Doing “Everything” for the Terminally Ill Older Person

By Joseph H. Flaherty, M.D.

“I want everything” said the 65-year old woman with metastatic lung cancer. She was just admitted to your hospital with dehydration and pneumonia. On exam, she is cachectic, she is weak, but she is alert and oriented. She is in mild respiratory distress, breathing at the rate of 24 per minute. She has a 6 centimeter axillary mass which she says has been growing recently. She weighs about 80 pounds. It is clear from her records and the consultants you have spoken to that there is no further treatment. No chemotherapy. No radiation therapy.

You ask her, “Do you want us to use machines to keep you alive.” You go further, “Even if there is a lot of suffering involved and even if there is a chance that you won’t regain consciousness?” She hesitantly but clearly says, “If it keeps me alive, that’s ok.”

You think about the following options that you have as a clinician. 1) Keep trying to convince her not to be a full code. 2) Consult psychiatry about competency. 3) Call an ethics consult. 4) Transfer her care to another doctor because you don’t think it is right to put this woman through something like a resuscitation effort.

As you walk out of the room, you (continued on page 2)
Doing “Everything” for the Terminally Ill Older Patient
(continued from page 1)

Forget about all those things as you think about the look on her face. Something is wrong. You ask yourself, “Why, why does she want all this?”

Your other patient, a 74 year-old man with prostate cancer diagnosed 4 years ago, is admitted to your hospital with severe weakness and he has not been eating or drinking. On exam he is thin, pale, and tachycardic, but like your first patient, he is alert and oriented x 3.

Fortunately, you find something to treat by discovering that he is anemic with a hemoglobin level of 6.5 mg/dl. Endoscopy, upper as well as lower, is negative for any bleeding, but nonetheless, you transfuse him and he feels a little stronger. In the process, a bone scan reveals metastatic lesions in the ribs and his left hip, both places where he has pain. Again, your consultants tell you, “There’s nothing more to offer except palliative care.”

You go into the patient’s room where his wife is sitting with him and you discuss the topic of hospice. You explain how much hospice will help and you think in the back of your mind how much the hospice people are going to help you in the care of this man as he becomes sicker and sicker, especially with his pain control issue. The patient and his wife are familiar with hospice as they had a friend who was in hospice about a year ago. They surprise you and ask you if you think that he only has 6 months to live. You fumble for words, when all of a sudden the husband looks at his wife, looks back at you, and says, “I don’t need hospice right now.”

You bring up the issue of code status and the patient sits up on the side of the bed and says, “Doc, I want to keep trying. I want to keep going as long as I can. I want you to do everything.”

As you walk out of the room, you think about those 4 options that you as a clinician have, just like with your other patient, and then you come back to that question again, the “why” question. Are these patients being unreasonable, you wonder? Maybe they just don’t understand. You ask yourself if you explained things properly. The doctor questions are soon overshadowed by your curiosity in both of these patients.

You go back to the first patient. You sit down and ask her, “Ma’am, why do you want everything? Why do you want to live as long as possible?” Her response will soon make everything crystal clear and will guide you as the clinician in how to take care of this patient. She looks up at you and says, “My husband died 6 months ago. My house is the only thing I have left, except my son.” She pauses then looks up again, “My son is in prison and there is a chance he will get out in about a month. If I die before he gets out, they tell me my house will go to the state. If I live long enough and he gets out of prison, I will be able to give him one last thing in life, my house.”

Later that day, curiosity gets at you again and you go back to your patient with prostate cancer. His wife is not in the room so you ask him, “Sir, why do you want to keep going? How long do you want to keep going?” He sits up on the side of the bed again, like he did that morning, looks at you straight in the eye and says, “Doc, my wife and I have been married 49 years. Next spring is our anniversary and that anniversary is 9 months away. I can’t take hospice because I know I’m going to live at least 9 more months.”

The questions you asked today were the most difficult ones you had ever asked a patient.
thought. “Those weren’t part of the history questions I learned in medical school. I had never seen other doctors ask these questions.” However, the “why” question and the “how long do you want to live” question would make all the difference in the world.

You are able to contact the prison about your patient’s son. They tell you that he is not going to get out in a month and it may be a very long time before he is released. After explaining this to your patient with lung cancer, she cries, yet she understands and realizes that she had misinformation from someone about her son. She is able to make plans for the end, and she admits to you that she was afraid to suffer through all those things you talked about, and now, she is very accepting of the natural course of events. She dies 3 weeks later of a second pneumonia, peacefully, without being resuscitated.

Your patient with prostate cancer goes home with his wife with regular home care visits by nurses and therapists. In the beginning of the year, in January and February, he becomes weaker. His anniversary is in May, so at this time you institute hospice with the agreement of both the patient and his wife. He actually becomes a little bit stronger after the hospice nurses get involved. He makes it through his 50th wedding anniversary and dies in July at home with his wife.

