Editorial

Improving End-of-Life Care for Older Adults:
An International Challenge

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END-OF-LIFE care, a dimension of care that is provided commonly within the context of both geriatric and palliative care, is now receiving more attention as an area of study. Despite a growing body of literature addressing care at the end of life, there is still little regarding how this care is provided for many geriatric populations. Two studies in the present issue of the Journal, though reflective of the country-specific organization of health and end-of-life care, demonstrate the international challenges to be faced in providing optimal end-of-life care for older adults.

Menec and colleagues (1) concern themselves with health services use for older Manitobans nearing the end of life. The researchers demonstrate substantial differences in care patterns among younger-old (65–74 years), old (75–84), and older-old (≥85) age groups. Perhaps not surprisingly, a much greater proportion of older-old deaths (nearly half) occur in long-term care institutions; however, also in that oldest group, deaths that occur at home are less likely to occur with the provision of in-home care. Further, the odds of hospital use at 1 month and 6 months prior to death are lower in the oldest-old category versus the middle group, and intensive care unit use for the same period declines significantly by age grouping. Among all older adults, fewer than 30% of deaths occurred in the home, the setting where many patients state they would prefer to die.

The fact that almost one half of all older adults in the 85+ age range die in long-term care settings highlights the need for improved palliative care in nursing homes. As noted by Teno and others, nursing homes have been among the slowest to adopt palliative care approaches to dying patients (1–3). Long-term care settings are often hindered by lack of knowledge regarding palliative care interventions at the end of life and a more rehabilitative orientation toward care, which may no longer be appropriate for these patients. This study provides compelling data on the large numbers of older adults in long-term facilities who could benefit from good end-of-life care.

De Gendt and colleagues (4) take a more granular look at decision-making and advance care-planning practices in acute geriatrics wards in Belgium. Their finding that approximately one fifth of patients have do-not-resuscitate (DNR) orders is similar to an older rate reported for an American ward (5), but much lower than the prevalence of DNR orders on Dutch geriatrics wards (6,7). The researchers focus on the process by which DNR status is obtained and observe marked variation in practice patterns for procuring DNR orders. Even in an acute geriatric setting, the bulk of orders appeared to be obtained very late in the course of disease with little use of advance directives, or consultation with patients’ general practitioners or the patients themselves. While head nurses were very frequently consulted prior to writing the order, geriatricians tended to make the decision during daily rounds rather than in weekly interdisciplinary team meetings. Of greatest concern was the relative infrequency of patient and family involvement in these treatment decisions.

Both studies highlight gaps in current end-of-life care for older adults. The absolute number of older adults receiving end-of-life care in institutional settings (hospital or nursing home) emphasizes the need for additional palliative care training. The continued disconnect between treatment decisions at the end of life, advance care planning, and patient autonomy suggest opportunities for improvement in systems-based practice. Indeed, in De Gendt’s cohort, simple practices such as having a DNR policy substantially improved information about DNR status.

The settings of long-term care and community-based advanced-illness care serve as natural intersection points for palliative care and geriatric care providers to collaborate and influence policy for better care for older patients at the end of life. Menec and De Gendt’s studies show us that, as providers within existing systems of care, we have a long way to go to providing optimal end-of-life care to aged adults.

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