In the abdomen there was a fusiform atherosclerotic aneurysm of the abdominal aorta and another of the right common iliac artery (fig 8). Both were firmly adherent to posterior structures.

Summary of findings

In summary, he had a leaking atherosclerotic aneurysm of the descending thoracic aorta with a fistula into the oesophagus, massive gastrointestinal haemorrhage, and left pleural haemorrhage. In addition, he had active pulmonary tuberculosis. He did not have evidence of myeloma; his monoclonal gammopathy was therefore presumably benign and related to his tuberculosis.

Comment

PROFESSOR MITCHELL: Dr Emerson clearly identified the site of the process correctly, but this is a different sort of process from the ordinary dissection that he was talking about. Did he have aortic medionecrosis?

DR SMITH: He did not have dissection, with blood tracking through the media.

PROFESSOR MITCHELL: Would Dr Emerson like to put it all together with investigations and management?

DR EMERSON: I have never seen a case like this before. I find it remarkable that blood at aortic pressure can go into the oesophageal wall and stay there as long as it did. The patient had a similar pain in his shoulder blades 12 years previously—was that relevant?

About the management. As I said, I think I would have done an aortogram and sampled the pleural effusion at the time when he was put on anticoagulants. But the diagnosis might not have been made. Even if it had been made, it would, I think, have been a hopeless situation.

DR W WHITAKER (9): I would like to ask Professor Mitchell if he can explain how the lesions which have been demonstrated caused the symptoms which brought the man into hospital?

Three days before admission the pain shifted to the right lower back and radiated to the right buttock and groin.

PROFESSOR MITCHELL: It is very easy to say what people die with, but difficult to say at necropsy what caused their problems or what caused their death. I think the aneurysmal masses could have been a source of pain as they got bigger. I would like to suggest a reverse CPC, in which a pathologist is invited to reconstruct the clinical history from what he finds at necropsy.

DR P P TURNER (10): How certain are we that the pathology is atherosclerotic? Multiple aneurysms are not common in atherosclerosis. How certain can we be that there was no arteritis?

DR SMITH: Multiple aneurysms, certainly below the diaphragm, are not infrequently found in atherosclerotic aortas. Numerous sections were examined and there was no evidence of aortitis or arteritis.

PROFESSOR MITCHELL: I should like to thank Dr Emerson for his excellent analysis of this difficult case history.

This conference was recorded and edited by Dr W F Whimster.

APPOINTMENTS OF SPEAKERS

- (1) Professor J R A Mitchell, MD, FRCP, professor of medicine, Department of Medicine, General Hospital, Nottingham NG1 6HA.
- (2) Dr Michael Hayes, MB, MRCP, senior medical registrar, Department of Medicine, General Hospital, Nottingham NG1 6HA.
- (3) Dr Peter A Emerson, MD, FRCP, consultant physician, Westminster Hospital, London SW1P 2AP.
- (4) Dr John Hampton, DM, MRCP, consultant physician, Department of Medicine, General Hospital, Nottingham NG1 6HA.
- (5) Professor A W Asscher, MD, FRCP, professor of medicine, Royal Infirmary, Cardiff.
- (6) Dr J P Hughes, MB, MRCP, consultant physician, Ipswich and East Suffolk Hospitals, Ipswich, Suffolk.
- (7) Dr N Compston, MD, FRCP, consultant physician, Royal Free Hospital, London NW3 2QG.
- (8) Dr Peter Smith, MB, MRCPATH, consultant pathologist, Department of Histopathology, General Hospital, Nottingham NG1 6HA.
- (9) Dr W Whitaker, MD, FRCP, consultant cardiologist, General Infirmary, Leeds LS1 3EX.
- (10) Dr P P Turner, MD, FRCP, consultant physician, Edgware General and Finchley Memorial Hospitals, London.

For Debate . . .