Mrs. Josephine D. is a 73 year-old woman who is very quiet, yet strong-willed. She is the matriarch of her family, having lost her husband many years ago. She has five daughters and one son whom you get to know very closely as the course of her illness progresses. In November 1997, she had a nephrectomy for renal cell carcinoma and was told, “They thought they got it all.” In April 1998, she was admitted for an upper GI bleed. On endoscopy, there was a lesion in the duodenum which was biopsied. This showed metastatic renal cell carcinoma. Both GI and Surgery were consulted and told you, again, that there were no options except to transfuse and treat symptomatically. You go to the textbook and find that the 5-year survival of stage IV renal carcinoma is less than 5%. However, this doesn’t help you very much. Mrs. Josephine D. looks fairly healthy and except for being weak, she has no pain, shortness of breath or mental status changes.

She is readmitted later in April 1998 and transfused again. In May, she is admitted twice for blood transfusions. In

To Those I Love and Those Who Love Me

When I am gone, release me. Let me go. I have so many things to see and do. You musn’t tie yourself to me with tears, Be happy that we had so many years.

I gave you my love, so you can only guess, How much you gave me in happiness.

I thank you for the love you each have shown, But it’s time I travel alone.

So grieve a while for me, if grieve you must, Then let your grief be comforted by trust. It’s only for a while that we must part, So bless the memories within your heart.

I won’t be far away, for life goes on, So if you need me, call, and I will come. Though you can’t see me or touch me, I’ll be near.

And if you listen with your heart, you will hear, All my love around you soft and clear. And when you must come this way alone, I’ll greet you with a smile and open arms, and say “Welcome Home!”

Questions? FAX: (314) 909-0443
5. High glucose levels result in a person having a higher perception of this modality.
8. This insulin is more rapid-acting.
10. This thiazolidinedione has a vitamin E moiety attached to it.
11. The receptor system most affected by thiazolidinediones (abbr.)
12. What needs to be monitored in persons receiving thiazolidinediones.
14. This is a drug that slows glucose absorption.
15. The trade name for pioglitazone.
17. Trade name for troglitazone.
19. This glycated protein can be used to determine diabetic control over a few weeks.
21. In thin older diabetics, insulin secretion is ___.
22. Insulin is produced from the ___ of Langerhans.
25. Diabetics are often deficient in this trace mineral and this can retard wound healing.
26. This drug blocks fat absorption.
27. Kind of obesity associated with the development of the metabolic syndrome.

1. In the UKPDS study, this anti-diabetic drug reduced death.
2. The UKPDS study demonstrated that the best outcomes were obtained when this was treated.
3. The type of coma experienced by many older, type II diabetics.
4. Diabetics often have low levels of this cholesterol.
6. Two-thirds of all of these occur in persons over 65 years of age and two-thirds of these persons are diabetics.
7. A non-sulfonylurea oral agent that increases insulin release.
9. A psychological condition that increases hospitalization and deaths in older persons.
13. Diabetics over 65 years have ___ deaths than non-diabetics.
16. Up to the age of 75, these are 2.5 times more common in diabetics than non-diabetics.
18. Metformin produces this kind of acidosis.
20. Older diabetics usually do not have abnormal regulation of glucose in this organ.
23. Function in older diabetics is ___ than in other older persons.

**Puzzled?**
The answer is on page 19.
Not too long ago, if you entered the word “geriatrics” on any Web search engine (GoTo, HotBot, Yahoo, etc.) the browser robot didn’t find too many choices, mostly academic medical center department listings. But today, pages and pages of selections appear. They fall into three categories: medical center geriatrics departments, government sites and professional organizations oriented to senior living and gerontology. Here are a few that stand out:

The American Physical Therapy Association website has a consumer information area for the aging adult: [http://www.geriatricspt.org/](http://www.geriatricspt.org/) then click on Consumer Information About Physical Therapy and the Older Adult.

In addition to listing geriatric certified specialists, the site provides For the Young at Heart, exercise tips for seniors; Taking Care of Your Back; and You Can Do Something About Incontinence. Just click the links on the site. The site also lists other resources available in hard copy, rather than online.

The Merck Manual on Geriatrics is an encyclopedic, fully searchable resource. While geared toward the professional, the determined health consumer in search of important information will find it here, though they might have to keep a medical dictionary nearby to understand what they are reading.

[http://www.merck.com/pubs/mm_geriatrics/](http://www.merck.com/pubs/mm_geriatrics/)

Another Canadian site, QEII Geriatric Internet Resources, located at [http://www.geriatrics.halifax.ns.ca/](http://www.geriatrics.halifax.ns.ca/) also offers an extensive collection of geriatric links.

