

## THE 10-MINUTE INTERVIEW

## Don't put off life-and-death discussions

Geriatrician stresses need to ask parents about end-of-life care

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Every week, Toronto geriatrician Michael Gordon deals with distraught families, desperate to do “the right thing” to help elderly parents or relatives live their final days with dignity.

Too often, they wait until it's too late for life-and-death discussions, such as how hard is their failing parent prepared to fight for life? Does that include tube feeding, which may add days but also discomfort?

Are there religious issues that may impact how your 93-year-old mother wants to be treated for a terminal illness?

Gordon, 68, director of palliative care at Baycrest Centre for Geriatric Care, and one of Canada's most respected specialists, helps answer those questions in a new book, *Moments That Matter: Cases in Ethical Eldercare*.

“Most families want to do the right thing because they know if they don't, they will have to live with it the rest of their life,” says Gordon.

Thanks to his own patients for more than three decades — and a leisurely walk years ago along Brooklyn's Brighton Beach with his now 98-year-old father — Gordon speaks from experience about discussing end-of-life issues openly, long before the end is on the horizon.

**Q: Bill C-384, a private member's bill that would have legalized assisted suicide in Canada, was recently defeated. Do you think Canadians will ever support euthanasia?**

**A:** I would not be surprised to see that happen as the baby boomers age. This will depend on how well we promote good palliative care. Even in countries where physician-



COLIN MCCONNELL/TORONTO STAR

Dr. Michael Gordon strolls the halls of the Baycrest Geriatric Centre, lined with photos of current and past residents of the housing area. He's written a book that guides families through the challenges of end-of-life care.

assisted suicide or euthanasia are allowed within a legal framework, when there is good palliative care, the demand for such extreme measures diminishes enormously.

**Q: What is a living will, and how important is it?**

**A:** That is the lay term for an “advance directive.” It means, in the event that I can't make a decision, I want you to act in such a way. The problem is that living wills are often written without discussion, so the substitute decision maker (the trusted relative or friend who oversees the terms of the living will) tries to interpret it, and sometimes in a way that's opposite to what was intended. That's why the conversation is very important.

**Q: Why is it important that families set some strict conditions for when end-of-life treatment be discontinued?**

**A:** It's emotionally much more difficult to stop a treatment than to not start it. You have to have a good sense of what the end point is and where you're allowed to say, “No more.”

**Q: What would you say is the greatest ethical challenge in elder care?**

**A:** The one that causes the greatest anguish is decisions around artificial nutrition and hydration (especially refusing or removing feeding tubes.) . . . Doctors see it as the withholding of an artificial technological provision of calories and flu-

ids. It's a very grey area emotionally because most people think of it as “starving” their parent. Studies have shown that after a relatively short period of deprivation, the body doesn't feel hunger or thirst — it shuts off those sensations. The law says this can be done.

**Q: You touch on the boom in “old love” in seniors' facilities, how important love and sex are as we age. Why is that so upsetting for their children and staff?**

**A:** That is a whole other book. To some extent, all of us have to get over our own hang-ups around romance, sex and love. Just because you're elderly, frail and have some problems, doesn't mean you shut off all the switches.

**Q: I was surprised that reviving the elderly with CPR (cardiopulmonary resuscitation) has a fraction of the success rate it appears to have on TV medical shows, but families frequently don't know that.**

**A:** The frail elderly often have so many medical problems that cardiac arrest is just one component of the body giving up. I don't believe CPR should be used on the frail elderly, especially those in long-term care, because it's so rare that anybody really responds.

**Q: You talk about the walk you took along Brighton Beach with your dad 12 years ago and the importance it will play at the end of his life.**

**A:** We talked about what we all experienced with my late mother, who died a terrible death. We had to make the final decision to not reinsert a feeding tube and then have her treated in palliative care. I said to my father, “I want to be sure I understand what it is you want so we avoid what we experienced with Mommy.” (His dad stipulated he wants no tube feeding or “heroic” measures to prolong his life.)

**Q: You are quite candid about ageism in the medical system — that older people can be deprived of treatment by doctors who take the view “they've lived a good life.” Is this changing?**

**A:** Ageism is fairly common in all of society, but we are seeing changes. Health-care training has evolved so that most curriculums now have courses and special exposure to the elderly. We still suffer from too few people choosing elder care as their professional focus. There have been enormous strides that I'm very proud of, but that doesn't mean we've reached the point I would like in terms of sensitivity, thoughtfulness, knowledge and a cohesive approach to caring for the elderly.

Susan Pigg focuses on issues around aging and baby boomers.  
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