

OPINION

Weighing the End of Life



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Published: February 2, 2013

SAN FRANCISCO

ONE weekend last year, we asked our vet how we would know when it was time to put down Byron, our elderly dog. Byron was 14, half blind, partly deaf, with dementia, arthritis and an enlarged prostate. He often walked into walls, stood staring vacantly with his tail down, and had begun wandering and whining for reasons we could not always decipher.

Attentive to Byron's needs, we softened his food with water and sprinkled it with meat; we cuddled him when he whimpered and took him outside to relieve himself seven, even eight times a night. We couldn't take a vacation because we couldn't imagine asking anyone, friend or dog sitter, to do what we were doing. Nor could we fully trust anyone to provide the care we thought Byron required.

But it was also true that Byron often toddled along happily on his daily walks. He sniffed bushes and stained storefronts with the measured attentiveness of a research scientist, flirted with passers-by, and on occasion raised his ears and tail, marked a spot, then kicked his hind legs while growling, barking and asserting his dominance over some generally long-gone canine competition. Since Byron was an evidently elderly eight-pound Yorkshire terrier, this invariably provoked fond smiles from passing strangers.

When asked whether it was time to put Byron "to sleep," our vet said he used the 50 percent rule: Were at least half of Byron's days good days? Or was it two bad days for every good? When you get to the latter, he explained, it's time.

This conversation gave me pause for two reasons. First, what did Byron want? Was 50 percent good enough for him? How about 70? Or 20? There was, of course, no way to know.

Which brings me to my second reason for pause. When not serving as faithful servant to our tiny dog, I am a geriatrician. Because older adults have a greater range of needs and abilities than any other age group, and because there is a national shortage of geriatricians, I care for the frailest and sickest among them.

To many people's surprise, most of my patients are as satisfied with their lives as they were when they were less debilitated. But this isn't true for everyone, and some are eager to say they've had enough. They are bedbound or dependent, unable to do any of the things they once valued so dearly — working, caring for their families, eating solid food or even hearing the conversation of those who come to see them. Still others cannot express their wishes or needs but sit propped in chairs frowning and grimacing, despite attentive care and trials of antidepressants and pain medications.

"Why doesn't God want me?" asked a 96-year-old felled by multiple strokes and fed through a tube.

"Can't you do something?" begged an 89-year-old with advanced Parkinson's disease and incontinence who would have killed himself if only he still could.

And these were two people who lived relatively comfortably with frequent visits from loving families. But others, even those with similar or equal disabilities, might feel just as strongly that they want to preserve their lives at any cost. They would never choose euthanasia.

Of course, we can't have a 50 percent rule for humans. Because who decides? These are vulnerable people, and while the world is full of dedicated, self-sacrificing caregivers, it also contains far too many people who stand to gain from death (through inheritance) or from continuing life (in the form of Social Security checks or cheap housing).

FOR Byron, the fateful day came both slowly and suddenly. Over his last year, he'd had a number of health problems, and we had intended to take a palliative approach: doing only those treatments that lessened his suffering and avoiding tests and stressful vet visits at all costs. But then his paw hurt, so we took him in. He didn't respond to the first antibiotic so sedation and a biopsy were required. Next, he developed bloody, watery stool. We talked the vet into prescribing standard antibiotics without a visit, and he improved. But a few months later, he was short of breath. He needed an X-ray to determine that it was pneumonia, then oxygen and more antibiotics. He stayed overnight. A few months after that, pus dripped from his red, swollen eyes — conjunctivitis. Each time he had to go to the vet, he shook, panted, climbed up our bodies, and tugged on his leash, his tiny body straining for the door.

Suddenly, I fully understood something I observed at work all the time — how it was possible to love a frail relative, prioritize his comfort and well-being, and yet repeatedly find oneself doing things that felt awful to everyone.

Finally we made an appointment with a hospice vet. When I returned home from work that night, the humans of our family were cradling Byron and looking sad. He ran to me, wiggling his tail. He hadn't eaten all day. I thawed some chicken, and he gobbled it down. Someone said, "You can't kill him."

Then he followed me to the bathroom and vomited the chicken onto the floor at my feet. He stood, tail down, facing the wall.

That night, the vet gave him the injection, and Byron died in our arms.

Since then, I have often wondered whether we waited too long. We counted the time he spent sleeping as contentment, tipping the scale above the 50 percent mark. But I know that in elderly humans, sleep is more often a sign of chronic exhaustion, depression and avoidance of pain. In dealing with the guilt brought on by our mixed feelings — we love him; he's ruining our lives — I realize we may have overcompensated to his detriment.

With dying humans, similar situations arise every day: hospital stays that fix the acute problem and worsen the chronic ones; emergency department visits that yield diagnoses but require weeks of recovery from the waiting and testing; surgeries that are themselves minor but provoke major confusion, complications and hated nursing home stays. On the other hand, there are the relatively simple problems that might be addressed by a doctor if only seeing one didn't require an ambulance for transportation, or time off work by an adult child, or more taxi fare than remains in the Social Security check, or more effort than seems worth the while.

And sometimes it's even more complicated than that. Last year, a patient of mine with 15 major medical problems, including a form of leukemia, decided he didn't ever want to return to the hospital, do chemotherapy, or try any of the other treatments we discussed. But for weeks after that, he railed and fumed at the prospect of palliative care, because he wanted very badly to live.

He wanted to live — just not in the hospital, with poisons in his blood. He was sick and tired of feeling sick and tired. Like so many, his was a reasoned and reasonable stance.

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