The Novartis Foundation for Gerontology has a very beautifully designed, easy to use, and comprehensive site, [http://www.healthandage.com/](http://www.healthandage.com/). It is filled with much valuable information, organized for three audiences: physicians and researchers, other healthcare professionals and consumers, though you do not need a password to enter any area.

For each audience, the site is then further subdivided by eight areas of interest: Alzheimer’s Disease, cardiovascular system, depression, diabetes, incontinence, mobility, nutrition and fitness, and other topics. In wonderful contrast to the well known and heavily-advertised health consumer sites, the Novartis site clearly distinguishes between the content appropriate for the professional and the consumer and, as a result, both audiences will find information that will be useful to them as they face or treat these common problems.
Dr. John E. Morley presented a talk on the special aspects of diabetes in boomers and older persons at the American Diabetes Association’s 47th Annual Post-Graduate Assembly in Hawaii. He started out by stressing that the majority of diabetics are over the age of 60 years and that over the next decade as boomers move into this age group, diabetes will truly become a disease of the elderly. It is now well established that many physicians are “sugar blind” and that over a third of older persons with diabetes do not have the diagnosis made.

The United Kingdom Diabetes Prospective Study (UKPDS) has provided clear guidelines for the management of boomers with diabetes (Fig. 1). This study showed that even with an aggressive attempt to maintain HbA1C levels below 7%, this is extremely difficult and that over time HbA1C levels tend to increase. The overwhelmingly most important finding of this study was that treatment of hypertension in middle-aged diabetics resulted in not only a decrease in mortality, but also in a decrease in microvascular complications. Beta-blockers were as effective as ACE inhibitors at producing this effect. Metformin in obese middle-aged diabetics decreased mortality, myocardial infarction, and microvascular complications. Sulfonylureas and insulin only decreased microvascular complications.

He then pointed out that the management of diabetes in boomers required attention not only to blood glucose levels and blood pressure, but also to multiple other concomitant diseases. The sword of Damocles of middle-aged diabetics is myocardial infarction. Aggressive primary and secondary prevention of risk factors for atherosclerosis is a key component of diabetic management. Not smoking, exercise, anti-platelet medica-
tion, beta-blockade, cholesterol lowering, and ACE inhibitors when persons have systolic hypertension and dysfunction are all components of the management of diabetes. The US trial demonstrated that diabetics had a greater reduction in cardiac events with cholesterol lowering than did non-diabetics.

With the increase in obesity in general, and visceral obesity in particular, at middle age, we are hearing more often the funeral music of the deadly quintet or Metabolic Syndrome (Fig. 2). This syndrome occurs because of the negative effects of peptide products, e.g., TNFα and leptin, produced by adipocytes. These lead to insulin resistance and hyperinsulinemia. The components of the Metabolic Syndrome are diabetes, hypertension, hyperuricemia, hypertriglyceridemia, altered plasminogen activator inhibitor-1, and other pro- and anti-coagulants (decreased HDL, increased LDL and low dense LDL).

Dr. Morley then turned to the problems of diabetes in older persons. Diabetes accelerates the aging process, making the average person with diabetes 10 years older physiologically than their chronological age. Many older persons with diabetes are not overweight, have poor insulin secretion, do not have excessive hepatic glucose production, have less insulin resistance than that present in older obese diabetics, and have decreased noninsulin mediated glucose uptake. Ten percent of older diabetics have antibodies to islet cells similar to those seen in young Type 1 diabetics. Dr. Morley suggested that this represents a new type of diabetes situated in the twilight zone between Type 1 and Type 2 diabetics, and therefore appropriately called, Type 1½ diabetes. Fig. 3 represents the spectrum of diabetics over the lifespan.

Dr. Morley then highlighted the fact that diabetes in older persons

Medical Students Have Article on Geriatric Textbooks Published

“I offer no apology for the publication of this volume. The subject [geriatrics] is one of the highest importance, and yet it has been strangely overlooked during the last half-century by the Physicians of all countries.” -George E. Day

Peter Chase and Kathleen Mitchell, medical students at Saint Louis University, along with John E. Morley, M.B., B.Ch., recently authored an article reviewing some of the major early geriatric textbooks of the last two centuries. Among the more important books is one by George Edward Day which appeared in 1849. The students’ article was published in the Journal of the American Geriatric Society 48:89-94, 2000. Congratulations to these students!
The Glidepaths Are Coming!

As we reported in Vol. IX, No. 2 of Aging Successfully, Glidepaths are a novel approach to developing critical pathways for disease management in older persons. This concept recognizes that different approaches to disease management are appropriate for the frail older person compared to the robust older person. Similarly, persons with dementia and those who are at the end of life will benefit from alternative strategies to enhance quality of life.

