How Hubris Impairs the Care of the Elderly

John M. Mandrola, MD, June 08, 2018

** hubris, - excessive pride or self-confidence.*

- (in Greek tragedy) excessive pride towards or defiance of the gods, leading to nemesis

synonyms: arrogance, conceit, conceitedness, haughtiness, pride, vanity, self-importance, self-conceit, pomposity, superciliousness, feeling of superiority:

A very elderly man with atrial fibrillation asks whether to continue taking a clot-blocking drug to prevent stroke. For the sake of argument, this patient could be male or female, 90 years old or 100 years old.

The pro-side of using preventive therapy in the elderly is that the older the patient, the higher the risk for stroke, particularly a devastating one. Use of an anticoagulant in an elder, therefore, provides a robust degree of probability benefit in the future, albeit with the downside of a higher risk for bleeding.

The scenario here is similar to the quandaries faced in treating a number of chronic conditions in the elderly patient. One of the main debates surrounding the 2017 American College of Cardiology/American Heart Association hypertension guideline is how aggressively to lower blood pressure in older patients. Similar concerns have been raised about aggressive blood glucose control in older patients with diabetes, resulting in the American College of Physicians issuing a guideline contradicting recommendations in the American Diabetes Association's 2018 Standards for Diabetes Care.

When There Is No Evidence

Evidence cannot help us here. Randomized controlled trials only rarely include patients in their ninth or tenth decade. The word for using evidence acquired in 60-year-olds to determine care in the very elderly is…foolish.

This decision, like so many in medicine, requires judgment. It also means resisting hubris.

Also foolish is the idea of letting the patient decide. How in the world is the patient supposed to know the right answer? *The way we frame the decision to treat or not will surely sway the patient*. Yes, it is right to share the decision with the patient, but the advisor must be clear about the decision at hand. Giving patients a menu of choices is akin to abandonment.

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The typical hubristic reasoning considers two potential errors. *An error of omission* occurs here if we choose not to use the anticoagulant or extra blood pressure medicine and the patient has an adverse event, such as a stroke from emboli or hypertensive disease.

An error of commission occurs if we choose to use the anticoagulant and the patient suffers serious bleeding. Or perhaps we add the extra blood pressure or antidiabetes medication and the patient suffers a catastrophic fall. We committed the patient to preventive therapy and that commission played a role in his demise.

Many doctors struggle with this choice.

The struggle exposes our hubris. *We falsely think that we control outcomes in a person who has lived for many decades. To be sure, we do not control outcomes in this group.*

One need not consult actuarial tables to determine the chance of a 90- or 100-year-old person dying in the next year. It is high—whether we recommend preventive therapy or not.

That being said, I would not take the nihilistic view that there is not a correct answer. I believe there is a best answer.

It is: Do not treat.

Let me explain.

When Not Treating Is the Best Treatment

During a recent trip to the University of Calgary, my electrophysiology colleague Dr George (Yorgo) Veenhuyzen taught me an important lesson about decision making under uncertainty. It goes like this: *When there is true equipoise of a treatment (a complete counterbalance), and that treatment has potential harm and added cost, the right answer is not to treat*.

Of course it is. The doctor's golden rule is: First, do no harm.

In the very elderly, there is no proven benefit of preventive therapies—such as anticoagulants or aggressive blood pressure control. This would require studies of very elderly people. There are none, nor will there ever be. There is, however, a well-known increased risk for harm (and added cost) from these therapies.

I would also add to my Canadian friend's logic that people who have been lucky enough to live to old age deserve the right to avoid iatrogenesis—or harm brought by us. Preventive therapies may work in younger people, but that does not apply to older people who have much less organ reserve.

The Fallacy of Doing Nothing

Some may make the decision to treat an older person a choice between "do nothing" or "do an intervention." I dislike this framing.

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"Do nothing" is not the alternative. One of the greatest errors of our time, one that frustrates me immensely, is the idea that not doing an invasive procedure or prescribing yet another drug equates to doing nothing. How many times have I heard a nurse or doctor say, "We have nothing to offer?"

We have plenty to offer people at the end of life. We can offer caring. And nowhere in the definition of caring is pharmacotherapy or invasive procedures.

We can care for our elderly patients by attending to their needs and trying to relieve suffering. *We can provide palliative care.*

Clinicians can also help the elderly by reframing our thinking about life and death. Rather than bemoan the end-of-life event in an elder who was previously vigorous, we could celebrate the fact that he or she lived a long life, one that was lived with a short period of illness before death. Stanford University rheumatologist Dr James Fries called this ideal situation the compression of morbidity.[1] Most people aim for an outcome described in the poem "The Deacon's Masterpiece" by Oliver Wendell Holmes, which memorialized a one-horse shay that worked perfectly for 100 years, then fell apart all at once. When we intervene at the end of life, we too often merely extend the period of illness before death.

In this era of death denial and increasingly invasive medical technology, it would be wise to heed the words of the late Ivan Illich, a critic-philosopher, and once Catholic priest.

Presciently, in 1975, *Illich wrote of three forms of iatrogenesis* wrought by the medical establishment.[2] *Clinical iatrogenesis is harm from medical error. Social iatrogenesis is the medicalization of normal life*.

But the most insidious form of harm from the medical guild is a cultural iatrogenesis—or medicalization that corrupts the essence of what it is to be human.

Illich wrote that "the medicalization of society has brought the epoch of natural death to an end. Western man has lost the right to preside at his act of dying."