
REVIEW ARTICLE

Reducing the potential for suffering in older adults with advanced cancer

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ABSTRACT

Objective: To deliver quality care at the end of life, understanding the impact of various changes and life transitions that occur in older age is essential. This review seeks to uncover potential sources of distress in an elder's physical, psychological, social, and spiritual well-being to shed light on the unique challenges and needs facing this age group.

Methods: Papers relating to older adults (aged 65 years and older or a mean age of 65 years and older) with advanced/terminal cancer receiving palliative, hospice, or end-of-life care published after 1998 were reviewed.

Results: Older adults with advanced cancer have unique needs related to changes in their physical, psychological, social, and spiritual well-being. Changes in each of these domains offer not only the risk of causing distress but also the potential for growth and development during the final stages of advanced cancer.

Significance of results: Being aware of the various changes that occur with aging will help health care professionals tailor interventions to promote dignity-conserving care and greatly reduce the potential for suffering at the end of life.

KEYWORDS: Older adult, Advanced cancer, Palliative care, Distress, Quality of life

INTRODUCTION

Providing excellent care to the older adult with advanced cancer requires an understanding of not only the inherent physical changes that occurs as one ages but also the impact aging has on other life domains. People grow old in a multitude of ways, influenced by social conditions, culture, and their own experiences and personality (Street, 2007). Aging, even in the most ideal circumstances, offers profound life changes and is accompanied by multiple losses (Matzo & Sherman, 2004). To understand the impact dying from cancer has on an older adult, one must consider the prior life course of the individual and the emotional, social, and spiritual context in which

the person lives. Death and dying are experienced in relation to life as a whole; thus health care providers benefit in knowing the prior life experiences of the individuals in their care. Many older adults have developed adaptive strengths during their life, which may contribute to them having a different outlook on life and death and displaying better mental well-being (Hallberg, 2004; Osse et al., 2005). However, adults in later life have often experienced multiple losses, such as loss of a job, loss of health, and loss of friends and/or a spouse (Kane, 1991; Veach & Nicholas, 1998), all of which may have a profound impact on a person's identity, sense of self, and his or her quality of life. Additionally, older adults have a higher prevalence of certain problems, such as dementia, multiple comorbidities, and communication difficulties, and may receive health and social care in a range of settings, including assisted-living facilities, nursing homes, hospitals, and at home.

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Assessing these changes and transitions in terms of the impact they may have on what gives meaning to the elderly is a critical aspect of delivering quality care in the final stages of illness. For many older adults living with and dying from cancer, the losses related to these life transitions are often difficult to deal with and may go unrecognized as important influences on their health, quality of life, and psychosocial well-being. Several of these issues have been explored by Thompson and Chochinov (2009). However, this article further elucidates potential sources of distress specifically for older adults with advanced cancer receiving palliative, hospice, or end-of-life care.

As suggested by Ferrell and Coyle (2008), the application of a quality of life lens to a person's illness experience helps to illuminate dimensions of potential distress that may cause suffering. Quality of life models typically subsume four dimensions of well-being: physical, psychological, social, and spiritual (Ferrell, 1996). Applying this model to older adults living with and dying from advanced cancer will help to shed light on the unique challenges and needs they experience, which may potentially become sources of distress and cause unnecessary suffering at the end of life.

METHODS

CIHAHL, MEDLINE, PsychInfo, and EMBASE databases were searched using the keywords *palliative care, end-of-life, hospice, elderly, older adult, and advanced or terminal cancer/malignancy*. The reference lists of selected papers were also searched for relevant articles. Inclusion criteria included papers relating to older adults (i.e., aged 65 years and older or a mean age of 65 years and older) with advanced/terminal cancer receiving end-of-life, palliative, or hospice care, published after 1998 in the English language.

FINDINGS

One of the challenges in searching this literature was the lack of a common definition for "older adult." Some consider older adults to be aged 50 and older, others start at 65 years, and others define older adults as over the age of 80 years. When age is not systematically standardized, it not only makes locating and retrieving relevant research difficult, it also impedes comparisons from being made across studies. In a similar vein, the majority of articles lump all adults together. For example, even though the mean of a sample may be 68 years of age, the age range may span from 18 to 90. Presuming one can apply such data to the elderly fails to

