Advanced Illness Care

Guest Editorial

Advanced Illness Care in Older Adults:
Many Lessons Yet To Be Learned

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Older adults comprise the vast majority of those contending with multiple medical problems and the burden of chronic illnesses and symptoms. They are the preponderance of those facing the final stages of life: about 70% are aged 65 years and older. Thus, it is fundamental that all health care providers understand the unique and diverse issues experienced by older adults with advanced illness. Studies from this issue’s Special Section on Advanced Illness Care highlight how much we have to learn about treatment preferences and symptom burden among older adults with advanced illness.

In a follow-up study of the original Framingham Heart Study cohort, McCarthy and colleagues (1) shed light on care preferences of these participants now predominantly in their 80s. Although most reported that they preferred comfort measures at the end of life, when presented with specific clinical scenarios, almost half of all participants stated that they would be willing to endure a chronic ventilator or tube feeding to avoid death, and over half stated that they would be willing to live out their life in a great deal of pain or confused rather than die. The desire to avoid death is, of course, not surprising; as Somerset Maugham said of death, “my advice to you is to have nothing whatever to do with it.” Nevertheless, McCarthy’s study highlights the complexity associated with end-of-life decision-making and methods used to elicit preferences. Many older adults who want “comfort care” still are willing to undergo the discomfort of life-prolonging interventions to avoid death. Because so few had conversations with their providers about their wishes, it is likely that the participants’ treatment preferences would not be fully understood should they develop an acute, life-threatening event.

As in McCarthy and colleagues’ study, Rose and colleagues demonstrate the rare occurrence of goals of care discussions with providers, even among older adults with advanced-stage cancer (2). The authors also demonstrate less connection between the health care team and older adults, despite older adults’ increased comorbidity burden. These findings highlight the importance of consistent, planned interactions with older adults and careful goals of care discussions that go beyond questions related to comfort care alone.

Others also offer insights into symptom burden and management in older adults with advanced illness. In Rose’s study of cancer patients, older patients were less likely to report severe pain or be prescribed opioids (2). Pain was present in half of all nursing home residents studied by Cadogan and colleagues (3). However, pain severity and its impact on function varied greatly, suggesting that pain is multidimensional and that pain severity alone is inadequate for evaluating the true impact of pain on quality of life and function.

Although pain in older patients is underappreciated and not well understood, strategies can be implemented to enhance pain management in this population. In Bailey and colleagues’ study of pain and dyspnea management in an inpatient setting, staff education and a decision-support tool to facilitate symptom management doubled orders for and quadrupled administration of opioids for patients with high symptom burden at the end of life (4).
cognition and other functional domains? How do we encourage institutions to assess and treat symptoms in a multidimensional way? We hope that the research reported and questions generated here will inspire others to find some answers and improve quality of life and function for the increasing number of older adults facing advanced illness.

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