

Virtual Mentor
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Quality of Life and Geriatric Patients

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FROM THE EDITOR

Autonomy and Quality of Life for Elderly Patients

“Why is it that the important problems of older persons are often not the ones that we know how to help?” [1]

By 2020, 60 percent of hospital patients will be 65 and older [2], due in part to the technological and medical advances that are allowing people to live longer lives. As physicians encounter this growing number of older patients, many of whom have comorbid conditions, they will need to know how to look beyond the patient’s physical health to the social environment and relationships that contribute to overall well-being and quality of life. How can physicians, accustomed to improving their patients’ quality of lives through medicine, take on responsibility for the circumstances that exist beyond the hospital and clinic doors?

Moreover, respecting a patient’s autonomy—a cornerstone of professional duty when working with younger adults—is not so easily accomplished when managing care for the elderly. These topics are the focus of this month’s *Virtual Mentor*.

Medical training traditionally emphasizes patient autonomy—that is, adhering to the wishes of the patient; physicians are taught that patients are the ultimate decision makers when it comes to their own care. Following this principle can be difficult when patients do not have full decision-making capacity or when they simply wish to defer to their family members’ decisions. In such situations, physicians may become frustrated by struggles within the family and the time-consuming processes of mediating and determining what their patients truly “would want.” In what ways can physicians continue to respect their patients’ autonomy when family members and others want to become part of the patient-physician relationship? The challenge of family-centered decision making serves as the basis for one of this month’s clinical cases.

“Most doctors treat disease, and figure that the rest will take care of itself. And if it doesn’t—if a patient is becoming infirm and heading toward a nursing home—well, that isn’t really a medical problem, is it?” [3]

Most physicians are comfortable with treating illnesses that compromise their patients’ quality of life. Prescribing an oxygen tank for a patient with COPD (chronic obstructive pulmonary disease), for example, or a medication for depression are fairly straightforward. But as patients grow older and develop advanced medical conditions, frailty, cognitive dysfunction, impaired vision or hearing, social isolation, and safety at home can become serious concerns. How can physicians justify limiting

a patient's independence in the interest of his or her "own safety," when independence and the ability to continue living at home are essential for most older patients' quality of life? This question is taken up in our other two clinical cases and in the health law article on physician duty to report older, impaired drivers.

Clinic visits are the optimal time to discuss with the elderly and their families these social issues as well as the patient's values and care preferences, including advanced directives, living wills, and resuscitation status. In the "real world," however, where 20 minutes are available to discuss blood pressure, blood sugar control, medication reconciliation, chronic back pain, and vague memory difficulties, there is rarely time to have this conversation. Because of lack of time—and training—physicians are seldom able to give adequate attention to the social factors that affect an elderly patient's day-to-day life and ability to stay out of the hospital.

A fine line exists between physicians' responsibilities and society's obligations to respect the autonomy and preserve the quality of life of elderly patients. This line is becoming less well defined as we discover that the successful management of an elderly patient's medical problems is often rooted in optimizing his or her social situation. Let's say, for example, that management of a patient's depression enables her to comply with her heart failure treatment which, in turn, minimizes hospitalizations. And let's say the management of her depression is dependent, in part, on her access to transportation to dine at the senior center with friends and to keep physician appointments. How much of this patient's limited clinic time should be spent on securing access to transportation and investigating other obstacles to social integration? The medicine and society section grapples with the physician's responsibility to help preserve a patient's quality of life.

Thomas, Leipzig, and Smith summarize the broad responsibilities of managing well-being for the elderly. They write that care for older patients requires

coordination with family; consulting physicians; and nonphysician health care providers, such as social workers, pharmacists, and therapists...No reimbursement is provided for the numerous telephone calls; family meetings; the office time and space needed to get a patient undressed and on an examination table; or 'geriatric procedures' such as...evaluating cognitive function...The time it takes physicians to access home care personnel, social workers, case managers, and other community resources...are often not reimbursed by Medicare [4].

Can medicine *afford* to shoulder the responsibility of managing patients' sociomedical well-being when the cost of medical care alone is so high and social issues rarely have a definite endpoint? This month's policy forum looks at the high cost of health care, specifically, the inadequacy of funding for long-term care. In a similar vein, the journal discussion examines nonpharmacological treatment and patient-centered techniques that can minimize the effects of behavioral and psychosocial symptoms of dementia—but at costs that are not typically reimbursed.

Finally, the op-ed considers reforms to Medicare that might restore that program's fiscal soundness as the baby boomers become eligible for its benefits.

While 39 percent of clinic visits by elderly patients are with general internists, even more patient visits in this population are with physicians trained in internal medicine subspecialties [5]. In a care system this fragmented, all medical students and residents should have a general idea of the unique aspects of providing geriatric care, a point emphasized in the medical education section.

