Living with AGEING and DYING

Dr Angel Lee

Medical Director & Director of Palliative Care

ST. ANDREW’S COMMUNITY HOSPITAL
(A Community Service of St. Andrew’s Mission Hospital)

Chairman

SINGAPORE HOSPICE COUNCIL
Lee Kuan Yew

Singapore’s 1st Prime Minister
(1965 – 1990)
Will you be surprised if he died in the next 12 months?

Photo of a very thin Lee Kuan Yew sparks concern

Jeanette Tan
Yahoo Newsroom April 24, 2014
11 months later
Objectives

1. Ageing and implication on the way we die
2. Challenge of EOL care in the elderly
3. What we can do to improve EOL care in the elderly
It is a protracted affair.
“Death keeps taking little bits of me...”

There is uncertainty.
More likely than not, we will die older ...

Chart 1: Life Expectancy at Birth of Singapore’s Resident Population

Life expectancy at 65 years old
- Females: 22.5 yrs
- Residents: 20.9 yrs
- Males: 19.1 yrs

Joshua A Salomon*, Haidong Wang, Michael K Freeman, Theo Vos, Abraham D Flaxman, Alan D Lopez, Christopher J L Murray

Lancet 2012; 380: 2144-62

HALE increased more slowly than did life expectancy over the past 20 years, with each 1-year increase in life expectancy at birth associated with a 10-month increase in HALE.

Compared with substantial progress in reduction of mortality over the past two decades, relatively little progress has been made in reduction of the overall effect of non-fatal disease and injury on population health.
... the price of increased longevity.

WHO – Global Health Observatory
CareShield Life gender-differentiated premium

Amy’s second justification is this: "Based on a longitudinal survey of older Singaporeans in 2009 and 2011 to 2012, researchers estimated women aged 60 are expected to spend 7.8 years requiring assistance with any of the ADLs (Activity Daily Living) compared to 2.6 years for men aged 60."

Under the new CareShield Life scheme, women will need to pay higher insurance premiums than men because they live longer and are likely to spend more years in severe disability, said Senior Minister of State for Health Dr Amy Khor in Parliament yesterday.

- 3 years
- 8 years
<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ischaemic heart disease</td>
</tr>
<tr>
<td>2</td>
<td>Stroke</td>
</tr>
<tr>
<td>3</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>4</td>
<td>Alzheimer disease and other dementias</td>
</tr>
<tr>
<td>5</td>
<td>Lower respiratory infections</td>
</tr>
<tr>
<td>6</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>7</td>
<td>Trachea, bronchus, lung cancers</td>
</tr>
<tr>
<td>8</td>
<td>Kidney diseases</td>
</tr>
<tr>
<td>9</td>
<td>Hypertensive heart</td>
</tr>
</tbody>
</table>

Select WHO region(s), year, sex and age of choice:
- World
- African Region
- Region of the Americas
- South-East Asian Region
- European Region
- Eastern Mediterranean Region
- Western Pacific Region

Year:
- 2016
- 2015
- 2010
- 2000

Sex:
- Both sexes
- Males
- Females

Age group:
- All ages
- Under 5
- 5-14
- 15-29
- 30-49
- 50-59
- 60-69
- 70+

http://www.who.int/gho/mortality_burden_disease/causes_death/top_10/en/
From 2007 to 2020

30% ↑

70% ↑

150% ↑

The Frailty Challenge
Ageing & Dying

We will die older and associated with longer and longer periods of pre-death chronic illness and frailty
Frailty

- Most problematic expression of population ageing
- It is a state of vulnerability with poor recovery following stress
Frailty

Fried Phenotypic Model

<table>
<thead>
<tr>
<th>Frailty indicator</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td>Self-reported weight loss of more than 10 pounds or recorded weight loss of ≥ 5% per annum</td>
</tr>
<tr>
<td>Self-reported exhaustion</td>
<td>Self-reported exhaustion on CES-D depression score (3-4 days per week or most of the time)</td>
</tr>
<tr>
<td>Low energy expenditure</td>
<td>Energy expenditure &lt;383 KCal/week (males) or &lt;270 KCal/week (females)</td>
</tr>
<tr>
<td>Slow gait speed</td>
<td>Standardised cut-off times to walk 15 feet, stratified for sex and height</td>
</tr>
<tr>
<td>Weak grip strength</td>
<td>Grip strength, stratified by sex and BMI</td>
</tr>
</tbody>
</table>

FRAILTY

In developed countries, it is now the leading cause of death in community-dwelling elderly.