acknowledge the developmental changes that occur as one ages. A third challenge encountered in this literature was the lack of age comparisons within studies. It appears that most frequently, age is collected simply as a demographic descriptor, not as a variable for which differences might be explored. By failing to use age as an independent variable in research studies, potentially significant areas of concern are not being identified. Finally, despite the fact that 64% of cancer diagnoses are in persons 65 years and older and that deaths due to cancer are rising in those aged 65 to 84 years (Ahmad & O'Mahony, 2007), little research has explored the psychological, existential, spiritual, and quality-of-life issues of older adults at the end of life. Geriatric oncology is an emerging speciality, but it appears from the published research that the majority of attention has been on the diagnosis, screening, and treatment of older adults with cancer; issues in palliative and end-of-life care have had scant attention. To redress these gaps, the identified literature is supplemented with theoretical and research literature from gerontology to explore the physical, psychological, social, and spiritual needs of older adults with advanced cancer receiving palliative, hospice, or end-of-life care.

Physical Well-Being

A key issue facing older adults with advanced cancer that influences their quality of life is the impact of the aging body on functional ability. Aging involves a process of decline in physiologic reserve capacity, resulting in an increased vulnerability to disease and the stresses associated with cancer therapies (Garman & Cohen, 2002; White & Cohen, 2008). Despite these age-related physical changes, assuming that all older adults will experience lower functional ability based on their biological age alone is erroneous. In evaluating quality of life in older adults using the European Organization for Research and Treatment of Cancer (EORTC) scale, Lundh-Hagelin et al. (2006) reported that 98% of their participants (median age 67 years; range 24–91 years) reported limitations in physical function. However, differences in the physical function between younger and older participants was not significant. Similarly, Thome et al. (2004) reported that older adults with cancer (age 75 years and older), when compared to a similar cohort without cancer, had worse scores in all the functional scales of the EORTC. Yet significant differences between cancer and noncancer groups only occurred in the youngest old group (those 75–79 years) and not in the other age groups (80–85 years and 85 and older). Older adults with cancer have been noted to have higher levels of functional ability compared to individuals of the same age without cancer or even those

younger cancer patients (Garman & Cohen, 2002). Possible explanations for these findings are that cancer is more likely to be diagnosed in healthier elderly individuals and that older adults have learned to compensate with functional limitations over a longer period of time.

Despite these findings, many older adults report limitations in their functional ability as they get older, restricting their ability not only to perform activities of daily living, but to remain independent in other parts of their lives as well. This transition from independence to dependence has been noted to cause significant existential distress in the elderly and to impact on reported quality of life (Bolmsjo, 2000; Hallberg, 2006; Eriksson & Andershed, 2008). Living with functional impairment and transitioning from living an independent life to becoming dependent and needing assistance is a significant challenge for older people. Our sense of self is often intimately tied to our functional abilities, and experiencing functional decline impacts our sense of control (Calnan et al., 2006). Indeed for many elders, feelings of inferiority and loss of self-esteem can become major issues in late life as a result of physical decline and changes in mental capacities (Kafetz, 2002; Dugleby & Raudonis, 2006). Striving to achieve a balance between remaining independent and asking for help is a fine line many elderly adults tread in order to avoid the perceived sense of being a burden to others. In their qualitative study, Eriksson and Andershed assessed a group of older adults (age range 54–82) regarding what it is like to be dependent on others for care. Participants reported the difficulties they encountered in asking for help, especially as care needs fluctuate. Many noted that to become dependent on others for care involves being estranged from one's body and triggers a range of feelings from gratitude to feeling a sense of burden.

As the body ages, changes may occur that affect the ability to communicate effectively. One area that receives little attention in the literature, yet affects many older adults, is sensory limitations, especially in terms of hearing and vision impairments. Hearing loss increases with age, with 20% of older adults over the age of 75 affected by mild hearing loss (Sparks & Nussbaum, 2008) and ultimately becomes one of the most common chronic illnesses reported by older adults (Garstecki & Erler, 2001). Individuals with hearing impairment report significantly more depressive symptoms, feelings of lower self-efficacy and mastery, more feelings of loneliness, and a smaller social network (Kramer et al., 2002). Vision problems affect proportionately more older persons, so that, by age 70, most individuals do not have normal vision, even with corrective lenses (Sparks & Nussbaum, 2008). With limit-

ations in hearing or vision, older adults may begin to withdraw from meaningful social networks, leading to a reduction in social activity, restricted independence, and ultimately more isolation (Rovner et al., 1996; Kronenfeld, 2006). Loneliness and social isolation are factors that have been reported to affect older adults disproportionately and are tied to feelings of worth, dignity, and quality of life (Seeman, 2000). Communication may become challenged due to sensory limitations; at times it may appear that the older adult does not understand or may not be understood (Amella, 2003). The inability to communicate impacts on the ability of health care providers to assess a person's comfort, establish goals of care, and provide emotional and spiritual support (Ley, 1989). Provision of adaptive equipment such as larger print material and ensuring hearing aids are in working order are vital to ensure that the older adult is able to communicate effectively throughout the course of cancer care in order to reduce the chance of sensory isolation and unmet needs. The consequences of sensory limitations may thus have a significant impact on the quality of life of a person and ability to appropriately plan for the end of life.