Saint Louis University has joined with GeriMed of America, Incorporated, to develop a series of glidepaths to enhance the care of elderly persons. Some of the other conditions for which Glidepaths are being developed are stroke, osteoporosis, prostate cancer, fecal incontinence, health maintenance, coronary artery disease, chronic obstructive pulmonary disease, and dyspepsia/GERD. Development of these glidepaths will be evidence-based.

In this issue of Aging Successfully, we have included an example of a Glidepath in development. We would appreciate your comments and thoughts on how to improve this Dementia Glidepath (see pages 9-12).

Doing “Everything” for the Terminally Ill Older Patient

(continued from page 3)

June, she is admitted once more, and her hemoglobin has dropped as low as 4.0 mg/dl. As the months go by, she becomes somewhat weaker. She continues to come in about once a month with symptoms of severe anemia and after transfusion, she goes home to her family. You begin to hear a few comments from your colleagues who sometimes have to take care of her in the hospital, “Are you going to do this forever? How long can this go on?”

Each time she is admitted to the hospital, you discuss code status and you get the same response from the patient, “Whatever my children decide.” You talk with her children, sometimes as a group, sometimes one on one. You find out that two of the daughters are very reluctant to talk about the option of not doing everything. Again, you go back to your doctor responses and try to explain to the family how much suffering she would have to endure if she were to be put on a ventilator or have CPR done. None of this changes their minds.

So now, you return to curiosity. Nothing medical you have said has made a difference. You finally muster up enough courage to ask the patient, “Are you ready to die?” The religious woman she is, she looks you right in the face and says, “No, not yet.” However, you feel like you have accomplished something by being able to ask that question. The next few times she comes to the hospital, you find it easier and easier to ask that question and you and the patient are able to discuss things more openly. You find most of your discussions now center around the daughters and the son, specifically around the two daughters who are reluctant to do anything.

As the course of her illness progresses, she develops bone pain from metastatic disease. She even develops a deep vein
**Clinical Glide Path – Dementia**

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Robust Elderly</th>
<th>Frail</th>
<th>Moderately Demented</th>
<th>End of Life</th>
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<tr>
<td>3. Exclude medication side effects.</td>
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<td>5. Consider head CT (cheaper), MRI if vascular dementia suspected based on clinical grounds. Treat abnormalities if found.</td>
<td>5. Consider head CT (cheaper) MRI if vascular dementia suspected based on clinical grounds. Treat abnormalities if found.</td>
<td>5. Consider head CT (rarely indicated without localizing signs).</td>
<td>5. Consider CT Head (rarely indicated without localizing signs).</td>
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<th>Management</th>
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<td>2. Reality orientation &amp; validation therapy.</td>
<td>2. Reality orientation and validation therapy.</td>
<td>2. Reality orientation &amp; validation therapy.</td>
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<td>3. Consider Donepezil.</td>
<td>3. Consider Donepezil.</td>
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<td>5. Consider Selegiline.</td>
<td>5. Consider Selegiline.</td>
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**Causes of Dementia**

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<tr>
<th>Reversible</th>
<th>Non-reversible</th>
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<tr>
<td>Thiamine deficiency</td>
<td>Alzheimer's</td>
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<tr>
<td>Drug intoxication</td>
<td>Picks (fronto-temporal lobe)</td>
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<tr>
<td>Hypothyroidism</td>
<td>Huntington's</td>
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<tr>
<td>Normal pressure hydrocephalus</td>
<td>Diffuse Lewy body disease</td>
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<td>Brain tumor</td>
<td>Vascular dementia</td>
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<td>Vitamin B12 deficiency</td>
<td>Leukoencephalopathies</td>
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<tr>
<td>Chronic infection</td>
<td>Parkinson's</td>
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<tr>
<td>Drug</td>
<td>Prion diseases (Creutzfeld, Jogger, Kuru, Bovine)</td>
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<tr>
<td>Emotional (depression, schizophrenia, conversion reaction)</td>
<td>Spongiform, Encephalopathy</td>
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<td>Metabolic (hypothyroidism, thiamine deficiency)</td>
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<tr>
<td>Eyes and ears (sensory isolation)</td>
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<td>Normal pressure hydrocephalus</td>
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<td>Tumor and other space occupying lesions</td>
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<tr>
<td>Infections</td>
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<td>Anemia (vitamin B12 deficiency)</td>
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# CARE COORDINATOR CLINICAL GLIDEPATH – DEMENTIA