CANCER
30% of deaths
Deaths preceded by hospice care
Integrated Care between services
Rolls Royce standard

FRAILTY
More than a third and increasing
Poor ownership of care
Fragmented care with multiple transitions
Unrecognised care needs
Disease Apartheid
Definition


Word origin of 'apartheid' C20: Afrikaans, from apart apart + -heid -hood.
Access to specialized palliative care service

Having a cancer diagnosis is the primary determinant.
• In-patient hospice (Singapore) 75-85% cancer
• Hospital-Based Palliative Care Services 70-85%

SACH Figures: 67% cancer, 33% non-cancer

Cancer accounts for only 30% of deaths
Why the discrimination?

- Different disease trajectory
  - Less predictable
  - More protracted
  - Funding challenges
- Multiple co-morbidity
- Mental capacity lost in many
- Lack of understanding (predominantly amongst HCWs)
“Important care decisions are transferred at the same time as patients are transferred”

- Prioritization of institutional processes over needs of patients
- Failure of support across settings
- Not being “heard”
- Loss of dignity

Associated with crises
Poor anticipatory care
Ageing & Dying

Many systems worldwide handle the needs of the dying elderly poorly
Doing nothing is not an option - current system is buckling under demands, severe consequences if we don’t change, too expensive, poor levels of care - we cannot afford to fail.
Case Study – Mr S

88 years old. Parkinson’s ds. Bed-bound.

Chest Infection. On iv antibiotics.

• Hypotensive
• Constipation
• Drooling and secretions
• Stiffness (and pain)

“Palliative Care?”

23/6/18

Asked to see this patient
Clinical Frailty Scale*

1. Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g., seasonally.

3. Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5. Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.


© 2007-2009 Version 1.2. All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada. Permission granted to copy for research and educational purposes only.
How accurate is the ‘Surprise Question’ at identifying patients at the end of life? A systematic review and meta-analysis

Nicola White, Nuriye Kupeli, Victoria Vickerstaff and Patrick Stone
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trials</th>
<th>Estimates</th>
<th>PPV Mean (SD), Range</th>
<th>NPV Mean (SD), Range</th>
<th>Sensitivity Mean (SD), Range</th>
<th>Specificity Mean (SD), Range</th>
<th>c-statistic Mean (SD), Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oncology</td>
<td>11,047</td>
<td>49.3 (13.5), 30.3–69</td>
<td>92.3 (4.9), 83.8–97.4</td>
<td>77.1 (13.7), 58.3–95.6</td>
<td>73.5 (20.5), 37–89.7</td>
<td>0.753</td>
<td>0.663–0.822</td>
</tr>
<tr>
<td>Renal</td>
<td>5327</td>
<td>38.5 (14.4), 24.8–63.8</td>
<td>90.2 (3.8), 83.1–95</td>
<td>60.6 (16.2), 37.9–83.3</td>
<td>77.2 (10.4), 57.6–90.8</td>
<td>0.689</td>
<td>0.631–0.78</td>
</tr>
<tr>
<td>Other</td>
<td>9344</td>
<td>46.4 (24.5), 13.9–78.6</td>
<td>85.5 (13.3), 61.3–99</td>
<td>62.8 (25.5), 11.6–93.3</td>
<td>71.4 (26.7), 13.8–98.2</td>
<td>0.671</td>
<td>0.512–0.822</td>
</tr>
</tbody>
</table>

