The Geriatric Cancer Experience at the End of Life: Testing an Adapted Model

Harleah G. Buck, PhD, RN, CHPN, Janine Overcash, PhD, ARNP, and Susan C. McMillan, PhD, ARNP, FAAN

Aging is a multidimensional process for older adults. A life course approach toward aging enables nurses to see older adults as unique individuals who continue to grow and develop throughout life and to understand that current choices and decisions also are shaped by life experience (Binstock, 2006). Health is critical in aging. If incident rates remain stable, the total number of cancer cases is expected to double by 2050 because of an aging population (Yancik, 2005). Improvements in screening, diagnosis, and treatment have led to greater numbers of cancer survivors. However, most cancer deaths still occur in older adults. The median age of patients with cancer at time of death, across gender and tumor types, ranges from 71–77 years (Yancik). In 2004, the National Institutes of Health (NIH) recommended the development of end-of-life conceptual models to increase scientific rigor and improve evaluation of outcomes in research. Valid conceptual models are needed on which to base healthcare practices and research specific to the complex needs of the older adult with cancer near the end of life. The purpose of the current study was to test an adapted end-of-life conceptual model of the geriatric cancer experience and provide evidence for the validity and reliability of the model for use in practice and research.

Purpose/Objectives: To test an adapted end-of-life conceptual model of the geriatric cancer experience and provide evidence for the validity and reliability of the model for use in practice and research.

Design: Nonexperimental and cross-sectional using baseline data collected within 24–72 hours of admission to hospice.

Setting: Two hospices in the southeastern United States.

Sample: 403 hospice homecare patients; 56% were men and 97% were Caucasian with a mean age of 77.7 years.

Methods: Confirmatory factor analyses using structural equation modeling with AMOS™ statistical software.

Main Research Variables: Clinical status; physiologic, psychological, and spiritual variables; and quality of life (QOL).

Findings: A three-factor model with QOL as an outcome variable showed that 67% of the variability in QOL is explained by the patient's symptom and spiritual experiences.

Conclusions: As symptoms and associated severity and distress increase, the patient's QOL decreases. As the spiritual experience increases (the expressed need for inspiration, spiritual activities, and religion), QOL also increases.

Implications for Nursing: The model supports caring for the physical and metaphysical dimensions of the patient's life. It also highlights a need for holistic care inclusive of physical, emotional, and spiritual domains.

Background

Geriatric Cancer Experience

Aging shapes patients' cancer experiences. Older adults with cancer have older organ systems, decreased immune function, and comorbid conditions. They also undergo the pharmacologic interventions associated with those issues. Geriatric syndromes and uncontrolled or poorly managed comorbid conditions affect cancer treatment choices and outcomes (Balducci & Beghe, 2000; Balducci & Extermann, 2000; Rao & Cohen, 2004). Functional status is a strong predictor of morbidity and mortality in older adults with cancer (Hurria, Lachs, Cohen, Muss, & Kornblith, 2006). Psychologically, older

adult patients with cancer are at risk for depression, with a prevalence range of 17%–25%. Separating the symptoms associated with cancer from those of depression and making a definitive diagnosis is a challenge to healthcare providers (Hurria et al.; Rao & Cohen).

Spiritually, older adults express a need to practice their faith but often are limited by energy levels or social isolation. Religious beliefs and spiritual practices promote coping for patients with cancer at the end stage of their lives. Patients who use positive religious coping strategies such as forgiveness, direction, helping, seeking support of clergy, surrender, having a benevolent view of religion, and connecting report lower levels of