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<thead>
<tr>
<th>Management</th>
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<th>Frail</th>
<th>Moderately Demented</th>
<th>End of Life</th>
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<tr>
<td>1. Assess driving status.</td>
<td>1. Evaluate driving status.</td>
<td>1. Confirm patient is not driving.</td>
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<td>3. Gather info from family/caregiver to support Dx; Hx of progression.</td>
<td>3. Gather info from family/caregiver to support Dx; Hx of progression.</td>
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<td>4. Consider/eval for day program, home care, home support services, LTC planning.</td>
<td>4. Consider/eval for day program, home care, home support services, LTC planning.</td>
<td>4. Provide resources for home care, home support services, Hospice, Support groups.</td>
<td>4. Provide resources for home care, home support services, Hospice, Support groups.</td>
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<tr>
<td>5. Advocate for caregiver support groups, counseling, etc. Refer to Alzh Support Group.</td>
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<td>5. Advocate for caregiver support groups, counseling, etc. Refer to Alzh Support Group.</td>
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<td>7. Reinforce toileting program.</td>
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**Alzheimer’s Association 800-272-3900**

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**Care Coordinator**

**Relevant Clinical Points**

Most patients with dementia are cared for by family members, spouses, or children. There is a higher incidence of psychological and physical problems with the caregiver of patients with dementia than in the general population. Caregivers do benefit from support services and close monitoring of their personal health. Patients with dementia who live with distressed caregivers exhibit higher incidence of behavioral problems.

DEMENTIA: RELEVANT CLINICAL DATA

For all patients being considered for the diagnosis of dementia, treatable causes need to be excluded. A thorough history, review of current medications, and physical exam are mandatory.


The Mini-Mental Status examination is an adequate screening tool for the primary care physician.


2. ACP Journal Club: Mini-Mental State Examination and the Informant Questionnaire on Cognitive Decline were efficient screening tests for dementia. Evidence Based Medicine Volume 126 1997 Jan-Feb;2:25.

Folate and Vitamin B12 deficiency can lead to cognitive impairment.


Serum-homocysteine (S-HCY) can be an early and sensitive marker for cognitive impairment.


The use of neuroimaging is useful for the detection and evaluation of dementia. Hippocampal atrophy may represent an early sign of AD. If vascular dementia is suspected, MRI may be of better value than CT.


SPECT and PET imaging may also be considered when the CT/MRI is negative and the diagnosis of dementia is still being considered.

Cognitive function can be enhanced by exercise in the elderly population.

AD patients require a diet of 35Kcal/Kg of body weight to maintain their weight on average.

Donepezil has been shown to improve cognitive function.

Vitamin E & Selegiline has also been shown to improve cognitive functional skills.

Estrogen can be considered, but insufficient evidence as to its beneficial effects and two controlled trials failed to demonstrate an effect.

Ginkgo Biloba Extract

Further Readings on various therapies of AD can be found in the following paper (Review of 117 references):
results in an impairment of function. The four major studies of function in older persons (PAQUID, the St. Louis Study, AWARE, and the Mexico City Study) have all demonstrated severe declines in function and a decrease in quality of life in older persons with diabetes (Fig. 4). The A W A R E study also showed a marked decline in activities, such as gardening or going out socially, that are generally considered to be key to one’s quality of life. Older diabetics also have an increase in falls and injurious falls.

While exercise remains a key to the management of diabetes in older persons, the role of diet is more controversial. Nursing home studies have suggested that diabetic diets have little or no effect on glycemic control. The American Dietetic Association has issued a position statement suggesting that therapeutic diet usage may be inappropriate in nursing homes. Dr. Morley pointed out that in diabetics with vascular ulcers or pressure ulcers, zinc replacement is important for wound healing. Hyperglycemia has been demonstrated to cause zinc wastage in the urine. High doses of vitamin C and vitamin E interfere with the ability to measure blood glucose levels.

Finally, Dr. Morley discussed the blossoming number of oral agents available to treat diabetes in the older person. He pointed out that lack of hypoglycemia is an important characteristic for the ideal anti-glycemic drug in older persons. This makes Metformin, the thiazolidinediones, and the α-1 glucosidase inhibitors potentially ideal drugs for older persons. The gut problems have limited the use of α-1 glucosidase inhibitors in older persons, but there is one study with miglitol at 25 mg before meals that showed successful effects in older persons. Metformin has proven to be an outstanding drug in young-old persons who do not have renal failure or NYHA class IV heart failure. In persons over 80 years of age, it is recommended that a creatinine clearance is obtained before using Metformin. This markedly limits its use in this population. However, Metformin appears to be the drug of choice in young old, particularly if they are overweight.

Thiazolidinediones decrease insulin resistance in the muscle. Dr. Morley has found troglitazone to be an excellent monotherapy for old diabetics in the nursing home. Troglitazone produces severe liver dysfunction in 1 in 56,000 patients. This is relatively minor compared to the 1 in 10,000 persons with isoniazid (INH) prophylaxis for tuberculosis who develop liver dysfunction. Nevertheless, this led to the withdrawal of troglitazone from the market. There are data supporting the use of rosiglitazone and pioglitzaone, two other thiazolidinediones, as monotherapy in young old persons.