A factor unique to elderly patients with cancer is that they are frequently affected by multiple medical problems of varying severity (Davies & Higginson, 2004; Smith et al., 2008). On average, adults over the age of 65 years report three or more comorbid conditions in addition to cancer (Kurtz et al., 2002). Smith et al. identified that cancer patients have a small but significantly higher prevalence of comorbid conditions than patients with no history of cancer. Thus, elderly cancer patients are not dying from cancer alone but, rather, their cancer may be one of several existing conditions. Several authors have written regarding the different dying trajectories: the short period of decline with advanced cancer patients; the long-term disability, exacerbations, and unpredictability of the time of death associated with many chronic diseases such as chronic obstructive pulmonary disease and congestive heart failure; and the slow and steady decline noted in conditions such as frailty (Covinsky et al., 2003; Lunney et al., 2003). Having multiple comorbidities will alter the profile of dying from one in which there maybe fewer restrictions on physical abilities to a pattern of longer periods of functional decline and increasing dependence (Goldstein & Morrison, 2005; Chen et al., 2007). Data suggests that the period before death among the elderly is often characterized by years of significant physical distress and that the cumulative effect of multiple comorbidities may be much greater than any individual disease (Rozzini et al., 2002; Morrison & Meier, 2003).

One area that has received considerable attention in the research literature examining care of the older adult with advanced cancer is symptom distress. The prevalence of symptoms in the last year and final weeks of life have been documented by several investigators. In their retrospective survey, Addington-Hall and Karlsen (1999) reported that people 75 years of age and older had a mean number of 7.71 ($SD = 3.04$) symptoms in their last year of life and those aged 65–74 reported 8.15 symptoms ($SD = 3.04$). In the last week of life, both groups reported similar frequency of symptoms with pain, loss of appetite, and dry mouth being the three most common symptoms. Similar findings were noted for lung cancer patients, who, in the final year of life, reported a mean number of symptoms of 6.9 and in the last week of life 5.6 symptoms (Edmonds et al., 2001). For patients (median 67 years, $N = 225$) attending an outpatient palliative care symptom management clinic, 85% reported at least one severe or moderated symptom (≥ 6) on the Edmonton Symptom Assessment Scale (ESAS) of which tiredness, fatigue, and poor well-being were the most distressing (Riechelmann et al., 2007). In exploring the effect of age on symptom experience and distress, Addington-Hall et al. (1998) identified an effect of age on the mean number of symptoms experienced, with those reported as distressing decreasing significantly with age. In particular, nine symptoms decreased significantly with age, including cough, constipation, dry mouth/thirst, insomnia, nausea/vomiting, dyspnea, dysphagia, mental confusion, and anxiety. However, urinary and fecal incontinence increased significantly with age, as did the mean number of symptoms lasting at least 6 months.

Research has frequently identified that younger patients report more pain than older adults (Morita et al., 1999; Gibson & Helme, 2001; Strassels et al., 2006) and that many older individuals believe pain is a normal part of aging (Cann, 2008). The belief that older cancer patients may experience less pain has translated into some findings on opioid prescribing patterns that is troubling. Rolnick et al. (2007) noted that 32.1% of women with end-stage ovarian cancer (mean age 75.3 years) had no prescriptions for analgesics. Another study found that with each decade of life after the age of 40, patients are less likely to be prescribed opioids greater than 120 mg/day oral morphine equivalents regardless of primary cancer site (Hall et al., 2003). The finding of an inverse relationship between patient age and opioid prescribing patterns has been reported by others (Turner et al., 1999; De Conno et al., 2002; Strassels et al., 2006; Rolnick et al., 2007). It may be that older adults do experience less pain and therefore require less analgesia. However, Pautex et al. (2003) report

that physicians and nurses consistently underestimated the pain experience in older cancer patients.

