

Editor's View – Older people's goals of care and person-centredness

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Goals of care

Geriatricians rightly pride themselves on being person-centred. It is easy to lose sight of what really matters to the people we serve as we navigate a sea of protocols, pathways, bed pressures and a prerogative to keep people out of hospital. In our May edition, van der Verle and colleagues [<https://doi.org/10.1093/ageing/afae097>] investigate older people's goals of care and report how these change according to their frailty status. It turns out, frailty had minimal impact on goals of care. The most important goals across people with a range of frailty were preventing nursing home admission, rated as 'very important' to 87% of respondents, with only slightly lower rates for 'staying independent' (84%) and 'preserving quality of life' (83%). Interestingly, less than a third of respondents thought extending life was very important to them. I was reflecting on the mismatch between this and the prevailing attitude of most specialist clinicians I encountered during my general medical training, where keeping the patient alive seemed to be the only thing that really mattered and death of a patient was seen as a failure. With the ageing population living longer lives with disease, it is important clinicians and healthcare systems adapt to keep goals of care relevant and person-centred.

Dementia

A further reminder that death is not failure comes from the work of the PISCES study group [<https://doi.org/10.1093/ageing/afae103>]. They commendably tackle the thorny issue of longing for death among carers of people with severe dementia. About a quarter of people looking after someone with severe dementia expressed a wish for death to come sooner in that person. This rose to almost half at some point during the two-year follow-up of the study, though only one in nine expressed it consistently. This shows the pressing extent of carer stress and the need for support. One potential intervention to minimise carer stress in dementia is via training of professional carers. The issue includes a process evaluation of NIDUS-Professional, a dementia training intervention for UK homecare workers [<https://doi.org/10.1093/ageing/afae109>]. Although it shows promise, there were familiar challenges with limited engagement and high turnover of healthcare worker staff. Watch out for a summary of the new SIGN guidelines on dementia in an upcoming issue of Age & Ageing, where the neglected topic of carer stress and grief will be covered further. For a sobering insight into how inconsistent the treatment of dementia must be for those living with the disease, check out the time-trend analysis of anti-dementia drug use across time and multiple nations [<https://doi.org/10.1093/ageing/afae106>]. If dementia management was a spectator sport, I could foresee the crowds jeering the classic football chant, 'You don't know what you are doing!'.

Treating iron deficiency anaemia

I often find the response to oral iron supplementation in older people with iron deficiency anaemia to be very disappointing. This perception is also backed up by observational studies and there are sound theoretical reasons why oral iron supplementation may be relatively ineffective in this population. A double-blinded, placebo-controlled, randomised controlled trial showed a single dose of intravenous iron supplementation in older people with anaemia after an upper gastrointestinal bleed significantly increased haemoglobin levels at 6 weeks of follow-up

[\[https://doi.org/10.1093/ageing/afae085\]](https://doi.org/10.1093/ageing/afae085). Health-related quality of life was not significantly different, but the study was underpowered to detect a significant difference in this metric. However, the improvement in the intervention group would be clinically significant if proven in a larger trial. The authors recommend intravenous iron supplementation should be routine in people aged over 65 years who have anaemia after a bleeding event.

COVID-19 – antithrombotics and rehabilitation

A large observational study of the first wave of the COVID-19 pandemic in the Netherlands shows mortality was significantly lower among nursing home residents that took anti-thrombotic agents [\[https://doi.org/10.1093/ageing/afae094\]](https://doi.org/10.1093/ageing/afae094) compared to those who did not. This was true for both anticoagulants and antiplatelet therapies. As with all observational studies, residual confounding could be an important factor, but it underlines the importance of continuing these medications when those who routinely take them contract COVID-19. It does not tell us whether taking such therapy should be recommended in other situations, or for those who are not routinely taking them. Such questions are best answered by randomised controlled trials and it is worth remembering that in the RECOVERY study, aspirin did not improve mortality. Perhaps an even bigger concern is the after-effects in survivors, be it 'long covid' or simply the deconditioning effects of the virus. In a large study of 59 geriatric rehabilitation centres across 10 European countries [\[https://doi.org/10.1093/ageing/afae084\]](https://doi.org/10.1093/ageing/afae084), the EU-COGER team map out the typical effects of COVID-19 and frailty on the degree of dependency of older people undergoing rehabilitation. The good news is that recovery was usually very good, irrespective of the degree of pre-morbid frailty. The key message is that geriatric rehabilitation should be offered to anyone with a dependency need, regardless of their premorbid frailty.