Dr. Morley concluded by stressing the importance of treatment of diabetes, not only in boomers, but also in older persons. He pointed out that in older persons, the appropriate care of diabetes requires an intensive interdisciplinary team approach.

Figure 4. Four major studies of function in older persons.
important as your medical skills. To check their gait and balance, I dance with them rather than doing the Tinnetti Gait and Balance Test. Dancing is much more fun for both of us and at least as effective.

However, the little men and women with green visors clearly do not appreciate my brand of medicine. To them, it is far more important that I document a meaningless physical examination than talk to my patients. They regulate what I should or shouldn’t examine to obtain reimbursement and then should I fail to document a meaningless symptom or sign, they accuse me of fraud and failing to practice medicine appropriately.

If physicians are feeling besieged by non-clinical bureaucrats, their problems are nothing compared to nursing homes which have truly come under siege. If I fall at home and fracture my hip, I’m unlikely to sue my wife or daughter; but if the same thing happens in a nursing home, I can rapidly become rich. Nursing homes have become one of the most regulated components of society. Certainly, the care given in nursing homes is in many cases far superior to that of hospitals and far more humane. Yet it is in vogue for the press, the Inspector General’s office, and Congress to continuously vilify nursing homes.

There is perhaps no job in the world that is harder, less emotionally rewarding, or poorer paid than being a nurses’ aide in a nursing home. Yet while failing as a society to provide greater reimbursement for nursing home care and therefore aide’s salaries, we have great expectations that nursing homes should provide better care for our spouses and parents than we can do at home. In St. Petersburg, there are billboards along the road encouraging relatives to contact lawyers who specialize in nursing home “liability” cases. Attorneys General across the country have criminalized the development of pressure ulcers in nursing home residents. And at least in my experience, they are far more interested in a conviction and the political capital they can gain from it than the truth.

Surely we must move from a one-mistake, punitive system to a system where overall quality of care becomes the goal. If we want good care to flourish, it needs to be rewarded and arbitration needs to replace an inept legal system. We are slowly becoming a nation where laws and paper compliance are replacing the ideas behind them which I presume are to provide the best possible care for all of us as we grow older. Certainly, some caregivers (doctors, nurses, administrators) have committed some egregious acts, but they are in general a small minority. Over the years we have developed a system that often punishes the good, protects the bad, and harms many in need of care.

It is time to re-empower health care professionals and allow them to develop a rational caring system where arbitration replaces legal shenanigans. Let us spend our money on caring, not on paper compliance and litigation. Bad things happen to good people and it is time to remember that, “to err is human, to forgive, divine.”

It is realized that there are many different viewpoints on this issue. I hope that my rhetoric will have stimulated some of you to take up pen or pound the keys of your computer to give your thoughts on how to solve the problems of health care for the elderly.
Only the Body Withers

This work is dedicated to the beauty of the spirit in each of us. The inspiration for this work is the artist’s grandmother. During a visit, her grandmother mentioned to Lucie that although she felt very young inside, outwardly she was frustrated by a body that could not do the things she wanted it to do.

It was at that precise moment that Lucie perceived her grandmother; the frailty of the body accompanied by the agelessness of the spirit. Lucie also felt strongly that this reality was not limited to her grandmother. Her grandmother had only voiced thoughts and feelings that in Lucie’s mind were shared by many.

With her grandmother and cousin posing, Lucie started the painting. The work itself, due to the closeness of the subject and composition and detail, evolved over a period of five years.

Initially sketched as a study on paper, Lucie then committed it to canvas. The original oil was completed in December 1992.

Lucie’s grandmother celebrated her 91st birthday on December 10, 1994.

Lucie Bilodeau is Canadian by birth. At the age of 14, she became a student of The Mission Renaissance School. Her formal technical training spanned over a period of three years.

Lucie has distinguished herself by competing for six years in the “Cercle des Artistes Peintre du Quebec” National visual arts competitions. She has received many awards, of which 3 were “People’s Choice.” Additionally, she is the recipient of 2 awards from The International Art Exhibition.

Many of her works can now be found around the globe from Japan to England and the Americas. Her paintings are enjoyed by hundreds of private collectors.

For more information about Lucie and her artwork, please contact the Joy Gallery, 1124 Duval St., Key West, FL 33040.
Living Longer....Living Stronger

Q My husband is 65 years old, somewhat overweight, and snores very loudly at night. I have noticed that while sleeping, he appears to have periods when he stops breathing. He has also been complaining that he is tired during the day. Recently when we had friends over, he fell asleep while they were talking. Should I be concerned?