Understanding the barriers in reporting symptoms may help to clarify why older adults appear to have less pain and symptom distress than younger cancer patients. Attitudes toward pain and analgesia play a significant role in symptom management. A recent study examining the barriers to pain management found significant differences between older (mean 81 years) and younger (mean 52 years) cancer patients; older adults believed that analgesia should be used only when pain becomes severe or intolerable (Closs et al., 2009). Additionally, older adults more frequently endorsed the beliefs that medical staff would become impatient if they complained of pain and that good patients should not complain. Many of these beliefs about symptom distress and pain management may be rooted in the fact that age is influenced by culture, so that each age cohort has its own identity and worldview (Matzo & Sherman, 2004). Those classified 82 to 100 years and older are members of the GI cohort, those individuals who came of age during World War II and who have a history of facing crises with courage and strength. The age cohort ranging in age between 63 and 80 in 2005 has been called the adaptive cohort and may face the end of life with equanimity and courage (Stillion, 2006). Understanding these cohort effect helps to illuminate held beliefs such as one that “good” patients do not complain of pain and the importance of maintaining a stiff upper lip in the face of adversity. Thus, it is prudent to thoroughly assess for pain and symptom distress within this population, as elderly individuals may not readily disclose sources of physical distress. Assessing and relieving symptom distress is vital, as there is a plethora of research, though not all specific to the elderly population, documenting the negative consequences of unrelieved symptoms on dignity, quality of life, and their contribution to suffering (Chochinov et al., 1995; Strang, 1998; Desbiens et al., 1999; Zaza & Baine, 2002; Yan & Kin-Fong, 2006; Kutner et al., 2007). Thus, being attuned to these facets of physical well-being will help health professionals to be proactive in stemming possible distress in the elderly cancer patient.

Psychological Well-Being

Though there is literature discussing psychological distress during the terminal or palliative phase of illness, few studies have examined these issues specifically within the older adult cancer population. What can be gleaned from this body of work is that individuals dying of cancer are at risk of experiencing mental health problems, which are too frequently

unrecognized and underdiagnosed (Fallowfield et al., 2001; Birrer & Vemuri, 2004; Kelly et al., 2006; Wilson et al., 2007a, 2007b). When we consider the psychological domain of aging, no other life event than facing one's impending death generates as intense emotionally directed thinking in the older individual and those around them (Cuttillo-Schmitter, 1996). The research on death acceptance is mixed, with some finding that older adults are more accepting of their death and are able to put death in the context of the life they have lived (Ando et al., 2007; Russac et al., 2007). Others have indicated that death anxiety increases as we age (Hallberg, 2004; Madnawat & Kachhawa, 2007). Helping to facilitate older adults coming to terms with their own death through life review, discussing what to expect during the terminal phase, and reflecting on important relationships reduces the potential for unnecessary suffering at the end of life (Payne & Massie, 2000; Duggleby & Wright, 2004; Wijk & Grimby, 2008).

Depression is not a normal part of aging, yet it appears to be more common in elderly persons with medical comorbidities and severe or chronic diseases such as cancer (Spoleitini et al., 2008). Lloyd-Williams et al. (2004) found that depression affects approximately one in four patients (mean age 66.8 years; range 28–89 years) receiving palliative care. Similar findings have been reported by others (Chochinov et al., 1995; King et al., 2005). Previous psycho-oncology research has identified that anxiety, depression, and psychological well-being differs by age. Older cancer patients, despite research indicating they cope with cancer better and have less diagnosed anxiety, depression, or emotional distress than do younger patients (Osse et al., 2005; Rose et al., 2008), may be at higher risk of psychological distress due to other life-cycle events and losses, such as retirement, widowhood, presence of comorbidities, and alterations to their physical abilities (Roth, 2008). Indeed, Gruneir et al. (2005) identified that social isolation and pain increased the likelihood of depression in their study of cancer patients (mean age 77.1 years). In an exploration of older adults' reports of pain, participants in Duggleby's (2000a) study described their worst pain as psychological in nature, which stemmed from feelings of helplessness, being dependent on others, and difficulty in reshaping relationships. It is important to note that older adults do not voluntarily discuss their depression or loneliness as frequently as younger patients (Lyness, 2004; Liu & Matulonis, 2006), with approximately 25% of older patients not reporting their psychiatric symptoms (Roth, 2008).