**Note:** PPV = positive predictive value, NPV = negative predictive value.

Still most accurate for cancer patients. Fairly good for the rest.
EXAMPLE: Gold Standard Framework

Three triggers that suggest that patients are nearing the end of life are:

1. The Surprise Question: ‘Would you be surprised if this patient were to die in the next few months, weeks, days’?
2. General indicators of decline - deterioration, increasing need or choice for no further active care.
3. Specific clinical indicators related to certain conditions.
General Indicators of Decline

- Decreasing activity
- Increasing dependence
- Weight loss 10% in 6 months
- Albumin < 25g/L
- Frequent crisis or unplanned admissions
- Co-morbidity / Adv ds
- Complex Symptom burden
- Choice of no active Rx
- Sentinel event e.g. fall
- Admission to NH
**General Neurological Diseases**

- Progressive deterioration in physical and/or cognitive function despite optimal therapy
- Symptoms which are complex and too difficult to control
- Swallowing problems and/or severe breathlessness or respiratory failure
- Speech problems: increasing difficulty in communications and progressive dysphasia. Plus the following:

**Motor Neurone Disease**

- Marked rapid decline in physical status
- First episode of aspirational pneumonia and difficult swallowing

**Respiratory difficulty**

- Significant complex symptomatic and medical complications
- Low vital capacity (below 70% of predicted using standard spirometry)
- Dyskinesia, mobility problems and falls
- Communication difficulties.

**Parkinson’s Disease**

- Drug treatment less effective or increasingly complex regime of drug treatment required

**Treatment difficulty**

- The condition is less well controlled with increasing “off” periods
- Dyskinesias, mobility problems and falls
- Psychiatric signs (depression, anxiety, hallucinations, psychosis)
- Similar pattern to frailty - see below.

**Multiple Sclerosis**

- Significant complex symptoms and medical complications
- Drug treatment less effective or increasingly complex regime of drug treatment required
- Cognitive impairment notably the onset of dementia.

**Complex Symptoms**

- e.g. Dysarthria + fatigue
c) Frailty / Dementia – gradual decline

**Frailty**

Individuals who present with Multiple co morbidities with significant impairment in day to day living and:

- Deteriorating functional score e.g. performance status – Barthel/ECOG/Karnofksy
- Combination of at least three of the following symptoms:
  - weakness
  - slow walking speed
  - significant weight loss
  - exhaustion
  - low physical activity
  - depression.

**Dementia**

There are many underlying conditions which may lead to degrees of dementia and these should be taken into account. Triggers to consider that indicate that someone is entering a later stage are:

- Unable to walk without assistance and
- Urinary and faecal incontinence, and
- Nausea
- Urinary tract Infection
- Bladder infection
- Recurrent fever
- Reduced oral intake
- Aspiration pneumonia.

Recurrent infection

Severe pressure sores

Plus:

- Weight loss
- Urinary tract Infection
- Severe pressures sores – stage three or four
- Recurrent fever
- Reduced oral intake
- Aspiration pneumonia.

It is vital that discussions with individuals living with dementia are started at an early to ensure that whilst they have mental capacity they can discuss how they would like the later stages managed.

PVS or minimally conscious or dense paralysis
No improvement after 3 months
Natural History of Parkinson’s Disease

- Mortality rate for PD: 5% per year following diagnosis
  = 25% die within 5 years

- TEN year survival rate is 50%

- 77% for breast cancer
Phases of Illness

- **DIAGNOSIS**
- **MAINTENANCE**
- **COMPLEX**
- **PALLIATIVE**

**Time spent in each?**

- Mean total – 14.6 yrs
  - 1.5 (18 months)
  - 6 (72 months)
  - 5 (60 months)
  - 2.2 (26 Months)
Case Study – Mr S

Diagnosed with Parkinson’s Disease

1995

Became chair-bound

2014

Bed-bound PEG inserted

2016

2018

Recurrent chest infections

23/6/18

“Dying” Referred to Palliative Care
Gold Standard Framework

Three triggers that suggest that patients are nearing the end of life are:

1. The Surprise Question: ‘Would you be surprised if this patient were to die in the next few months, weeks, days’?
2. General indicators of decline - deterioration, increasing need or choice for no further active care.
3. Specific clinical indicators related to certain conditions.