Frailty

Our latest issue includes several studies focussing on frailty. These include qualitative studies on the role of the community pharmacist [\[https://doi.org/10.1093/ageing/afae089\]](https://doi.org/10.1093/ageing/afae089) and general practitioner in frailty [\[https://doi.org/10.1093/ageing/afae093\]](https://doi.org/10.1093/ageing/afae093). Some uncertainties about their roles and precise interventions emerge across both papers, and the importance of specialist input and multidisciplinary working shines through. Healthy plant-based diets are significantly associated with a lower risk of frailty, according to a prospective cohort study of circa 25,000 UK residents [\[https://doi.org/10.1093/ageing/afae092\]](https://doi.org/10.1093/ageing/afae092). An analysis from the Helsinki Birth Cohort Study shows that variation in the brain insulin gene network predicts the onset of frailty in women [\[https://doi.org/10.1093/ageing/afae091\]](https://doi.org/10.1093/ageing/afae091). The authors suggest this could present a novel therapeutic target for the prevention of frailty. Research into frailty can be challenged by issues of definition and management of frailty, as well as recruitment. Birch and colleagues tested the ability of three different tools employing routinely collected data to detect frailty among patients with colorectal cancer [\[https://doi.org/10.1093/ageing/afae105\]](https://doi.org/10.1093/ageing/afae105). They all performed equally well in this setting. This may have a number of practical applications, such as allowing a fairer comparison of performance and outcomes that accounts for the underlying frailty of the studied populations. In a study of Parkinsonism, Tenison and colleagues found that a strategy of additional support when approaching potential volunteers reduced exclusion of participants on grounds of frailty, multimorbidity and cognitive impairment [\[https://doi.org/10.1093/ageing/afae108\]](https://doi.org/10.1093/ageing/afae108). Improving representation of complex patients in research is critical to maintaining an evidence-based approach to today's clinical problems.

Teaching the next generation

We are very pleased to have launched online our special collection on undergraduate geriatric medicine education, including all the best papers on the topic from the last ten years. To celebrate this, our latest issue also looks forward in a New Horizon article [<https://doi.org/10.1093/ageing/afae050>]. With a growing ageing population, it is essential future doctors are equipped to deal with the challenges that brings. Teodorczuk and colleagues highlight important issues around the future workforce, what works well and modern approaches to undergraduate education such as inter-professional learning, simulation, longitudinal clerkships and learning from patients.

Predicting post-operative delirium

Finally, I wanted to highlight that in this issue we publish two articles about tools to predict post-operative delirium. In an original research article, Benovic and colleagues use machine learning to come up with an algorithm that they claim is clinically useful in predicting delirium in this setting [<https://doi.org/10.1093/ageing/afae101>]. Especially for those working in perioperative medicine, I recommend the editorial on delirium prediction by anaesthetist Ian Moppett [<https://doi.org/10.1093/ageing/afae095>]. He eloquently argues that providing patients with information about their risk of postoperative delirium should be routine. Knowing the risks and benefits of a procedure are at the heart of the principle of informed consent. Patients are routinely given pretty precise risks of complications that are far less likely than delirium, so why not delirium? He evaluates the Pre-Interventional Preventive Risk Assessment (PIPRA) tool that we published in a previous edition [[10.1093/ageing/afad086](https://doi.org/10.1093/ageing/afad086)] but the present article by Benovic et al has similar predictive performance and is arguably easier to comprehend. Indeed, they discuss the trade-off between predictive accuracy and ease of use that is common to prediction tools. Although tools to predict delirium are still rare, I anticipate this emerging area of research may proliferate and it may be worthwhile achieving consensus. The next question is whether we could do more with such tools than simply inform patients and clinicians of the risk. With the wealth of evidence that delirium is often preventable, high-risk patients may perhaps merit additional attention to any modifiable risk factors. However, delirium prevention interventions look very much like 'good basic care', so it remains to be seen whether targeted approaches based on individual risk are effective at minimising postoperative delirium.

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