geriatrics and palliative care: the best of both worlds ...

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Managing and comforting a terminally ill patient most of the time means managing and comforting an elderly person at the end of life.

Geriatricians and healthcare professionals in palliative care have complementary approaches that can only enrich each other. But from this interaction, there arises the hope that palliative care and geriatrics will jointly contribute to the improvement of the care and comfort of patients whose prognosis is not necessarily shortened.

Beyond the 'curative-palliative' duality, beyond continuous care, there now appears the concept of supportive care, and this is a real challenge.

Geriatrics has often benefited palliative care in European countries, especially in France, but palliative care has often provided geriatrics with an opportunity for renewed dynamism. Geriatrics has helped to enlarge the scope of palliative care, which, for a long time, had been confined to cancer patients. This enlargement has fostered further thought in palliative care, particularly with regard to prognosis (the notion of a three-month life expectancy is now obsolete), multiple pathologies, the absence of verbal communication and a protracted dying process.

In the same way, palliative care has also had a significant impact on non-palliative geriatrics, in particular on the management of pain and symptoms. That is just one aspect of the creative interaction between these two fields of medicine. We are now going to see a few concrete examples in the realm of sociology, the philosophy of care, organisation, somatic and psychological management, and ethics.

Sociological aspects

End-of-life care is, most of the time, the provision of care for elderly patients at the end of life: three-quarters of deaths occur after the age of 65; two-thirds after 75; and even one-third after the age of 85. However, as Renée Sebag-Lanoë reminds us, old age should not be a criterion for access to palliative care. What is important is pain management, together with the provision of comfort for patients and their family circle; it is 'to respect their death when their life can no longer be maintained'.¹ We urgently need to improve the circumstances in which older people die.

But it has to be admitted that resources are insufficient, regarding both staff and equipment. Moreover, the refusal to confront old age and death does not facilitate access to palliative care. What is more, 'traditional' geriatrics does not always give optimal relief to terminally ill patients with dementia, and palliative care units are

not used to managing patients with cognitive and behavioural problems.^{2,3}

Another aspect of the problem is the part played by the social community in caring for geriatric and terminally ill patients. In this case what is best is rather to be found in the palliative world, where well-meaning but incompetent volunteers have been changed into carers with a real status – into people who have been selected and trained, and are supervised. In geriatric wards, voluntary work is still too often in need of evolving towards what Dame Cicely Saunders has called a 'therapeutic community'.

The philosophy of care and organisation

Autonomy

Geriatrics stresses the importance of doing (such as the ability to walk, to wash and eat by oneself), whereas palliative care is rather focused on being. Being autonomous is to be ruled by one's own choices, but doing and being can be combined so as to avoid both fatalism and overtreatment.

Continuous care

Alzheimer's disease embodies the concept of continuous care perfectly and illustrates the duality of palliative and curative care. On the one hand, it meets the various criteria for palliative care. On the other hand, though the disease itself is incurable and has a course which is difficult to predict, with a protracted dying process, there are additional but curable pathologies which must be treated so as to improve the prognosis and the quality of life of these patients.

In palliative care, and particularly in cancer cases, it would be possible to follow the same procedure: cancer patients need not wait until the very end of life to benefit from palliative care! Thus, there now appears the concept of supportive care for such patients. Such treatment should be discussed within the framework of a multidisciplinary team and explained to the patients and their families. May one dare to say that, as a rule, patients suffering from dementia and wanting to be managed by a palliative care unit ought to remember to develop some form of cancer?

Accessibility of palliative care

Though geriatrics has long taken on board the concepts of a comprehensive approach, of multidisciplinary teamwork and of continuous care, it has not often been able to acquire the means of attaining these goals. Palliative care units, however, not only quickly adopted such an approach but were also able to obtain the necessary means for its implementation, regarding both staff and equipment.

Geriatricians are often like kindly nuns: they are precursors but not always, alas, able to put their ideas into effect, though there are exceptions. But it must be said that the main problem is probably the cost of care, and, therefore, a political and economic issue. One may wonder whether palliative care is only accessible mainly to those who undertake to die quickly.

The availability of palliative care is still restricted for people with dementia, in particular because of an uncertain prognosis.⁴ A protracted dying process is costly, and elderly people are 'too' numerous.⁵ Therefore, the risk of a drift towards economic euthanasia is a real one and it is urgent to realise this, to denounce it and to find ethically acceptable solutions.

Specific somatic characteristics

This is another area of healthcare in which the contribution of geriatrics (especially in the sphere of evaluation) can be usefully combined with that of palliative care (especially with regards to optimal pain control and the relief of other troubling symptoms).

Rating pain

Self-rating of pain has long been used in palliative care, and the unmasking of pain in patients that cannot communicate verbally has greatly progressed with the creation and validation of behavioural scales (called 'heteroevaluation'). This strategy has been initiated in paediatric oncology by Annie Gauvain-Piquard⁶ and pursued by geriatric research, a well-known example of which is the DOLOPLUS scale.⁷ This work has fostered more research, such as the DESS grid for poly-handicapped patients, and it should encourage even more research with comatose patients or those with psychiatric illnesses.

Hydration and feeding

Palliative care has carefully analysed thirst and demonstrated the usefulness of adequate mouth care, while geriatrics long ago developed the use of the subcutaneous route. By combining these two approaches, one can avoid 'useless tubes' and ensure both somatic and ethical comfort simultaneously.

Regarding food, geriatricians have, for a long time, suggested convivial meals, cooking workshops, or outings to restaurants. But, in spite of giving careful consideration to the matter, geriatric hospitals still serve only too frequently the 'splatsch' so vehemently censured by Charles-Henri Rapin,⁸ whereas palliative care units have been able to acquire appropriate resources in this domain and have resolved the problem.

