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Ethical Issues: A Good Death

It was a good death. It took two days, but in that time she remained unresponsive and did not appear to be suffering, other than the faint periodic groan, and her rapid shallow breathing. Her annual winter bronchitis had progressed to the long awaited pneumonia, and the family held to their decision that further hospitalization or aggressive treatment would not be in her best interest. Previous hospitalizations for hip fractures and pneumonia had not gone well, often requiring narcotics and sedation leading to confusion and agitation; while in hospital she remained in bed and skin breakdown was a problem. Hospital stays also brought the added danger of injury due to falls and exposure to forms of infection that are often very difficult to treat. Her family and physicians knew that, because of the added suffering and risk of death that hospitalization brings to older patients already suffering from chronic conditions, it would be better to treat her in familiar surroundings and cared for by familiar faces. Death was inevitable, and in some ways welcomed, as the final relief from many years of progressive dementia and painful arthritis; she had not walked for two years following hip fractures, but her heart was still strong. Knowing that aggressive treatment of any acute illness would be burdensome and without proportional benefit, she would be treated and cared for in her home, now a room in a long term care facility, filled with her own furniture, family photos, and mementoes from the home she had not seen for years and no longer asked about. The time was now, and the process had begun. It was time to care rather than treat, and to join her in welcoming the natural death she had long awaited following the death of her husband and ultimate caregiver three years before.

When the end came it was quiet. To relieve the distress of breathing she was given several drops of morphine under her tongue each hour. Nasal oxygen was also given. Secretions causing intermittent upper airway congestion were relieved by gentle oral care, but suctioning was needed only infrequently. The nurses in the long term care facility where she had been living for three years since the passing of her husband were quietly serving her needs often coming in to stand with her a few minutes, softly speaking her name, and stroking her hair as they had done so many times in the past. Her home hospice nurses were also in and out, attending to her needs and those of the family and caregivers who were now constantly at her side. Her nurses and caregivers grieved as well, and sought closure for the loss of one they had pledged to serve and grown to love, all hoping that this would be the “good death” they had been hoping for and expecting for this good woman.

Families can't always be there when death arrives, but when given the news two sons were able to get there. Following their emotional reunion they sat together near

mother and shared news of each other's lives, remembered the past, and periodically touched and stroked her head while awaiting the inevitable. The sons shared an odd mixture of tears and laughter while sharing last moments with the one ultimately responsible for their lives. Her caregivers, the dedicated souls who had been with her day in and day out for three years, continued their vigil, knowing their task was near its end. It was an emotional time, one of grief, relief, joy and sadness. For nearly 93 years this grand and gracious lady had nurtured family, friends, and community, and her presence would live on in the minds and hearts of those she touched—this was her legacy. When it came it was a good death. Her sons stroked her forehead and quietly wept, each comforting the other, as respirations slowed and the last quiet breath passed her lips...it was done.

So it goes and will continue to go exponentially as this scenario plays itself out many times each day for millions of elderly patients and their families. The elderly presently account for 13% of the population in the United States but is anticipated to grow logarithmically in the years to come.ⁱ By the year 2030 one in five Americans will be over the age of 65. The very old (80 and over) is the demographic projected to have the greatest growth in the next quarter century, and these patients are at greatest risk for death and complications resulting from infection, particularly pneumonia.ⁱⁱ The adage, “pneumonia is the old man's friend” rings true because this is often the means of death for the frail elderly who are at high risk for death by any means. Studies have shown that 15-20% of elderly patients admitted to the hospital with pneumonia die, and in the subsequent year almost half succumb.^{iii iv} Nursing home patients and patients with dementia are at particular risk for developing fatal pneumonia.^v Additionally, among the elderly the hospitalization or death of a spouse may be associated with increased risk of death in the surviving spouse.^{vi}

For elderly patients, especially those in long term facilities, the risk of death is obviously high. The challenge, therefore, as health care providers is knowing when to employ our healing powers to enable a “good death” when it is clear that further aggressive intervention is medically futile, will be overly burdensome, or will not reasonably offer benefit to the patient. When that time comes, and come it will, we must use our skills to promote and enable “good death” as a natural extension of the good life. For those who have shared and invested in the life of this mother-client-friend-patient to be given the gift of time and space to participate, nurture, and find closure at the moment of her death was a healing moment that cannot be prescribed, it can only be discovered through its experience.

ⁱ U.S. Bureau of the Census. Decennial census of population, 1900-1980 and projections of populations of the United States: 1982-2050. Current Population Reports Series P-25, no. 922. Washington, D.C.

ⁱⁱ Yoshikawa T. Epidemiology and unique aspects of ageing and infectious diseases. *Clin Inf Dis.* 2000;30:931-933

ⁱⁱⁱ Brancati F, et al. Is pneumonia really the old man's friend? Two year prognosis after community acquired pneumonia. *Lancet.* 1993; 342(8862):30-33

^{iv} Kaplan V, et al. Pneumonia: still the old man's friend? *Arch Int Med.* 2003; 163(3): 317-323

^v Beck-Sague C, et al. Infectious disease and death among nursing home residents results of surveillance in 13 nursing homes. *Inf Cont Hosp Epidemiol.* 1994; 7: 494-496

^{vi} Christakis N and Allison P. Mortality after hospitalization of a spouse. *NEJM.* 2006; 3354:719-730