Slow euthanasia—or “she will be better off in hospital”

A A BAKER

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The scene must be familiar to many doctors, social workers, and members of the public: an old lady lives alone, with a neglected garden and dilapidated house. She has gradually lost her contacts with the outside world, and the circle of friends and neighbours who had helped her with shopping and visits has

diminished as she has become increasingly dirty and neglected. She has discouraged home help and meals on wheels services and is now living in squalor and is perhaps incontinent. Her memory is failing and general health becoming frail. She may already be known to the police because of wandering from the house, and neighbours and others have begun to put pressure on the medical and social services to have her removed. An incident such as a fall in the house, a fire, or another episode of wandering or fear of hypothermia has brought the firm request that she should be admitted to hospital. Admission is often arranged, sometimes by simple persuasion of a muddled old lady and sometimes by use of section 25 of the Mental Health Act, or other legal framework. Most of those concerned feel a

Coney Hill Hospital, Coney Hill, Gloucester GL4 7QJ
A A BAKER, MD, FRCPsych, consultant psychiatrist

sense of relief and say to themselves that she will be better off in hospital.

There, it is usually argued, she will be safer and have a longer life, a better quality of life, and better medical and nursing care. The facts, however, are not so comforting.

Effects of admission

For patients of this kind, hospital admission is very traumatic both mentally and physically. A recent survey in this hospital showed the death rate to be 25% within three weeks of admission. Although many of the patients were physically frail, others were relatively well physically, with no immediate disease to threaten health. One or two patients had been admitted for short-term assessment only or while supporting services were not available and with a view to an early return home. The cause of death is usually a terminal bronchopneumonia, but the pattern of events is often similar.

The patient is admitted, bathed, redressed, and within twenty-four hours may be hardly recognisable as the same person as the dirty tattered, old woman crouched at home by her fire. On the other hand, the old woman crouched by the fire often had a good deal to say for herself, showed both individuality and determination, and could be self-assertive. In hospital, however, the same old woman may appear bewildered, restless, look around in perplexity, and seem unable to express any need other than, perhaps, the desire to get home. The initial restlessness, often with wandering round the ward and looking in vain for familiar places or people, will give way to apathy and dejection. This may happen spontaneously, but it may also be induced by medication. In the phase of apathy, appetite is often diminished, incontinence develops, and physical frailty with falls becomes more obvious. At some point, perhaps after a fall, or because the change in the patient's appearance causes concern, she is put to bed, within a day or two develops chest symptoms, and dies a day or two later. Patients who have been living contentedly at home, while populating the house with old memories; who believe their children or parents are still present in the house, though they have left years ago; and who in lay terms are "living in the past" are particularly at risk when moved into a strange institution. The forced removal into a modern setting destroys their fantasy world and the adjustment that went with it.

Obviously, some patients survive the shock of hospital admission, the risks of falls, accidents, and fresh infections, and if not discharged to their home or alternative accommodation stay on in hospital. Surely their quality of life is better than if they stayed at home? The problems of institutionalisation have been well chronicled. The effects of institutional life are felt particularly severely by elderly people, whose resistance to stress is low, whose vitality and initiative is already reduced, and whose loss of memory makes learning in a new surroundings particularly difficult.

Life on a long-stay ward

The ward is of reasonable size, with 24 beds, it has a satisfactory nurse:patient ratio, and nursing morale is high. So far as possible, patients are treated as individuals, relatives are welcomed, and supplies are satisfactory. The day begins at 7 am, when the patients are roused. About half a dozen can find their way to the lavatories; the others have to be helped and guided by a nurse, or sometimes two. The problems of mobility are obvious, with clear expressions of pain on their faces and occasional cries as stiff joints begin moving. They are taken to the table ready for breakfast at 8.30. About 10 can feed themselves reasonably well; the others need varying degrees of help, and nearly half have to be fed by the nurses for one or more meals. In many cases there is a "bird's nest" reflex: as the nurse brings the food and the spoon near to the old person's chair or table the mouth opens in expectation, and after each mouthful the expectant mouth opens again. The nurses are remarkably good at this process, which is rather like feeding a recently weaned infant. They are equally good at maintaining a high fluid intake, and they are helped by the modern drinking bottles, which, again, look like large ungainly infants' feeding bottles. The patients are as dependent on nursing staff for survival from day to day as any patient plugged into machinery in an intensive care unit. It is highly improbable that in their own homes, even with the most devoted relatives, food and fluid intake would be maintained as it is in hospital. After breakfast, there is a further round of going to the lavatory, which because of the frailty, stiffness, and lack of co-ordination of many patients takes a long time.

