AGING AND DEATH

AGING

The fact that we are getting older often comes to us as a complete surprise. There is a big difference between the actual feelings of a person growing older and society's image of that person — we are as young or as old as we feel.

The gap between our mental age and our physical age starts to close around 50 years of age. It becomes more difficult to avoid the reality of our own aging as our bodies begin to betray us. Many people in their fifties have a major illness, such as prostate problems or arthritis. Some healthy people experience subtle body reminders of aging; for instance, a person may no longer find the energy and mobility to play tennis for hours as done in the past. When our bodies do not allow us to do what we would like to do, that is usually evidence of aging.

The elderly population is growing faster than any other group, and physicians are now treating more and more older patients. Between 1980 and 1991, the elderly population increased by 11 percent. Consequently, health needs for the elderly involve more than treating chronic and debilitating conditions. As people live longer, healthier, and more active lives, physicians will also need to deal with the patient's concern about appearance and sexual health. This concern should include a planned prevention program for good health, such as a healthy diet (rich in vegetables), good health habits (no smoking), moderate or no alcohol consumption, and daily exercise.

MYTHS ABOUT SEX AND THE ELDERLY

Myth: Old people are not interested in sex. Actually, people may stay sexually active until the day they die. Sexuality can continue, barring intervening medical conditions, and should be recognized as a reasonable and expected form of behavior.

Myth: Older people can't perform sexually. Getting old doesn't mean becoming dysfunctional, however, the prevalence of chronic illnesses and use of medications are higher among older adults. These can interfere with normal sexual function. Assessment of sexual problems can provide early signs of other conditions which adversely affect sexuality, such as anemia, high blood pressure, alcoholism, and diabetes. Medications such as antihypertensives, diuretics, digitalis, and antidepressants can depress the sex lives of men and women.

Myth: Sexual dysfunction in the elderly can't be treated. Usually, treatment is possible, provided the problem is correctly diagnosed. While there isn't a cure for everything, there are treatment options. Medications, prostheses, and sexual assistant devices can remedy many problems. Sometimes psychological counseling is helpful.

Myth: Sex is only for healthy people. Issues of sexuality can be complex for those who are impaired, but these patients still may be able to choose whether to be sexually intimate. It is important to talk with a partner about problems or when to use nonsexual expressions of attentiveness and caring.

Myth: Old people don't get sexually transmitted diseases. The safe sex message is almost never given to older adults, but it should be. Among people over 50 years of age, approximately 10 percent have one or more risk factor for AIDS (according to a study released by the Center for AIDS Prevention Studies at the University of California, San Francisco).

DEMENTIA AND ALZHEIMER'S DISEASE

(See Brain and Nervous System chapter under Degenerative Disorders.)

ANTIAGING DRUGS

The National Institute on Aging (NIA), part of the National Institutes of Health, is launching an education effort urging consumers to use caution when it comes to "antiaging" hormone supplements that have recently become popular. Consumers can call 1-800-222-2225 to order a free NIA fact sheet about hormone supplements. The NIA also is releasing television announcements encouraging consumers to call the toll-free number.

Contrary to popular claims, none of the supplements described in the fact sheet, including melatonin, DHEA (dehydroepiandrosterone), human growth hormone (hGH), testosterone, and estrogen have been shown to prevent or reverse aging. Research ultimately may reveal important health benefits from some of the supplements in addition to those already confirmed. In the meantime, scientists are concerned about the dangerous side effects associated with some of the supplements, and about the possibility of undiscovered health risks.

Consumers can buy DHEA and melatonin over the counter, resulting in widespread use unsupervised by physicians. Part of the scientists' concern stems from the fact that research on melatonin and DHEA, and of unconventional "antiaging" uses of other, more well-established hormone supplements, is relatively new. With the exception of testosterone and estrogen, researchers have not had time to complete the carefully controlled, long-term studies that are needed to show how these hormone supplements affect people over time.

Testosterone, estrogen, and hGH are available by prescription only, and in cases of genuine deficiency, have been shown to confer important health benefits when taken under a doctor's supervision. However, unsupervised use of any hormone supplement can lead to health problems.

DHEA supplements may affect the body in some of the same ways as testosterone and estrogen. Research has demonstrated that melatonin supplements can, under certain circumstances, affect the body's sleep/wake cycle to enhance sleep.

Hormones are powerful chemicals produced by glands. Whether made internally by glands or taken externally as supplements, hormones enter the bloodstream and travel throughout the body. Tiny amounts of hormones may have far-reaching effects. Several NIA-funded studies of hormone supplements are under way.

NIA publications on aging-related topics are available through the same toll-free number, 1-800-222-2225, and on the NIA home page (http://www.nih.gov/nia/).

The NIA leads the Federal effort supporting medical and social research on aging and the special needs of older people.

NUTRITION AND NUTRITIONAL SUPPLEMENTS

A balanced diet is essential to sustain health. Many health activists also suggest takeing nutritional supplements to regress the effects of aging. Most of these supplements contain common vitamins, antioxidants, and minerals.

AVAILABLE RESOURCES

AIDS Risk Behaviors Among Late Middle Aged and Elderly Americans, The National AIDS Behavior Surveys, by Ron Stall, PhD, MPH, and Joe Catania, PhD (Archives of Internal Medicine, Jan 10, 1994).

