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MANAGEMENT

Palliative Care of Aged Nononcologic Patients

Prof. univ. Dr. Ioana Dana Alexa

University of Medicine and Pharmacy “Grigore T. Popa” Iași, România, Geriatric and gerontology, Internal medicine

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Abstract

The care process of senior patients approaching the end of life is a complex one as it should combine the care of the multiple chronic diseases that are usually the attribute of this age category with the alleviation of the burden of suffering, pain and humiliation. This is the reason why, in recent years we noted an increasingly higher emphasis on the early integration of the palliative care team in the geriatric assessment and geriatric team.

We present two recent projects that aim to develop a common curriculum – geriatric and palliative medicine -, to be implemented to the teams dealing mainly with the medical-social assistance of the elderly with severe concomitant diseases These teams are thought to require complex geriatric and palliative knowledge, with a special focus on assessing their degree of frailty and functional decline rate. The results of these projects showed that both teams have gained valuable experience in a more efficiently human approach of complex elderly patients, with superior results in attending to their needs and in improving the quality of life as they near their death. It has been noticed that, although the dying elderly accept with resignation, and often with serenity, their end, they fear abandonment or dying in a hospital room, surrounded not by loved ones, but by intensive care devices they dislike. Associating palliative care to senior patients at the end of life improves greatly the quality of medical care we can provide for both patient and loved ones.

Keywords: *palliative care, elderly, geriatric assessment*

MANAGEMENT

Îngrijirea paliativă a bolnavilor vârstnici non-oncologici

Rezumat

Procesul de îngrijire a pacienților vârstnici care se apropie de sfârșitul vieții este unul complex, deoarece ar trebui să combine îngrijirea multiplelor boli cornice, care sunt de obicei atributul acestei categorii de vârstă, cu atenuarea sarcinii suferinței, durerii și umilinței. Acesta este motivul pentru care, în ultimii ani, am remarcat un accent din ce în ce mai mare pe integrarea timpurie a echipei de îngrijire paliativă în echipa de evaluare de geriatrie și geriatrie.

Vă prezentăm două proiecte recente care vizează dezvoltarea unui curriculum comun - medicina geriatrică și paliativă -, care urmează să fie implementate echipelor care se ocupă în principal de asistența medico-socială a persoanelor în vârstă cu boli concomitente severe. Acestor echipe le sunt necesare cunoștințe de geriatrie și paliație complexe, cu un accent special pe evaluarea gradului lor de fragilitate și rata de declin funcțional. Rezultatele acestor proiecte au arătat că ambele echipe au dobândit o experiență valoroasă într-o abordare umană mai eficientă a pacienților vârstnici complexi, cu rezultate superioare în atenția la nevoile lor și în îmbunătățirea calității vieții pe măsură ce se apropie de moartea lor. S-a observat că, deși persoanele în vârstă muribund acceptă cu resemnare și adesea cu seninătate, sfârșitul lor, se tem de abandon sau de moarte într-o cameră de spital, înconjurată nu de cei dragi, ci de dispozitive de terapie intensivă, pe care le displace. Asocierea îngrijirii paliative la pacienții vârstnici la sfârșitul vieții îmbunătățește considerabil calitatea asistenței medicale pe care o putem oferi atât pentru pacient, cât și pentru cei dragi.

Cuvinte cheie: *îngrijire paliativă, vârstnici, evaluare geriatrică*

Longer life expectancy has inevitably increased the occurrence rate and incidence of chronic irreversible diseases (heart failure, chronic respiratory failure, chronic renal failure, diabetes mellitus), of chronic disabling diseases (stroke, Parkinson's disease, different degrees of cognitive impairment) and the incidence of geriatric syndromes with deeply negative effects on the degree of independence and quality of life of the senior patients. This phenomenon had given rise to the need to integrate palliative medicine as a central component of the care process of the elderly nearing the end of their life, so as to relieve them of the burden of suffering, pain and humiliation, as is still the case in many situations in Romania.

