

Palliative Care in the Ambulatory Geriatric Practice



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KEYWORDS

• Advance care planning • Pain management • Geriatrics • Elderly

KEY POINTS

- Clinicians should recognize the “the widespread and deeply held desire not to be dead (WDHDNTBD)”, inquire about understanding of illness, and approach advance care planning with great care.
- For chronic pain, clinicians should reject the idea of a pain-free drug-centered cure; nonpharmacologic approaches should be emphasized.
- The risks of chronic narcotics and their common failure in eliminating pain and improving function should be explicitly stated.

INTRODUCTION

“Geriatrics” and “palliative care” are each poorly defined and the 2 overlap greatly. In both, early diagnosis and aggressive treatment of disease have become less important. In both, the patient’s family and community may be more essential to the patient’s care. In both, patient goals and careful attention to symptoms are central (although patient centeredness and symptom management are part of good care for nearly all patients). In both, the difficult task of suggesting explicitly to patients that they are mortal must often be undertaken.

Geriatrics care is mindful of the progressive frailty, vulnerability, comorbidity, and cognitive impairment that often accompany advancing age, with the correspondingly increased risks from medical treatments. Palliative care focuses on quality of life and symptom management, especially in patients with serious illness or limited life expectancy.

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In this article, we focus on 2 important topics: (1) advance planning and limitations of therapy in geriatrics and in palliative care and (2) pain management in the frail elderly.

In Part 1, we discuss the tempo of decision making. Palliative care consultants often see patients with acute or subacute life-threatening illness, whereas patients in ambulatory geriatrics tend to be more stable. The close relationship between palliative care and hospice means that patients may expect a discussion about limiting life-sustaining treatments. In ambulatory geriatrics, initiating such a discussion can be extremely fraught, and decision making often develops more gradually.

In Part 2, we suggest an approach to pain management in the frail elderly. For patients receiving palliative care, the long-term complications of narcotics may be limited and the need for narcotic pain relief clearer. In ambulatory geriatrics, chronic narcotics are clear and present dangers, and their effectiveness is uncertain.

We emphasize that commonalities shared by the 2 specialties are far greater than their distinctions. We emphasize too that our generalizations about vulnerable elders and patients with life-threatening illnesses are suspect in many ways. People can be unpredictable when confronted with the unimaginable. What is more, the 2 fields are changing rapidly. In 20 years, when Baby Boomers are the old-old, ambulatory geriatrics and palliative care will look very different. And it will be very difficult to know the reasons for the change.

PART 1: PLANNING ABOUT DYING: AMBULATORY GERIATRICS AND PALLIATIVE CARE

Two fundamental principles outline the paths to medical decision making for patients with life-threatening illness. The first is that life is the greatest good. If circumstances are uncertain, the default action should be to preserve life. The second and equally compelling principle is autonomy, in particular “Everyone has the right to say ‘Keep your hands off me.’”¹ Tension may arise when patients who have capacity to make decisions are asked the “palliative care question”: will you choose a focus on comfort and dignity with a greater chance of death or will you choose burdensome treatments that may help you live longer? A second, arguably more difficult set of problems arises when caring for patients who cannot make decisions.

Unwanted Conversations

Although death is thus far the universal fate of all humans, most of us retain a strange and powerful reluctance to imagine ourselves dead and to engage in explicit planning about medical events that will lead to that stage. In a qualitative, longitudinal study of 20 housebound, chronically ill, community-dwelling elders with an expected survival of less than 2 years, 13 had wills and 19 had funeral plans, but “Our patients were least likely to envision and help to plan for a period of chronic serious illness when death is not certain. It is precisely in this interval that the most difficult decisions often arise.”² Two factors make it difficult for patients to plan for the contingencies of serious, potentially fatal illness. The first is technical; physicians cannot predict the future. In “Characterizing predictive models of mortality for older adults and their validation for use in clinical practice,” Minne and colleagues³ conclude “their use is premature.” Of 193 models, only 4 were validated in more than 2 studies. Fox and colleagues,⁴ using detailed data from SUPPORT on 2607 severely ill patients who had survived hospitalization, tried to identify those who would die in the next 6 months. In this large sample, many seriously ill patients “never experience a time during which they are clearly dying of their disease.”

Parenthetically, this inability to provide good prognostic information for most patients leads to a necessarily incoherent use of the popular trope of “end-of-life

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