End-of-Life Care for the Elderly

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In Japan’s aging society, where 19.3% of the total population is aged 65 or over, end-of-life care for the elderly is a key issue. At the Japanese Society for Research on Death and Dying, established in 1977, physicians and nurses have led discussion on the palliative care of terminal patients with malignant tumors, which is the primary cause of death in Japan. In 1981, the Seirei Hospice in Hamamatsu became the first palliative care unit (PCU) to be certified in Japan, paving the way for the establishment of 143 units nationwide. PCU hospitalization costs began being covered by health insurance in 1990, but since only patients with malignant tumors or acquired immunodeficiency syndrome can be admitted to PCUs, many elderly do not qualify for palliative care.

At centers for the elderly (special nursing homes for the elderly, public health centers for the elderly, grooming homes, etc.) used by those incapable of leading an independent life at home and in need of care, many patients have cognitive disorders and are incapable of clearly indicating how they intend the fast approaching last days of their life to be. Those whose condition takes a sudden change for the worse are taken to hospital. Here, their families are asked whether they intend life-prolonging treatment to be administered, but more often than not little consideration is given to the opinions of the elderly persons themselves.

In 2000, Richard Smith, Editor of the British Medical Journal, put forward 12 principles of a good death in a final report on the Future of Health and Care of Older People1 and, to achieve this, care using an integrated care pathway for the dying patient is offered.2 This consists of palliative care respectful of the dignity and privacy of the individual and considerate of the wishes of the individual in the final stages.

The article, “A qualitative exploration of Japanese elderly patients’ preferences for end-of-life care” records the findings of interviews conducted by Ayako Hattori et al. with 17 university hospital in-patients and 13 outpatients of university-affiliated hospitals aged 65 or over to find out their preferences for end-of-life care. Elderly patients’ preferences for end-of-life care are influenced by emotional factors, decisions sometimes change and consideration for family members also has an impact. Elderly patients would prefer to spend their last days at home, but out of consideration for the strain on their families they would also consider hospitalization. They would prefer a comparatively quick, peaceful death without long-term care in a bedridden state.

When considering the end-of-life care of elderly patients with cognitive disorders who are no longer able to indicate how they intend to die, carers must consider the wishes and opinions that have been made clear by the elderly patients at that point and ensure that they are able to die with care that they and their families are satisfied with.

References

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