

# At the end of a loved one's life, why is it so hard to let go?

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MINNEAPOLIS — I know where this phone call is going. I'm on the hospital wards, and a physician in the emergency room downstairs is talking to me about an elderly patient who needs to be admitted to the hospital. The patient is new to me, but the story is familiar: He has several chronic conditions — heart failure, weak kidneys, anemia, Parkinson's and mild dementia — all tentatively held in check by a fistful of medications. He has been falling more frequently, and his appetite has fallen off, too. Now a stroke threatens to topple this house of cards.

The emergency room physician and I talk briefly about what can be done. The stroke has driven the patient's blood pressure through the roof, aggravating his heart failure, which in turn is threatening his fragile kidneys. The stroke is bad enough that, given his disabilities related to his Parkinson's, he will probably never walk again. In elderly patients with a web of medical conditions, the potential complications of any therapy are often large and the benefits small. It's a medical checkmate; all moves end in abdication.

I head to the emergency room. If I'm lucky, the family will accept the news that, in a time when we can separate conjoined twins and reattach severed limbs, people still wear out and die of old age. If I'm lucky, the family will recognize that their loved one's life is nearing its end.

But I'm not always lucky. The family may ask me to use my physician superpowers to push the patient's tired body further down the road, with little thought as to whether the additional suffering to get there will be worth it. For many Americans, modern medical advances have made death seem more like an option than an obligation. We want our loved ones to live as long as possible, but our culture has come to view death as a medical failure rather than life's natural conclusion.

These unrealistic expectations often begin with an overestimation of modern medicine's power to prolong life, a misconception fueled by the dramatic increase in the American life span over the past century. To hear that the average U.S. life expectancy was 47 years in 1900 and 78 years as of 2007, you might conclude that there weren't a lot of old people in the old days — and that modern medicine invented

old age. But average life expectancy is heavily skewed by childhood deaths, and infant mortality rates were high back then. In 1900, the U.S. infant mortality rate was approximately 100 infant deaths per 1,000 live births. In 2000, the rate was 6.89 infant deaths per 1,000 live births.

The bulk of that decline came in the first half of the century, from simple public health measures such as improved sanitation and nutrition, not open heart surgery, MRIs or sophisticated medicines. Similarly, better obstetrical education and safer deliveries in that same period also led to steep declines in maternal mortality, so that by 1950, average life expectancy had catapulted to 68 years.

For all its technological sophistication and hefty price tag, modern medicine may be doing more to complicate the end of life than to prolong or improve it. If a person living in 1900 managed to survive childhood and childbearing, she had a good chance of growing old. According to the Centers for Disease Control and Prevention, a person who made it to 65 in 1900 could expect to live an average of 12 more years; if she made it to 85, she could expect to go another four years. In 2007, a 65-year-old American could expect to live, on average, another 19 years; if he made it to 85, he could expect to go another six years.

Another factor in our denial of death has more to do with changing demographics than advances in medical science. Our nation's mass exodus away from the land and an agricultural existence and toward a more urban lifestyle means that we've antiseptically left death and the natural world behind us. At the beginning of the Civil War, 80 percent of Americans lived in rural areas and 20 percent lived in urban ones. By 1920, with the Industrial Revolution in full swing, the ratio was around 50-50; as of 2010, 80 percent of Americans live in urban areas.

For most of us living with sidewalks and street lamps, death has become a rarely witnessed, foreign event. The most up-close death my urban-raised children have experienced is the occasional walleye being reeled toward doom on a family fishing trip or a neighborhood squirrel sentenced to death by car tire. The chicken most people eat comes in plastic wrap, not at the end of a swinging cleaver. The farmers I take care of aren't in any more of a hurry to die than my city-dwelling patients, but when death comes, they are familiar with it. They've seen it, smelled it, had it under their fingernails. A dying cow is not the same as a person nearing death, but living off the land strengthens one's understanding that all living things eventually die.

Mass urbanization hasn't been the only thing to alienate us from the circle of life. Rising affluence has allowed us to isolate senescence. Before nursing homes, assisted-living centers and in-home nurses, grandparents, their children and their grandchildren were often living under the same roof, where everyone's struggles were plain to see.

In 1850, 70 percent of white elderly adults lived with their children. By 1950, 21 percent of the overall population lived in multigenerational homes, and today that figure is only 16 percent. Sequestering our elderly keeps most of us from knowing what it's like to grow old.

This physical and emotional distance becomes obvious as we make decisions that accompany life's end. Suffering is like a fire: Those who sit closest feel the most heat; a picture of a fire gives off no warmth. That's why it's typically the son or daughter who has been physically closest to an elderly parent's pain who is the most willing to let go. Sometimes an estranged family member is "flying in next week to get all this straightened out." This is usually the person who knows the least about her struggling parent's health; she'll have problems bringing her white horse as carry-on luggage. This person may think she is being driven by compassion, but a good deal of what got her on the plane was the guilt and regret of living far away and having not done any of the heavy lifting in caring for her parent.

With unrealistic expectations of our ability to prolong life, with death as an unfamiliar and unnatural event, and without a realistic, tactile sense of how much a worn-out elderly patient is suffering, it's easy for patients and families to keep insisting on more tests, more medications, more procedures.

When families talk about letting their loved ones die "naturally," they often mean "in their sleep" — not from a treatable illness such as a stroke, cancer or an infection. Choosing to let a loved one pass away by not treating an illness feels too complicit; conversely, choosing treatment that will push a patient into further suffering somehow feels like taking care of him. While it's easy to empathize with these family members' wishes, what they don't appreciate is that very few elderly patients are lucky enough to die in their sleep. Almost everyone dies of something.

Close friends of ours brought their father, who was battling dementia, home to live with them for his final, beautiful and arduous years. There they loved him completely, even as Alzheimer's took its dark toll. They weren't staring at a postcard of a fire; they had their eyebrows singed by the heat. When pneumonia finally came to get him, they were willing to let him go.

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