

The Care of Sick and Terminally ill Elderly

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Introduction

As far as we know, the maximum human life span has remained 120 years for the past one million years. Ageing is clearly a function of both genetic and environmental factors. Though as a result of the advancement in the treatment of chronic illnesses and heart diseases, mortality rate could be reduced, however yet morbidity has increased. This has contributed to the increase in the rate of growth of elderly population in Kerala more than that in any other state in India.

Condition of the elders in Kerala

In Kerala, almost every house may have one or two elderly persons, most of them having age related disabilities and diseases.

The relatives on whom they have to depend on may not be in a position to look after them. As the joint family system is disappearing fast and nuclear family norm has come into existence in all communities, the number of members in the families have reduced to one or two. Most of them may be far away or even abroad for their job. Even if they are staying with their parents or elders, they will have to go for their job, look after their children and may not get enough time to spend for their elders. Most of the elderly are left alone in their homes. When they become sick or totally bedridden, it will be difficult for their children or relatives to give them proper care.

Causes for the elderly to become sick and bed ridden

The common causes include:

1. Acute conditions such as post stroke coma and paralysis, post fracture, especially fracture neck of femur and inter trochanteric fracture of femur, post operative disabilities and depression.

2. Chronic conditions as Parkinsonism, malignancies, Alzheimer's and related diseases.

In acute conditions, the patients will be hospitalized.

As their condition stabilises after treatment, they will be discharged from the hospital often with Ryle's tube for feeding, urinary catheter, bowel incontinence and bed sores. In the hospital, patient is under care of doctors, nurses and other staff. The relatives would not have known anything about the care given to the patient. When they bring the patient home they will be in a very embarrassing and helpless situation, when the catheter gets blocked or Ryle's tube is pulled out by the patient. In most of the cases, the relatives stop feeding the patient because when they feed orally the patient starts coughing and choking due to aspiration. Usually these patients die after one or two weeks due to aspiration pneumonia, dehydration, starvation or some infections.

In my professional career, I have come across many such cases, a few of which I can highlight here.

Case I

A 72 year old lady, known hypertensive patient but very irregular in taking medicines, was brought to my clinic with symptoms of impending stroke. I referred her to the nearest tertiary care center immediately.

After about 2-3 weeks, her son came to me and told me that this patient was brought home after a week's treatment in the hospital. She was fed through Ryle's tube, but she started vomiting. I was asked to go and see her in their house. When I saw her, she was unconscious and her breathing was laboured. The Ryle's tube was blocked and the urinary catheter was also blocked. I was told that when she started vomiting, they had stopped feeding her. The Ryle's tube and the urinary catheter were changed and tube feeding was started. The next day, she passed away. Here the relatives were not aware of anything about the nursing care to be given to the bedridden patient.

We have a lot of experiences to show that, when proper nursing care and other supportive management were given to such patients, many of them could be brought back to their normal life.

Case II

One day when I gave a talk on "The care of elderly sick and terminally ill" in the Inner Wheel Club meeting, a member of the club, asked me to come and see

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her brother, who is a doctor. He was in the nursing home of his son-in-law. When I saw him, he was lying in a bed with railing of the cot raised on all sides. His body was thin and emaciated with eyes closed. He was surrounded by his relatives, nurses and attendants, all ready to obey his orders. He was not opening his eyes or mouth, though he was fully conscious. I was told that he had a minor surgery on the tongue for biopsy. After that he was neither taking any food or drink nor getting up from the bed. He was reluctant to talk to any one and highly depressed.

He was known to me a long time back and my husband was also closely associated with him a few years ago. To make him talk, I reminded him of his old days when he was having good practice. Suddenly he started talking about his old friends. I utilized this opportunity to gain his confidence and within two weeks he started taking proper food and started walking. Soon he went home. Only a few regular visits and reassurance was needed to make him feel better instead of over protection and compulsory feeding.

Case III

In another incident I had to witness the very tragic and miserable end of an eminent lady professor. One afternoon I got a call from an old man asking me to come and see his sister who was very sick and bedridden. On my way I asked about the patient and I knew that she was not staying with her brother, but in an old age home. She was sent out from her own house by her daughter and son in law when she had a fall and fracture femur about 3 to 4 years ago. I was shocked to see her condition, she was an eminent professor in a very famous college in Palghat and had taught a lot of very eminent personalities including a cabinet minister.

I had to witness her end as it happened within a few minutes of my visit. She did not have proper food, clothes, medicines, or a good bed. The old age home was only a portion of a house run by a young couple for their livelihood. I can never forget this event in my life and I had to do her last rites though I saw her for the first time.

Case IV

In chronic diseases like Parkinsonism, Alzheimer's dementia etc. even if the relatives are willing to look after the patient because of the longevity of the morbidity period, the care takers will become dejected, exhausted and finally neglect the patient's needs.

I was called to see a patient who had been bedridden and had incontinence of urine. He had been suffering from Parkinsonism for about 14 years. He had

become totally bedridden 4 months back following a respiratory tract infection for which he had been admitted in a hospital. He was discharged from the hospital with Ryle's tube feeding and on a urinary catheter. He also had bowel incontinence. When I examined him, he was semi conscious. All his limbs were flexed and rigid, his mouth and tongue were full of fungal infection. He was swallowing small sips of fluid. There was no Ryle's tube. Though two sons were staying with him, they had to go out for their job in the morning and they came home only by night. His wife, a 72 year old retired teacher, was alone in the house. She was so weak that she could not even change the clothes or bed sheets, which were soiled with faeces and urine. The patient was given only one or two glasses of liquids orally per day.

I suggested to shift him to our hospice, which is very near to their home, so that he could be given proper food, care and necessary medicines. The next day the patient was shifted to our hospice. When he was given proper care, his condition improved and many of his relatives started coming to the hospice to see him. For the next two weeks he was looked after very well and he had a peaceful and comfortable time. He expired in the hospice in a dignified manner in the presence of all his near and dear ones.

With these few examples and much experience, my humble request to my professional colleagues is that when we discharge the patients in such conditions, the relatives should be properly informed of the condition of the patients. Proper instructions and guidance in the management of the patient at home should be given. They also should be instructed to contact the local doctor whenever required. This will at least prevent a lot of misery during the last days of human life.

Santhitheeram

Even among the educated and elite class, the relatives are not able to give proper care to the elderly sick persons. I have come across many heart breaking incidences, where many persons who had high standards of living, died miserably. This prompted me to start "Santhitheeram" where we admit the totally bedridden, the terminally ill and patients who need help for their daily routine activities. They are looked after by trained care givers. Doctors give them necessary medical care. The training for the care givers is conducted by doctors. These care givers are sent to the house of the bedridden patients, if requested by the relatives. Our aim is to prevent much misery and to make the last days of human life peaceful, comfortable and dignified as far as possible.