Predicting needs rather than exact prognostication. This is more about meeting needs than giving defined timescales. The focus is on anticipating patients’ likely needs so that the right care can be provided at the right time. This is more important than working out the exact time remaining and leads to better proactive care in alignment with preferences.
Identifying care needs

Symptom Control
• Constipation
• Drooling and secretions
• Stiffness (and pain)
  • Readjusted Parkinson’s meds
  • Physiotherapy
• Postural symptoms
  • Fludrocortisone and midodrine

For a while, he improved …
• Able to sit out of bed!!
• Participated in therapy!!
• Looked happy after a hair cut and grooming
• Still not verbally communicative
• Wife expressed caregiver stress. Unable to cope anymore with him at home
Identifying care needs

Then he developed another chest infection ...

• Anticipatory Care Planning
  • Limited trial of treatment
  • Institutional Care
• Symptom control and trial of antibiotics

Again, he improved ...

• But not able to sit out of bed anymore
• Wife continue to visit daily – but expressed caregiver stress
• Arrangements made for transfer to an in-patient hospice
• Not for further escalation of antibiotics
Planned but not planned

On day of transfer to Hospice ...  
• Desaturated  
• Hypotensive  
• Chesty  
Decision not for further trial of antibiotics

Symptoms controlled on ...  
• SC hyoscine butylbromide  
• SC morphine

Passed away on 7/8/18 “comfortable looking”. Family grieving but accepting.
A FRAMEWORK FOR PALLIATIVE CARE IN COMMUNITY-BASED* AGED CARE PATIENTS

Would you be surprised if your patient were to die in the next 6-12 months?

**YES**

Prognosis: Greater than 6-12 months
Key clinical process: ADVANCE CARE PLANNING

- Document – advance care plan
- Clinical management plan
- Continue patient centred clinical management
- Look for general indicators of deteriorating health
- Look for clinical indicators of advanced conditions
- Clinical improvement
- Clinical deterioration

**RECOGNISE**

Also ‘no’ but because death is expected within a week, clinical management is very specific.

**NO**

Prognosis: Less than 6 months
Key clinical process: CASE CONFERENCES

- Review and update advance care planning decisions and clinical management
- Identify clear management goals of care and Document management care plan (*all on the same page*)
- Regular clinical re-assessment
- Clinical improvement
- Clinical deterioration

**NO**

Prognosis: Less than 1 week
Key clinical process: TERMINAL CARE PLANS

- Management plan based on patient’s wishes and clinical condition
- In private home
- RACF
- Document and commence terminal care management plan
- Commence Residential Aged Care End of Life Care (terminal) Pathway (RAC EoLCP)¹
- Close clinical monitoring
- Clinical improvement
- Clinical deterioration
- Death

* covers private homes and residential aged care facilities


Version 5.0 July 2015
“I took away a few simple lessons. People have priorities in their lives besides just living longer. These priorities are individual and change over time. The most effective and important way to learn these priorities is to ask people about them. The overwhelming majority of time, however, we don’t ask, whether as clinicians or as family members. When we don’t ask, the care and treatments we provide usually fall out of alignment with people’s priorities. And the result is suffering. But when we do ask, and work to align our care with their priorities, the results are extraordinary.”
Advance Care Planning
or
Anticipatory Care Planning
If you have advanced dementia ...

Would you want to live out your days with tube feeding?

- What you value most about your life?