In recent years, an increasingly higher emphasis has been placed on the early integration of palliative care (PC) in the geriatric assessment of the elderly patients with chronic medical conditions, as it may have an essential contribution to the correct control of symptoms (especially pain) and to the assessment and resolution of physical, psycho-social and spiritual problems, both for the elderly and for the family members directly involved in their care (1).

Experience has shown that there are many commonalities between Geriatrics and Palliative Care. For this reason, a first project was born that aimed to create a common curriculum, geriatric-palliative medicine, to be implemented to the teams dealing mainly with the medical-social assistance of the elderly with severe concomitant diseases. These teams are thought to require complex geriatric and palliative knowledge, with a special focus on assessing their degree of frailty and functional decline rate. The project has been discussed with members of the complex geriatric and PC care teams and the result was, not surprisingly at all, that the geriatric team gained a vast and beneficial experience in recognizing when the PC team should be actively involved. In addition, the geriatric team has acquired increased skills in addressing the needs of the senior patient, communicating with them and their family, changing therapeutic and care goals as they near death (2).

A second project aimed at the development of a palliative model of geriatric staff education, called GEPaC (Geriatric Education using a Palliative Care framework). In a paper published in 2018 (3), the authors specify that both Geriatrics and Palliative Medicine address individually the elderly with concomitant diseases, without having a common much-needed basis. For this reason, the authors develop an educational framework for both specialties, the goal of which is to develop a common care plan for these categories of patients.

This project aims to develop:

- communication skills with the complex senior patient (burdened with multiple diseases, with complicated treatment plans, with a high degree of disability and inexorable progress towards death);
- the skills of educating these patients and their families/caregivers regarding the expectations related to quality of life, life expectancy and how to approach the final outcome;
- the application of scales for assessing survival skills (nutritional, physical, cognitive, social insertion, frailty, spirituality and belonging to the community and family) in order to develop a common long-term care plan (within the limits of possibilities).

The results of the project showed that both teams (geriatrics and PC) have gained valuable experience in a more efficiently human approach of complex elderly patients, with superior results in attending to their needs and in improving the quality of life as they near their death (3).

Care to the elderly has a number of specific aspects that should be taken into account in their holistic assessment. A first aspect is the presence of comorbidities, which require evaluation, pharmacological and non-pharmacological treatment and long-term care. For instance: the coexistence of chronic diseases in their final stages, such as: heart failure with diabetes mellitus and polyarthrosic disease, with degenerative diseases caused by the aging process, such as: Alzheimer's disease, Parkinson's disease, and with diseases whose incidence rate increases with aging (stroke, cancer) will have several consequences:

- independence decrease due to decreasing muscular strength and increasing frailty;
- increased feeling of fatigue and weakness, with further reduction of physical activity and muscle mass reduction;
- decrease of the quality of life and deepening of depression.

The role of PC in this category of patients consists of monitoring the progression of concomitant diseases and of intervening at difficult times, in order to treat the acute symptoms, to provide physical or mental rehabilitation programs, to ensure good communication with the patients in order to make them understand what is happening to them, to discuss the choices they have at hand and which would be the best future approach. PC association to the long-term treatment plan of these patients may give them access to a series of financial and social resources that could have a major contribution to improving the quality of life and lowering the costs of health and social care services (1).

Therapy stage planning

- It is particularly important for both the elderly patient and his/her family/caregiver, especially when/if the elderly loses his/her judgment/decision-making abilities and the family/care giver must make decisions regarding his/her medical and/or social options.

- ADP = Advanced Care Planning – represents a medical-social entity that deals with the exploration and recording of options for patients who have concomitant serious illness, severe frailty or life-threatening conditions. These discussions between ADP - most often represented by the family doctor, the person who knows the patient best

- and the patient usually occur in several sessions, allowing to explore all the existing therapeutic variants for the medical profile of each individual (4).

- The patient's therapeutic decisions should be made only after he/she has been well informed by the medical team about his/her options and their consequences on his/her subsequent evolution; age is not a criterion of exclusion from all existing therapeutic options.