A The symptoms you describe are classical of sleep apnea. This is a condition characterized by temporary absence of breathing during sleep that lasts for at least 10 seconds and occurs multiple times during the night. It is associated with severe daytime drowsiness. It is a very common condition occurring in up to one-half of all people over 60 years of age. It is particularly common in moderately overweight men with large necks. It is a serious condition that can eventually lead to hypertension, heart failure, and abnormal heart rhythms (arrhythmias). The diagnosis requires monitoring of breathing during sleep in a sleep laboratory. Treatment can be as simple as weight loss, sleeping in specific positions, and avoidance of alcohol. However, the majority of people with sleep apnea require the use of a machine at night that blows air through the nose under positive pressure, thus preventing collapse of the airway. This is called a continuous positive airway pressure or CPAP machine. In some cases, surgery may be necessary. This is a serious condition, and your husband needs to see a physician as soon as possible.

Q I’ve been told DHEA will increase my energy and my lifespan. Is this true?

A DHEA has been shown to produce a variety of effects in rats and mice including improving memory and enhancing immune function. Unfortunately, the findings in controlled studies in humans have been less positive. Only very high doses (50 to 100 mg per day) have been found to produce effects, and these effects have been small and variable, and for the most part, can only be seen in men. A number of the DHEA products on the market fail to produce significant amounts of DHEA in the blood, and so ingesting them may result in a purely placebo effect. In women, DHEA has the potential to produce breast cancer. At present, there is no rational reason to take DHEA.

Q I have mild arthritis which is particularly troublesome in the mornings when I first wake up. Is there anything I can do to wake up without pain and stiffness?

A The best way to stop morning symptoms is to take a medication the night before to prevent the pain from starting during the night. Many of my patients have found that taking two Tylenol ER (extended relief) tablets before going to bed works extremely well to stop them from having pain the next morning. To be effective, this needs to be done every night.

Q I’m worried that the Government will take a substantial amount of my heir’s inheritance. What can I do to maximize my children’s inheritance?

A First, make sure that you have an up-to-date will. At present, there is a $625,000 exemption for estate taxes. By 2006, the exemption will be $1 million. If you have more than $1 million in assets, you should consider a bypass trust. Transfers to a spouse are, of course, tax free.

If you have a question, please send it to Living Longer, Living Stronger, Division of Geriatric Medicine, Saint Louis University Health Sciences Center, 1402 S. Grand, Room M238, St. Louis, MO 63104.
Geriatrics on the Web
(continued from page 5)

Moreover, HealthandAge offers consumers and professionals the
somewhat unique opportunity to understand these health issues from
the others’ perspectives, certainly an im-
portant component in the effective manage-
ment of these quality of life conditions.

Some of the information on the
HealthandAge website was created in co-
operation with Cyberounds, http://
www.cyberounds.com, a professional-orien-
ted website, featuring original geriatrics
and 14 other subjects, presented in grand rounds-style. These interactive
conferences are written by John Morley, M.B., B.Ch. and other experts
from 15 U.S. medical schools. Cyberounds
Geriatrics is crisp and to the point and is a
chance to interact with the virtual John E.
Morley, the next best thing to hearing John
E. Morley in person. For those outside the
healthcare field, John has also revised his
conferences for a consumer audience. These articles are available at http://
www.TheDoctorWillSeeYouNow.com,
where John also answers medical and so-
cial questions of relevance to senior living.

GIGS Group Grows

On February 22nd, the GIGS (Geriatric Interest Group for Students) had
their tenth annual meeting at John E. Morley’s home. A large number of
faculty and students shared personal histories and professional goals over
pizza and dessert. Students take part in many activities including feeding
patients on the ACE unit, an Adopt-a-Grandmother program, as well as
having regular meetings on a variety of geriatric topics throughout the year.
**Coming Programs and Opportunities**

**Special Program for Retirees**

**The University of the Third Age**

**October 14, 2000**

These one-day conferences, targeted to seniors, are held three times a year in St. Louis at the Margaret McCormick Doisy Learning Resources Center on the Saint Louis University Medical Campus. U3A meetings enable healthy elders to explore successful aging in an academic environment. These conferences are Sponsored by the Saint Louis University Health Sciences Center in cooperation with the GRECC at the VA Medical Center. Contact (314) 577-8462 for more information.

**Special Programs for Professionals**

**The Twelfth Annual Saint Louis University Symposium for Medical Directors in Nursing Homes**

**December 9, 2000**

This one-day symposium will be held at the Saint Louis University Health Sciences Center. This conference covers clinical practice guidelines, malnutrition, safety, pain management, and polypharmacy. CME credit is available for physicians, nursing home administrators, family physicians, certified nurse practitioners, and medical directors. For more information or to be added to the mailing list, please call (314) 577-8462.