Studies have noted that psychological distress stems from unmet physical, psychological, spiritual, and existential needs, resulting in undue suffering

(Morasso et al., 1999; Arnold et al., 2004, 2006; Abraham et al., 2006; Peters & Sellick, 2006). Oftentimes when such distress reaches a critical level, many patients feel they can no longer go on living. A recent study by Miller et al. (2008) noted that the risk of suicide in older adults is higher among patients with cancer, especially those with metastatic disease, than those with other medical illnesses. In their literature review, Chochinov et al. (1995) reported that clinical depression, poor pain control, and lack of social support are significantly related to desires for hastened death and that the degree of distress in these individuals is very high. In a more recent study examining depression and anxiety disorders in palliative care, Wilson et al. (2007b) identified that those who met the criteria for an anxiety or depressive disorder were significantly more likely to express a desire for death, report they were suffering, and feel a loss of dignity. For many who experience depression, a profound sense of hopelessness exists (Breitbart et al., 2000; Duggleby, 2000b). A sense of hopelessness has been reported throughout the literature as a main reason many terminally ill patients would request a hastened death (Wilson et al., 2007a).

Social Well-Being

Supportive relationships are one of the most significant factors influencing the well-being of older adults at the end of life (Mackey & Sparling, 2000; Nussbaum et al., 2003). The presence of social support and social networks have been shown to have a positive influence on quality of life (Unger et al., 1999; Shaw et al., 2007). Social support can provide an older adult emotional connectedness and acceptance, both of which contribute to feelings of enhanced self-efficacy (Hansson et al., 2007). As one ages, however, several factors conspire against the availability of social support. In general, the family network, often the key provider of social support to older adults, is aging itself. As such, it may become smaller, frailer, and less able to provide the needed support to the dying adult (Hansson et al., 2007). Jackson et al. (2007) identified that 60% of women with advanced ovarian cancer lived alone and that approximately 8% lacked social connections in their last 6 months of life. Unmet emotional support needs are generally greater for those individuals who live alone (Morasso et al., 1999) and social loneliness contributed greatly to feelings of powerlessness and helplessness in patients dying at home (Sand et al., 2008).

In later life there is a general thinning of one's social network, either through the deaths of friends, family, and/or a spouse; the need for relocation to a nursing home or assisted living facility; or retirement

or worsening health. The combination of these losses may create a sense of isolation, loneliness, and potential suffering in the older cancer patient. Social isolation caused by restricted mobility or deteriorating health can negatively impact a chronically ill individual and her or his caregiver (Fitzsimons et al., 2007). Several authors have noted the important link between social support, especially in terms of close relationships with family and friends, and feeling that life has purpose and meaning (Chochinov et al., 2002; Krause, 2007). Studies exploring the experience of older adults living with a chronic illness have noted that individuals longed to have social spontaneity (Giddings et al., 2007), yet they often suffered from loneliness because of their inability to participate in social activities and, thus, felt that life lacked meaningful content (Elofsson & Ohlen, 2004). Having the support of close friends and family contributes to one's sense of identity and self-esteem (Elofsson & Ohlen, 2004); when these are lacking, a loss of dignity and suffering may ensue. People 65 years of age and beyond tend to interact less frequently with those who are not in their closest networks and devote more emotional resources to fewer but intensely close relationships (Nussbaum et al., 2003). Feeling that one continues to contribute and is still important to others remains a significant aspect of defining a good life in the last phase of life (Andersson et al., 2008). When daily life becomes lonely and there are fewer opportunities to contribute to others, family and the supportive attitudes from nursing home staff helped bolster elderly individuals sense of self, meaning, and dignity (Franklin et al., 2006).

Due to the nature of advanced terminal illness, older adults may face a change in the nature of their role within the family. With the progression and worsening of their condition, older adults may experience role reversal, whereby they become the recipient of care from their children. However, caregiver issues are a significant concern in that there is often a lack of informal caregivers available to older adults. In a study examining caregiving issues, it was noted that those over 70 years of age had fewer informal caregivers than younger adults (Teunissen et al., 2006). This is troubling given that limited social support diminishes elderly cancer patients' access and referral to palliative care services and to the possibility of dying at home (Addington-Hall & Altmann, 2000; Burge et al., 2002; Lackan et al., 2003; Aabom et al., 2005; Gilbar et al., 2005; Rosenwax & McNamara, 2006; Shugarman et al., 2007). It appears from these studies that there is an inverse relationship between palliative/hospice care referral and age, with the oldest age group, those 85 years and older, consistently less likely to receive these

services. Two literature reviews have noted that cancer patients are less likely to receive palliative care services if they are older, have no informal support, require high nursing care, have poor functional status, and are of low economic status (Grande et al., 2003; Ahmed et al., 2004). Several studies have found no significant differences in age and hospice referral (De Conno et al., 2002; Chen et al., 2003; Gagnon et al., 2004; Keating et al., 2008); however, a major limitation of studies examining the relationship between age and palliative care referral is that they fail to address the level of need required.

