

*Advance Care Planning in HIV and Aging

Older HIV-infected patients, especially those with substantial illness burden, should be counseled to complete a durable power of attorney (DPOA) for health care and an advance directive such as the “Physician Orders for Life Sustaining Treatment” (POLST) form.

Before the advent of potent antiretroviral therapy, the autonomy and rights of people with AIDS was a common theme of discussion among patient advocacy groups and care managers (Mor et al. 1989). When HIV infection was more acutely life-threatening, it was incumbent upon everyone involved in the care of these individuals to ensure that they had considered advance care planning and surrogate decision-making as a routine part of care. Early in the epidemic it was common for HIV-infected patients to have a durable power of attorney (DPOA) for healthcare and an advance directive or living will (Steinbrook et al. 1986). Since the arrival of potent combination ART, this practice has declined substantially as persons with HIV infection have led healthier, longer lives (Selwyn et al. 2003). Recent data show that less than half of HIV-infected patients age 45-65 have completed advance care planning and advanced care planning discussions between patient and provider are less likely amongst certain patient groups, such as ethnic minorities, intravenous drug users, and those with lower education levels (Erlandson et al. 2012, Wenger et al. 2001).

For persons with advancing age and longstanding HIV infection, particularly those with even modest cognitive or functional impairment or with multiple comorbidities, it seems wise to re-emphasize the importance of establishment of power of

attorney and advance directives, since, as it was 20 years ago, many persons with HIV infection may not want their closest blood relative or other default surrogate decision maker (based on state law) to make medical decisions for them in the event of serious illness. While rates of opportunistic infections and AIDS-related malignancies have decreased, many individuals with HIV suffer from multiple, complex chronic conditions, making end-of-life discussions as valuable as ever. The increased longevity of persons living with HIV leads to increased opportunities for advanced care planning and providers should incorporate such discussions into routine care for these individuals (Selwyn et al. 2003).

Additionally, over the past 2 decades, confidence in the effectiveness of established advance directives has grown. Research during the 1990's led to some discouragement about the effectiveness of advance directives in guiding care decisions (SUPPORT) (Teno et al. 1997). More recent evidence, using agreed upon directives established between providers and patients or their surrogates, such as the “Physician Orders for Life Sustaining Treatment” or POLST form (2010), have indicated that patients and providers may be able to have more confidence that directives will actually be followed as patients move from home to various care settings (Hickman et al. 2010).

References

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