Management of pain and other symptoms

For over 30 years, palliative care has been at work and has proposed protocols that are more and more diversified, personalised and efficient for the management of the painful symptoms that occur at the end of life. Fortunately, geriatricians have also been able to make use of them in order to improve the care given to elderly people at the end of life. However, what is remarkable is that they have been able to adapt them for the benefit of older and very frail patients at the end of life, while also offering them to

elderly people without the pathologies that come under palliative care.

This is a major contribution of palliative care to the wellbeing of patients whose prognosis is not shortened: one may thus expect comfort without having to die quickly.

Specific psychological characteristics

No pain hierarchy

Losing a young child, a friend, a father or a grandmother, whether because of cancer or Alzheimer's, is a separation, and every separation deserves attention, compassion and comfort.

Age and aetiology have repercussions on the way to help and give comfort but not on the importance of the trauma produced by the separation. We should be careful not to establish a hierarchy of the different sorts of pain!

Protracted death

With the very elderly, however, we are often confronted with the special circumstance of a protracted dying process.^{9,10} One might imagine that the death of a 95-year-old person is something to be expected, even prepared for, and yet what really happens is quite different. Even at that age, the indicators of prognosis can remain very uncertain, predictions can be off the mark, and doubt is perpetually fuelled. While the 70-year-old children who watch over their mother become worn down by such a protracted dying process (which can finally seem meaningless to them), the mother is herself worn down by the long wait for a death that refuses to come.

These are situations in which one must learn to be content with simply being without always wanting to do something. One must learn to recognise the problem instead of denying its existence and one must know how to give comfort, especially by availing oneself of the different forms of non-verbal communication.

A protracted death must be seen as a slow shedding of garments, and when the underwear of life is reached, then the person's modesty, their individuality and their dignity must be respected.

It should be explained to all those around the person – in particular to the family and the volunteers – that they must understand this and agree to release the patient's hand so that the dying person can also let go, cast off and allow the boat sail towards other shores.

Elderly people, who have gone from one bereavement to another, who have experienced loss and renunciation, wounds and scars, already know what separation is and they have a kind of serenity in the face of death. This is not the case with adults or young patients. Taking care of elderly women and men over such lengthy periods is a truly educative experience for all carers and family members who are willing to learn from such lessons of life.

Communication is always possible

The absence of communication, which is felt in geriatrics, is often merely a pretext to protect oneself from a relationship that is frightening because it is strong and bonding. The end of life is not simply an accumulation of losses and deficiencies; not only are the person's emotions and creativity unimpaired but they are also frequently enriched by the manifold experiences of life. Once freed from

physical discomfort, the elderly person will be able to communicate, even with dementia or aphasia, motionless and even when comatose.

Absence of communication can only be due to the carer, who excludes himself or herself from the relationship by hiding behind the concept of digital communication, and by forgetting the existence of analogue communication. In the latter, it is impossible not to communicate. Indeed, our sensory functions compel us to remain related to others, whether we want to or not – at least in the non-verbal register. The expression in our eye, our bodily posture, our behaviour, the way we dress, our smells, the rhythm and the tone of our voice, all these relate us to other people.

Thus, we can remain human to the very end and thwart any temptation towards euthanasia.

Music therapy, art therapy, massage, reading, listening and simply being present are all ways that enable us to avoid fatalism. They help us to express clearly our desire to assert the claims of life while respecting otherness, our wish to communicate until the last breath, to relax dying patients, that is to say to make them free.¹¹

Ethical issues

Geriatric palliative care frequently raises ethical issues about the boundaries between curative, palliative and useless care. In this case, deviation towards euthanasia is either concealed under the guise of 'ethical cocktails' or, on the contrary, very crude. The specific difficulty comes, above all, from the fact that it is frequently impossible to share the decision with the patient.

Cognitive impairment and the absence of verbal communication make such decisions difficult, even hazardous. Caring is less rewarding, at least in the first instance: there are no wonderful reconciliations and no family reunions round the patriarch. But vulnerability implies ethics. Moreover, because the patient is so vulnerable, there is clearly an ethical problem.

We must, however, accept this state of things and assert that, in spite of appearances, no human being is ever a 'cabbage' or a 'pot plant' simply because their brain no longer functions 'normally'. We should trust in a renewal of courage and mind to make up for somatic deficiencies, and this will enable us to approach patients who suffer from a breakdown in communication and those unable to defend themselves.

Geriatrics has opened routes that have also been enriched by palliative care; this has been done, particularly with the management of terminally ill neurological patients; for instance, those suffering from

Charcot's disease. The care and comforting of a patient with amyotrophic lateral sclerosis (ALS) (90% of whom, we must remember, retain their superior functions unimpaired) require information, proposals and foresight, but never imposition, and the same attitude is required towards those around a person with impaired cognitive faculties, especially the family. The complex decision to place a gastrostomy feeding tube, to continue blood transfusions or dialysis or to operate on arthritis at an advanced stage requires prudence and thoughtfulness, and they should even be shared. But, at the end of the road, it is nevertheless the physician who must endorse the decision as the patient's family needs support without being overburdened with responsibilities.¹²

Conclusion

The dignity of a society can be measured by its concern for the most destitute of its members, among those are quite obviously the elderly at the end of life. Both healthcare professionals in palliative care and geriatricians have greatly contributed to easing the very delicate passage from life to death, and making it more bearable.

It is, however, much to be deplored that our society offers quality of life only to those that are nearing its end, and we must bear in mind that not everyone has access to it. Beyond the duality of curative treatment and palliative care, beyond the concept of continuous care, the time has now come to develop the concept of supportive care. The best of all possible worlds is still to be built ...

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