[Tube feeding has not been proven to prolong life in patients with advanced dementia.]
# Serious Illness Conversation Guide

## Conversation Flow

1. **Set up the conversation**
   - Introduce the idea and benefits
   - Ask permission

2. **Assess illness understanding and information preferences**

3. **Share prognosis**
   - Tailor information to patient preference
   - Allow silence, explore emotion

4. **Explore key topics**
   - Goals
   - Fears and worries
   - Sources of strength
   - Critical abilities
   - Tradeoffs
   - Family

5. **Close the conversation**
   - Summarize what you’ve heard
   - Make a recommendation
   - Affirm your commitment to the patient

6. **Document your conversation**

## Patient-Tested Language

- **Set up**
  - “I’m hoping we can talk about where things are with your illness and where they might be going — is this okay?”

- **Assess**
  - “What is your understanding now of where you are with your illness?”
  - “How much information about what is likely to be ahead with your illness would you like from me?”

- **Share**
  - **Prognosis:** “I’m worried that time may be short.”
  - **or** “This may be as strong as you feel.”

- **Explore**
  - “What are your most important goals if your health situation worsens?”
  - “What are your biggest fears and worries about the future with your health?”
  - “What gives you strength as you think about the future with your illness?”
  - “What abilities are so critical to your life that you can’t imagine living without them?”
  - “If you become sicker, how much are you willing to go through for the possibility of gaining more time?”
  - “How much does your family know about your priorities and wishes?”

- **Close**
  - “It sounds like ________ is very important to you.”
  - “Given your goals and priorities and what we know about your illness at this stage, I recommend...”
  - “We’re in this together.”

---

© 2015 Ariadne Labs. A joint Center for Health Systems Innovation (www.ariadanelabs.org) and Dana-Farber Cancer Institute. Revised Feb 2016. Licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License, http://creativecommons.org/licenses/by-nc-sa/4.0/
1. What do you value most about your life?
   (One workshop participant suggested that you might list those things that “bring you joy.”)

2. How do you feel about death and dying? Do you fear death and dying? Have you experienced the loss of a loved one? Did that person’s illness or medical treatment influence your thinking about death and dying?

3. Do you believe life should always be preserved as long as possible?
4. If not, what kinds of mental or physical conditions would make you think that life-prolonging treatment should no longer be used? For example, it may be when you are:

• unaware of your life and surroundings;
• unable to appreciate or continue the important relationships in your life;
• unable to think well enough to make everyday decisions;
• in severe pain or discomfort; or
• other circumstances:
5. Could you imagine reasons for temporarily accepting medical treatment for the conditions you have described? What might they be?

6. How much pain and risk would you be willing to accept if your chances of recovery from an illness or injury were poor (less than one in ten)?

7. Do you hold any religious or moral views about medicine or particular medical treatments? What are they?

9. What other beliefs or values do you hold that should be considered by those making medical care decisions for you if you become unable to speak for yourself?

10. Most people have heard of difficult end-of-life situations involving family members or neighbors or people in the news. Have you had any reactions to these situations? If so, describe:
Disease Specific Issues in ACP in elderly

• Dementia
  • Feeding issues – Tube vs No Tube Feeding
  • Antibiotic use

• Respiratory and Neuromuscular Diseases
  • Ventilator

• Renal Failure
  • Initiation and withdrawal of dialysis
“...we never said that we only work to give comfort. We have increasingly used cytotoxic chemotherapy over the years and you will see from our annual report that we feel it very important that the way back to the “acute care system” should always be open... I think it is extremely important that Hospice care should be integrated with medical care of other kinds and not just be seen as a ‘dead end’.”

Writing to Patricia Parkes (1979)
Diagnosed with Parkinson’s Disease

**Caregiving journey**
Associated with physical fatigue, emotional/mental stress, financial concerns

Respite, home help, financial assistance etc

- 1995: Diagnosed with Parkinson’s Disease
- 2014: Became chair-bound
- 2016: Bed-bound, PEG inserted
- 2018: Recurrent chest infections
- 23/6/18: Admitted to Palliative Care Ward
Death Preparation

- Rituals
- Estate
- Legacy
- Organ Donation
Ethical considerations – Modern Paradox