Spiritual Well-Being

As we age, spirituality increases in importance (Atchley, 2006). According to gerontological theory, the significant developmental tasks of older adulthood are to find purpose and meaning in life, two core aspects of spirituality (Tornstam, 1996). Transcending loss, finding hope, sometimes in the face of despair, and finding a new intimacy with God and/or others are additional spiritual tasks of older adulthood (MacKinlay, 2006). Many of these tasks resonate in Hermann's (2001) study of the spiritual needs of hospice patients (mean age 72 years). Participants described a range of spiritual needs that are captured under six themes and include (1) a need for involvement and control, (2) a need for companionship, (3) a need to finish business, (4) a need for religion, (5) a need to experience nature, and (6) a need for a positive outlook. A follow-up study addressing hospice patients' (mean age 67 years) spiritual needs found that needs that could be fulfilled by the participants independently (e.g., praying) were met more frequently than those requiring the cooperation of others, such as attending religious services (Hermann, 2007).

Failing to adequately address spiritual needs can contribute greatly to the suffering experienced by many older adults, resulting in spiritual and existential distress. Mako et al. (2006) reported that over 96% of advance cancer patients experienced spiritual pain during their lives, 61% reporting such pain at the time of the interview. Frequently spiritual pain was described in existential terms, such as suffering, despair, and feelings of loss. Researchers have found spiritual well-being is negatively correlated with loneliness, depression, and anxiety (Fehring et al., 1997; Nelson et al., 2002). Indeed, spiritual despair or pain may manifest in different ways: physically, psychologically, religiously, or socially (Chochinov & Cann, 2005). This despair may translate into feelings of hopelessness and demoralization, both of which can contribute to feeling a loss of will to live and desire for hastened death (Breitbart et al., 2000;

McClain et al., 2003). The ability to find and sustain meaning in life during terminal illness is a strong deterrent to despair at the end of life (McClain et al., 2003). The intimate connection between spirituality and a sense of purpose or meaning is especially important in light of research that connects these to a sense of dignity in older adults. Older adults report that serving a purpose, feeling important, feeling involved, and belonging are essential to their notions of dignity and, thus, spiritual well-being yet report difficulty in meeting these needs (Franklin et al., 2006; Wijk & Grimby, 2008).

Striving to find hope and meaning in the face of advancing disease is a challenge faced by older adults living with and dying from advanced cancer. Lin and Bauer-Wu's (2003) review of the literature identified that psycho-spiritual well-being is largely predicated on finding meaning and having hope. A study of patients receiving palliative home care (median age 65 years) found that their experience of hope involved a will to find meaning, to envision something better, or to make life easier (Benzein et al., 2001). Older adults receiving palliative care have identified several areas that provide them with hope, including hope for relief of pain (Duggleby, 2000b), for being well cared for and supported (Clayton et al., 2005), for living as normally as possible (Benzein et al., 2001), for the well-being of their family (Herth, 1990), and for life after death (Duggleby & Wright, 2004). As hope is central to life and an essential dimension for successfully dealing with critical illness (Miller, 2007), encouraging elderly patients to explore hope-fostering strategies is imperative. Several studies have identified hope-fostering strategies used by palliative care cancer patients including setting short-term goals, drawing on their faith, leaving a legacy, finding meaning and purpose, and conducting a life review (Chochinov et al., 2002, 2004; Duggleby & Wright, 2004; McClement et al., 2004; Johnson, 2007).

CONCLUSION

Older adults dying from cancer are at risk of suffering due to the inherent physical, psychological, social, and spiritual changes that occur as we age. However, as people age, different developmental tasks and opportunities present themselves, offering the potential for growth, development, and change (Blank & Bellizzi, 2008). Drawing on the inner strengths, previous life experience, and life-acquired wisdom will help older adults feel valued and help them to cope with the inherent changes of aging and facing life's end. As health professionals, it is important for us to view older adults for the strengths they possess rather than simply seeing aging as

problematic and associated with increased dependence and incapacity (Bailey & Corner, 2003; Blank & Bellizzi, 2008). By fostering the inner resources of older adults, health care professionals promote dignity-conserving care (Chochinov, 2002, 2007) and greatly reduce the potential for suffering at the end of life.

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