Sexuality and the Alzheimer's Patient, by Edna L Ballard and Cornelia M. Power (Duke University Family Support Program, 1994). Call (919 660-7510).

Love and Sex After 60, by Robert N. Butler, MD, and Myrna I. Lewis (Ballantine Books, 1993).

A Thousand Tomorrow's — Intimacy, Sexuality and Alzheimer's, Terra Nova Films, Chicago; for purchase ($265) or rental ($55), call (800) 779-8491.

Sex Information and Education Council of the United States, (212) 819-9770.

DEATH

Epidemics, wars, and disasters have taken a great toll on lives in past generations. Improved medical care, public health programs, and decreasing world conflicts have all contributed to fewer early deaths and a larger population. It is likely that most of us will live to become elderly. It is difficult to face death calmly. In many ways, it can become lonely and impersonal because the patient is often taken out of a familiar environment and taken to a care facility or rushed to an emergency room. A cry for rest, peace, and dignity is often lost to lifesaving equipment hospitals. Eighty percent of deaths occur in an institution — only twenty percent occur elsewhere.

A terminally ill patient's desires about death are often not heard by the physician. A recent study of terminally ill patients with a living will that states "Do Not Resuscitate" showed that 30 percent had never been entered in the medical records for the physician to see, and of these patients, 38 percent spent their last ten days in an Intensive Care Unit (ICU).

EMOTIONAL STAGES OF DYING

Denial and Isolation Denial is usually a temporary defense that is soon replaced by partial acceptance.

Anger When death is imminent, calmed emotions are often replaced by feelings of anger, rage, envy, and resentment. Families are often required to tolerate anger whether it is directed at them or elsewhere. The anger may well pass, allowing the patient to express inner feelings, accept the reality, and find peace in being loved and accepted.

Bargaining Bargaining is an attempt to postpone the ultimate and is often linked to "good behavior," which may replace anger. Most bargains are made with a God and a promise for "a life of dedication" or "a life in the service of a church."

Depression When a dying person can no longer deny illness, becomes weaker and thinner, has financial burdens accumulated through treatment, and attempts to laugh, cheering them on is no longer effective. At this point, listen to the patient express any sorrow, showing your acceptance of the depression.

Hope Through all of these emotional stages, a patient should always sustain hope that some treatment will become available to ease any suffering.

Acceptance Acceptance should not be mistaken for a happy stage. It is almost void of feelings and listening to the patient talk about life satisfactions and describing his or her terms of the meaning of life is most important. When you listen patiently, you are helping the dying person take a great step toward acceptance.

WHEN TO STOP RESUSCITATION

The elderly population is growing faster than any other group. Physicians will be seeing more and more older patients in the future. At this time of life, the realization of death becomes emotional, as well as intellectual. People start to pay more attention to the obituaries and recognize their contemporaries are listed with increasing frequency. This causes a reorientation in the meaning of life and time. Many people start to think in terms of how long they have to live, rather than how long they have lived.

Doctors go to heroic lengths to keep terminally ill patients alive — often against their wishes. One ongoing and repetitively observed fact is that doctors either are unaware of, or ignore, the last wishes of dying patients. A landmark study in the Journal of the American Medical Association quoted the coauthor as saying, “There is a tragic mismatch between the care many seriously ill patients want and the care they get. This is hard on patients, their families, and the health professionals who care for them.” It appears that the concept of last minute miracles combined with the notion of “not giving up too soon” is so powerful that behavior cannot be changed despite the suffering of the patient and the cost to society. The authors concluded that society needs to think creatively to allow patients their desires about the best way to live their last days.

The increasingly popular Hospice management offers a terminal patient a more acceptable and dignified plan outside of an intensive care unit and in the comfort of their home with loved ones. The patient deserves a choice about the death process, should make a living will, and discuss his/her desires with responsible loved ones.

The essence of life is change, and without change, the whole organism dies. There are choices that can be made through the aging process that can offer surprising new possibilities. Look back on your life — the significant events and experiences — and consider what new opportunities are available to you. Give to life what made and still makes you grow.

AVAILABLE RESOURCES

How We Die, by Sherwin B. Nuland, MD (Random House, 1993). This tells how most people are likely to die and suggests how to live more fully and meaningfully.

The Troubled Dream of Life by Daniel Callahan, PhD (Simon and Shuster, 1994).

Death, the Final Stage of Growth, by Elisabeth Kubler-Ross, MD (Prentice Hall, 1975). Also by Dr. Ross, "Working it Through — Workshop on Life, Death and Transition" (Collier Books 1992).

Coping with Death and Dying, An Interdisciplinary Approach, by John T. Chirban (University Press of America, 1988.) Physicians, psychologists, and clergy relate their approaches for helping people to cope.

The Path Ahead, Readings in Death and Dying, by Lynne Ann DeSpelder and Albert Lee Strickland (Mayfield Publishing Co., 1995). Writings by anthropologists, physicians, and others.

Final Gifts, Understanding and Helping the Dying, by Maggie Callahan and Patricia Kelley (Hodder and Stroughton, 1995). The authors are hospice nurses.

Framing Death: Where Culture, Religion and Medicine Meet, papers from the 1994 Yale conference "Ars Moriendi," 1996.