

End-of-Life Care *in older adults*

There is a growing consensus that care for older, sick individuals nearing the end of their lives needs to be significantly improved.¹ Several consensus panels have identified areas for improvement, including the need to: measure advance care planning and the aggressiveness of care near death;^{2,3} examine care inconsistent with preferences and prognosis and under-use of care to treat symptoms;³ and overcome financial, legal, and regulatory barriers to care.^{3,4}

End-of-life care is designed to facilitate a “good death”: “one that is free from avoidable distress and suffering for patients, families and caregivers; in general accord with patients’ and families’ wishes; and reasonably consistent with clinical, cultural and ethical standards.”³

A review of the recent literature includes the following findings:

*Studies show that patients would like to discuss end-of-life issues with physicians and have positive views about advance directives, but such discussions are uncommon and advance directives are completed by a minority of patients.*⁵⁻⁷

For patients who lack decision-making capacity and are admitted to the hospital, it is suggested that soon after admission the medical record show documentation of who the surrogate decision-maker is or contain an advance directive.⁸ If the patient is capable and has no family members or legal surrogate, discussions should be initiated by the healthcare provider regarding designation of an appropriate surrogate decision-maker.^{8,9}

*Consensus reports endorse that discussions about preferences for resuscitation and other life-sustaining treatments and the completion of advance directives occur in the outpatient setting with the patient. It is suggested that these documents be included in the inpatient medical record when patients are admitted to the hospital.*⁹⁻¹¹

Observational studies and widespread consensus argue that hospitalized patients who have decision making capacity should, if they wish, participate in decisions about resuscitation and withholding or withdrawing life-sustaining treatment and that the hospital medical record should reflect this.^{5,8,9}

For hospitalized patients whose deaths are expected and who are conscious toward the end of life, studies and expert consensus strongly encourage physicians to document in the medical record evaluation of and, if necessary, treatment of pain, suffering, and emotional distress.^{3,8,9,12}

There is a great deal of observational experience and consensus opinion about end-of-life care, however there is little solid clinical trial evidence on which to base treatment decisions.^{7,13} As our population ages, the importance of understanding a quality end-of-life experience heightens. More rigorous clinical attention and research studies need to be aimed at end-of-life care.

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References

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