Later in the morning the doctor may visit the ward and talk to the patients. About half a dozen can respond, at least to the level of saying "Hello" or "Good morning." The others, however, will ignore greetings, mumble, or answer incoherently. A marginally better response can be obtained by the nurses in day-to-day contact with the patients. Many patients will grin or show a flash of awareness when a nurse touches them or speaks. Indeed, there is a close symbiosis between patients and nurses; the patients are totally dependent on the nurses for survival, and the nurses take obvious pleasure and pride in attending to the patients' basic needs, often addressing them by special names or endearments. The similarity between care for these totally dependent old women and the care required by a newborn baby is, of course, striking. Some patients seem to survive in a totally demented and dependent state for several years, thanks to the most excellent and devoted nursing care. Death however, cannot be evaded for ever, and the final months of many of these patients' lives can be very distressing, as the following case report shows.

Case report

This 84-year-old woman had a mild degree of diabetes, controlled by diet, and long-standing arthritis. The hospital notes for the last 10 months of her life showed the following train of events (she had been dementing for two or three years).

In June 1975 an ulcer on the left foot that was discharging was treated with frequent bathing and ointment but failed to heal. In July she was seen by the doctor because of necrotic ulceration of her toe. A month later indomethacin was prescribed and ulceration of the toe was treated by packing with eusol and paraffin. On 2 October she developed a sore throat and cough. Ampicillin was prescribed for five days. On 20 October she developed an unexplained fever, and a seven-day course of ampicillin was prescribed. In early November ulceration developed on the sacral area; this was treated with Conotrane. Five days later she was treated with penicillin and streptomycin for an acute chest infection. There was limited response, so this treatment was discontinued and penicillin G sodium and streptomycin (Crystamycin) was prescribed. On 14 November she developed a venous thrombosis and had a course of phenylbutazone. On 17 November Crystamycin was stopped and she was given erythromycin estolate. Cellulitis recurred on 24 November. In December she had a fresh attack of cellulitis and was treated with a fresh course of ampicillin. It was noted that there was ulceration on the buttocks and broken skin on other pressure areas. From then on she was treated on a ripple bed. Ampicillin was continued until 27 February 1976, when Crystamycin followed by penicillin G was prescribed. On 3 March she was advised to sit out of bed because of her arthritis, which seemed to be deteriorating. She still had cellulitis of the left leg, with a deep necrotic ulcer on her left foot and a pressure sore on the sacrum extending into both buttocks several inches across in each direction. Until then she had had no medication for her pain, though when transferred to another ward the nurse there pointed out at once that she was in great pain on movement and that when her sores were dressed her cries could be heard outside the doors. She died on 7 March 1976.

Conclusions

There can be no doubt that the life of some of these elderly patients is considerably extended by nursing and medical care. There must be considerable doubt whether this extension is in any sense beneficial to the patient. Skilled nursing care can maintain life in a frail, elderly patient whose general condition is such that a comparable state in an animal might well lead to prosecution of the owner. Senile dementing processes sometimes lead to a relatively quick and peaceful death. Many, however, particularly under modern conditions of treatment, can be very cruel illnesses indeed. The problems of dying, particularly in patients with pain from tumours, have been discussed fairly widely recently, and there is a much better understanding of the process and of the medical and nursing approach that is needed. There is a similar need to discuss the problems of dying when there is no acute process and a prolonged terminal phase is likely. Cruelty to the elderly can take many forms.¹ Co-operation between medical practitioner and social services should make it possible for the frail elderly to die in peace and dignity in their own homes, even if alone.

Reference

- 1 Baker, A A, *Modern Geriatrics*, 1975, 5, 20.