**Conquering Incontinence Across the Continent Conference**

**January 19, 2001**

This conference will feature Dr. Diokno, a world-renowned expert on incontinence from the Department of Urology at the William Beaumont Hospital in Michigan. The conference will stress practical management of incontinence in community-dwelling and nursing home residents. The conference is co-sponsored by the Departments of Urology, Family Practice, and Geriatric Medicine at Saint Louis University. For more information, please call (314) 577-8462.

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**Central Society for Clinical Research Meetings to Feature Geriatrics**

This yearly meeting, held at the Drake Hotel in Chicago, will have three days of geriatric lectures. It represents a wonderful opportunity for geriatricians in the Midwest to network with one another.

On the first afternoon (Thursday, September 21, 2000), a series of lectures representing a geriatric update will be given. Lecturers will include Professor Evans from the University of Arkansas talking on exercise. A variety of other topics including biology of aging, the aging gut, epidemiology of Alzheimer’s disease, regulation of balance, DHEA, introduction to Glidepaths, and enteral nutrition will be presented.

On Friday, two symposia, one on the Aging Heart and the other on Diabetes and the Elderly, will be held. Friday evening, the “Aging Successfully” dinner club will meet for a time of education and fellowship.

Saturday’s schedule will include a poster session and updates on research presented by geriatricians from around the Midwest.

Mark your calendars now for September 21-23, 2000!
Managing Diabetes (Answer to crossword puzzle from page 4)

Answer to crossword puzzle from page 4

MOVING?
Please let us know if this issue is misaddressed or if you will be moving soon. Please fax the label from the back of this issue along with the new address to 314-909-0443. Please allow 8-12 weeks for the change to be effective.

New Book Published

In Endocrinology of Aging, a panel of distinguished physicians critically reviews the clinical consequences of the endocrinological changes that occur with aging and examines the use of hormonal therapy to reduce them. Topics range from bone disease and water balance in all older people, to androgen deficiency in aging males, gynecomastia, and menopause. Type II diabetes, cognitive benefits of glycemia control, and the interaction of nutrition and metabolism are also covered. Timely and authoritative, this book offers endocrinologists, geriatricians, and primary care physicians critical insight into the endocrine problems of our rapidly growing elderly population. The information presented here will greatly augment every physician’s ability to enhance function in their aging patients. This book, published by Humana Press, was edited by John E. Morley, M.B., B.Ch. and Lucretia van den Berg, M.B., B.Ch.

 Doing “Everything” (continued from page 8)

thrombosis and subsequent pulmonary embolus. You cannot give her heparin, but you put a filter in and she survives, although she is now on oxygen and short of breath. She continues to tell whoever asks her about code status “Whatever my children decide.” On her 22nd and final hospitalization, you realize that she is still this strong-willed matriarch of the family. You realize that she has been waiting for her children to “get ready.” You understand that when you asked the question, “Are you ready to die?” and she said, “No, not yet,” she was really saying, “I’m not ready to go until my children are ready for me to go.” Finally, two days before she dies, all four daughters and one son are able to say, “It’s okay to go, Mama. We’ll be all right.” Despite her lack of energy the last few days and her inability to sit up, she hugs every one of her kids, and you.

She is able to communicate that she does not want “any more.” Her code status is changed to no code. Her pain is controlled. Her breathing is not labored. Mrs. Josephine D. dies peacefully in the presence of her family.

Thus, in the “end,” sometimes doing “everything” entails asking the tough questions: “Why?” “How long do you want to live?” and “Are you ready to die?”

Questions? FAX: (314) 909-0443
Aging SUCCESSFULLY

Division of Geriatric Medicine
Saint Louis University School of Medicine
1402 South Grand Boulevard
St. Louis, Missouri  63104

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John E. Morley, M.B., B.Ch.
Dammert Professor of Gerontology and
Director, Division of Geriatric Medicine
Director, MOGGECC
Department of Internal Medicine
Saint Louis University School of Medicine
and Director, GRECC, St. Louis Veterans
Affairs Medical Center

Nina Tumosa, Ph.D.
Editor
Health Education Specialist
GRECC
St. Louis VAMC-Jefferson Barracks
and Co-Director, MOGGECC
Associate Professor
Division of Geriatric Medicine
Department of Internal Medicine
Saint Louis University School of Medicine

Please direct inquiries to:
Carolyn Phelps, Assistant Editor
Division of Geriatric Medicine
Saint Louis University School of Medicine
1402 S. Grand Boulevard, Room M238
St. Louis, Missouri  63104
(314) 909-1894
GRECC: (314) 894-6510
FAX: (314) 909-0443