

# Palliative Care for the Geriatric Anesthesiologist



Allen N. Gustin Jr, MD<sup>a,\*</sup>, Rebecca A. Aslakson, MD, PhD<sup>b,c</sup>

## KEYWORDS

- Geriatrics • Palliative care • Hospice • Do not resuscitate • Ethical dilemma
- Palliative sedation • Physician-assisted suicide • Perioperative palliative care

## KEY POINTS

- The geriatric population is increasing, the number of chronic conditions within the geriatric population is rising, the use of palliative care and hospice within geriatrics has dramatically risen, and patients with chronic illnesses and end-of-life issues will present to the operating room more frequently.
- Palliative care and hospice are complementary and improve the patient's and family's experience with chronic illness and end-of-life care, but differences exist.
- Palliative care is not just care for those at "end of life" but is appropriate for any patient at any age in any setting (including perioperative settings) with chronic health conditions.
- Do-not-resuscitate (DNR) orders should not be automatically rescinded in the perioperative setting, but rather, conversations should occur to establish alignment of the goals of care of the patient with goals of care of the anesthesia and the surgical procedure.
- For actively dying patients, refractory symptoms that do not respond to conventional therapies may require the addition of palliative sedation for management of severe patient distress and suffering.

## INTRODUCTION

The American population is aging. The percentage of the population older than age 65 was 9% in 1960 and is projected to reach 20% by 2050.<sup>1,2</sup> With increases in life expectancy, the burden of serious illness among older adults has also increased with

---

Dr A.N. Gustin and Dr R.A. Aslakson have no financial or industrial relationships to disclose.

<sup>a</sup> Department of Anesthesiology, Stritch School of Medicine, Loyola University Medicine, 2160 South 1st Avenue, Building 103, Room-3102, Chicago, IL 60153, USA; <sup>b</sup> Department of Anesthesiology and Critical Care Medicine, Palliative Medicine Program at the Kimmel Comprehensive Cancer Center at Johns Hopkins, The Johns Hopkins School of Medicine, 1800 Orleans Street, Meyer 289, Baltimore, MD 21287, USA; <sup>c</sup> Department of Health, Behavior, and Society, The Johns Hopkins Bloomberg School of Public Health, 1800 Orleans Street, Meyer 289, Baltimore, MD 21287, USA

\* Corresponding author. Department of Anesthesiology, Loyola University Medicine, 2160 South 1st Avenue, Building-103, Room-3102, Chicago, IL 60153.

*E-mail address:* [allen.gustin@lumc.edu](mailto:allen.gustin@lumc.edu)

Anesthesiology Clin 33 (2015) 591–605  
<http://dx.doi.org/10.1016/j.anclin.2015.05.013>

[anesthesiology.theclinics.com](http://anesthesiology.theclinics.com)

1932-2275/15/\$ – see front matter © 2015 Elsevier Inc. All rights reserved.

two-thirds of patients greater than 65 years old having multiple chronic conditions.<sup>3</sup> Moreover, providing high-quality end-of-life care is challenging because of multiple factors, such as the increasing number of elderly patients, structural barriers to access of care for older patients, and a fragmented health care system.<sup>4</sup> In a 1997 report that evaluated end-of-life care in the United States, the Institute of Medicine described significant patient and family suffering related to end-of-life care and emphasized the need for improvements<sup>4</sup> (**Box 1**). In the last decade and a half, hospice use has doubled and palliative care has made improvements with the development of guidelines and quality measures for the care of geriatric patients with chronic and/or severe illness.<sup>5,6</sup> A follow-up Institute of Medicine report in 2014 revealed that more work is needed to improve the quality of care for patients at the end of life, recognizing that palliative care services are underused and are too frequently unavailable, and that current providers should seek out further training in palliative care–related skills<sup>7</sup> (see

#### **Box 1**

#### **Institute of Medicine recommendations and challenges for providing quality end-of-life care in America**

##### *1997 Recommendations for End-of-Life Care*

1. *Raise the Issue.* People should think about, talk about, and learn about decisions they may face, as they or those they love approach death.
2. *Raise Expectations.* Dying people and their families should expect good, dependable care. They should expect their beliefs and wishes to be respected.
3. *Do What We Know Helps.* Doctors, nurses, social workers, and others need to use what we already know to prevent and relieve pain and other symptoms.
4. *Get Rid of Barriers to Good Care.* Doing this often requires support of lawmakers, voters, the media, and health care managers.
5. *Build Knowledge.* The National Institutes of Health and other public/private groups should work together to find out more about end-stage disease and end-of-life care.

##### *2014 Challenges for Providing Quality End-of-Life Care in America*

1. Increasing number of elderly Americans, including those with some combination of frailty, significant physical and cognitive disabilities, multiple chronic illnesses, and functional limitations.
2. Growing cultural diversity of the US population, which makes it ever more important for clinicians to approach all patients as individuals, without assumptions about the care choices they might make.
3. Structural barriers in access to care that disadvantage certain population groups.
4. A mismatch between the services patients and families need most and the services they can readily obtain.
5. Availability of palliative care services has not kept pace with the growing demand.
6. Wasteful and costly systemic problems, including perverse financial incentives, a fragmented care delivery system, time pressures that limit communication, and a lack of service coordination across programs.
7. The resulting unsustainable growth in costs of the current health care delivery system over the past several decades.

*Data from* Institute of Medicine. *Approaching death: improving care at the end of life.* Washington, DC: National Academic Press; 1997; and Institute of Medicine. *Dying in America: improving quality and honoring individual preferences near the end of life.* Washington, DC: National Academies Press; 2014.

Download English Version:

<https://daneshyari.com/en/article/2744458>

Download Persian Version:

<https://daneshyari.com/article/2744458>

[Daneshyari.com](https://daneshyari.com)