**Enteral Feeding**
Commercial Preparations widely available from 1960s

**Penicillin**
Discovered by Alexander Fleming in 1928.

**Opioids**
Around since time immemorial.
Ethics, from the Greek word "ethos" meaning "well-developed habits".

Whether a given behaviour is acceptable or the norm depends on the culture the individual exists within and the values he holds. Whether these behaviours become ‘habits’ requires cultivation.
Common Ethical Issues in care of elderly

• Futility
  • Artificial feeding and hydration in patients with advanced dementia and severe stroke
  • Antibiotics in patients with advanced dementia

• Autonomy and Veracity
  • Decision making in the elderly - collusion
  • Decision making in patients with dementia

• Beneficence and Maleficence
  • Use of opioids – principle of double effect
  • Use of restraints and patient dignity
Special Considerations for EOL in Elderly

RECOGNISE

A. Advance Care Planning (and disease-specific discussions)
B. Balanced Management (between disease-specific and palliative)
C. Caregiver Support and Education
D. Death Preparation
E. Ethical Framework
Number of births and deaths

2017
- Total Live Births: 39,615
- Total Deaths: 20,905

Total Live Births  Total Deaths
Fewer births, more deaths as S’pore population ages

Number of babies born in 2017 down by 4% to seven-year low; deaths up 4% from 2016

Theresa Tan
Senior Social Affairs Correspondent
and Cara Wong

In rapidly ageing Singapore, the demographics are worrying. Last year, the number of babies born fell to a seven-year low, while the number of deaths was the highest in at least two decades. A total of 49,615 births were registered, 4 per cent fewer than the 52,521 in 2016. Last year’s number is also the lowest since 2010. 22,667 babies were born.

20,017 in 2016 to 20,905 last year, the Report on Registration of Births and Deaths 2017 showed. The report was released by the Immigration and Checkpoints Authority (ICA) on Wednesday.

The number of deaths has been on an upward trajectory since at least 1998, as the number of people aged 65 and older has more than doubled in that timeframe, academics say. There were 15,657 deaths in 1998, the furthest back that the 2017 ICA report goes.

The most common causes of death were cancer and heart and hypertensive diseases, which account for eight out of 10 deaths.

With fewer births and more deaths, this creates challenges for society, experts said.

In Tan’s view, assistant professor at the Lee Kong Chian School of Public Policy, said fewer babies born means a smaller workforce.

Health crisis: Numbers needing palliative care in UK to rise 42 per cent by 2040

A NEW report reveals a care timebomb as up to 42 per cent more people will need end of life care in England and Wales by 2040.

PUBLISHED: 01:00, Thu, May 18, 2017
FRAILTY IS THE FUTURE ... Doing nothing is not an option.
EOL CARE IS EVERYBODY’S BUSINESS

SPECIALISTS

Hospice and Palliative Care Specialists
Workforce: Estimated 500

GENERALISTS

Hospital /Nursing Home/ Home Care staff
Nursing Homes
Workforce: Estimated 60,000

LAY PEOPLE

Public
5 mil
Palliative Care Approach for All

**Specialist vs Generalist Palliative Care**

**Generalist Palliative Care**
- Provided by primary care clinician or non-palliative specialist
- May be alongside any and all other desired treatments
- Part of good medical care delivered by existing providers

**Specialty Palliative Care**
- Provided by a clinician with specialty training in palliative care
- May also be alongside any and all other desired treatments
- May require more specialized knowledge and training
- Potentially be restricted to more difficult cases
- May be consultative or primary management
Care Based on Patient Stratification

Needs Complexity

Primary Physician / Team

Variable Threshold

Specialist

Generalist

Time (months)
More than in cancer, EOL care in frail elderly is everyone’s business. Not just those in Palliative Care.
Ageing and Dying – In summary

#1 Dying in elderly tends to be preceded by long period of frailty
#2 Compared to cancer care, it tends to be poorly handled worldwide
#3 RECOGNISE A-B-C-D-E

Finally ... It is everybody’s business.
“Our ultimate goal, after all, is not a good death but a good life to the very end.”

Atul Gawande
Advisor to The Conversation Project
Thank you.