- The 4 fundamental ethical principles, namely the principle of autonomy, beneficence, non-maleficence and justice, will be strictly observed:

Autonomy implies respect for the patient's right to decide his/her own fate but only being perfectly aware of all the aspects involved;

Non-maleficence means that the patient is not overwhelmed with unnecessary or highly invasive investigations or treatments without having a clear benefit or increasing life expectancy;

Beneficence means that the application of a treatment plan must be based on the risk/benefit ratio, and the benefit should always be higher than the risk;

The principle of justice means that all patients have the same rights to health and social care.

Patients who are usually referred to geriatric clinics have 14-15 different diagnoses and prescriptions containing 18-20 different types of medications. Unfortunately, these drugs address to a very small extent the patient's symptoms, they treat especially the disease mechanisms and clinical signs.

The PC team is extremely necessary for the elderly nearing the end of their lives:
- patients with a severe deterioration of a severe chronic condition, including the frailty syndrome;
- patients suffering from an acute life-threatening event;
- patients suffering from a severe chronic disease at risk of sudden death (5).

The existence of cognitive disorders, hearing and/or visual impairments can greatly influence the conversation with the senior patient, which will lead to a significant decrease in the quality of the anamnesis and the patient's education, the feed-back needed to build a doctor-patient relationship based on trust and respect. The existence of different degrees of locomotor disability will make it difficult to examine the patient in outpatient clinics and will make diuretic and/or laxative treatments especially difficult due to difficult trips to the toilet. Moreover, the risk of falling, very common in these patients, may be exacerbated by analgesic or psychotropic medication (6).

Elderly supervision during palliative care may be done both at home and in long-term or hospice care institutions. Aged individuals in Romania, however, avoid these two types of institutions because, most of the time, they do not have the necessary financial resources and are afraid of family abandonment. Regardless of the environment in which palliative care will take place, the team will have to develop a care plan, based on the wishes of the patient's and family.

In general, discussions with the patient and his/her family will need to clarify (7):
- if the patient wants to undergo invasive, aggressive therapeutic procedures, which could - at high risk - extend his life; for example, entry into the dialysis program of 80 years old people with chronic renal failure or implantation of a heart pacemaker in very elderly patients with severe heart failure;
- the assessment of quality of life expectations should be done with the patient, not with the family, even if there are communication disorders or cognitive disorders on the part of the patient;
- the ability to correctly estimate the prognosis in elderly patients with chronic long-term illnesses is difficult, although of immense importance for the PC team;
- the patient's options regarding cardio-respiratory resuscitation and, if he/she chooses no resuscitation - signing the related documents;
- the place where the elderly wishes to spend the last days of his/her life - at home, hospitalized in a chronic care center or in the hospital.

Conclusions

It has been noticed that, although the dying elderly accept with resignation, and often with serenity, their end, they fear abandonment, they fear dying in a hospital room, surrounded not by loved ones, but by intensive care devices they dislike, and which, most of the times, extend their suffering instead of offering a sense of closure, that would allow them to leave his life with serenity. Giving palliative care means deeply knowing the needs of the human being in general and the needs of the person at the end of their life, in particular.

The philosophy of palliative care essentially includes five principles:

• to accept that dying is a natural phenomenon;

• improving the symptoms that disturb the terminal stage should be a major treatment goal;

• the care unit includes the patient and his/her immediate family;

• the need to support the family during the mourning period;

• the multidisciplinary team must also include PC specialists to apply this type of treatment.

In recent years, as one may notice, a common Geriatrics-Palliative Medicine platform has been created, capable to provide a full treatment plan, from the first day of registration to the final stages, with the dedicated purpose of permanently ensuring a quality of life according to the elderly's wishes and expectations. The realization of such a common work plan remains to be refined and implemented in the coming years, all the more so as the number of such beneficiaries has been constantly increasing.

Conflict of interest: none

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