Physicians are the ultimate advocates for patients' autonomy, and, inasmuch as social situations play a larger part in inhibiting (or allowing for) successful medical care, physicians must learn how to preserve quality of life even as they prolong it. I hope this issue of *Virtual Mentor* will provide not only practical suggestions for approaching some of the difficult situations and conversations mentioned above, but also insight into the growing concerns of maintaining quality of life and autonomy through old age.

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CLINICAL CASE

Family-Centered Decision Making

Commentary by Muriel Gillick, MD

“Let’s pause here,” said Dr. Lawrence during morning rounds. “This is Mrs. Burke’s room. She’s a 78-year-old woman who came in for a knee replacement 4 months ago and was re-admitted a month later with fever, weakness, and *Staph. aureus* bacteremia. She continues to have bacteremia. We have done a complete work-up multiple times, but we’ve yet to find the source of her infection. She’s been back to the OR twice on the recommendations of the infectious diseases consultants, but the orthopedic surgeons have stated this is not coming from her knee. Mrs. Burke has also had imaging of her spine and knee five times, an echo of her heart three times, and almost daily blood cultures. She has been on several antibiotics, all based on susceptibilities. Today we will have our fourth family meeting. Mrs. Burke’s daughter is very expressive of her own wishes and requests, which lately do not seem to be correlating with her mother’s, and we have found that regular family meetings help to keep everyone on the same page.”

After he finished his report, Dr. Lawrence led the team into Mrs. Burke’s room, and Mrs. Burke asked about the day’s plan. “Are you going to poke and prod me again or will I finally get a little peace?” Dr. Lawrence replied that her anemia, a possible side effect from the antibiotics, was slightly worse and that Mrs. Burke had the option of waiting until tomorrow to recheck her blood counts or receive a blood transfusion that day in the hope of making her feel better.

Mrs. Burke replied, “Dr. Lawrence, I’m so tired of everything. I don’t want the transfusion. I want to be left alone for a while. I really just want to go home.”

Later that morning during the family meeting, Mrs. Cominsky—Mrs. Burke’s daughter—said, “We want everything possible done to locate the source of my mother’s infection so that we can eradicate it. If that means more labs, running more tests, getting more fluid samples, doing more MRIs and echoes, don’t hold back! I want my mother to get well.”

Dr. Lawrence looked at Mrs. Burke, who sat quietly by her daughter’s side. “Is this what you want?” he asked.

“Of course that’s what she wants!” Her daughter exclaimed. “She wants to get better!”

“Well, we had a discussion earlier today, and your mother indicated that she was not interested in undergoing more tests. She has been here for several months now, and, understandably, she is tired. Her preferences—and you can correct me if I misunderstood you, Mrs. Burke—are to hold off on further testing right now and to possibly... .”

“My mother is sick! She is not clear-headed! Of course, she wants everything done!” interrupted Mrs. Cominsky.

Dr. Lawrence asked Mrs. Burke to state her preferences so that everyone knew what she wanted, but Mrs. Burke simply shrugged her shoulders and replied in a defeated tone, “My daughter takes care of me at home. She knows what’s best.”

Commentary

Frustrated by his inability to find a source for Mrs. Burke’s fever and convinced that she is dying, Dr. Lawrence is ready to accept her statement, “I really just want to go home,” as an indication of her wish to limit treatment. Her daughter, Mrs. Cominsky, asserts confidently that her mother may be tired but that her goal is “to get better.” In truth, neither goal is realistically achievable, and the emotions swirling through the clinician-patient-daughter triad may be preventing a productive discussion of how best to approach Mrs. Burke’s care.

Mrs. Burke’s goals. Mrs. Burke’s wish to just “go home,” articulated when she is weak and febrile after months of illness, needs to be further explored. Does she mean “home” literally, or is “home” a euphemism for dying? If home is taken at face value, Mrs. Burke needs to understand that she would most likely require 24-hour care, preferably with hospice services. If Mrs. Burke does understand that “going home” would be going home to die, or if in fact her words mean “going home to heaven,” she should be assessed to determine whether her wish stems from severe depression or from a judicious assessment of her condition.

Mrs. Burke’s daughter’s goal. Although Dr. Lawrence may have come to the conclusion that all reversible causes of fever have been ruled out, he and the house staff have probably continued to report even the small fluctuations in blood cell counts or the results of the latest set of blood cultures to the family. But this may not have been presented in relation to Mrs. Burke’s overall health state. Precisely because no single, terminal illness has been identified and the cause of the recurrent fevers remains elusive, the medical team may never have explained to Mrs. Cominsky that her mother is dying. Anthropological studies of hospital care have demonstrated that the clinical staff’s shift from trying to improve a patient’s condition to acknowledging her dying typically takes place only shortly before death [1].

Family-centered decision making. The physicians seem to experience Mrs. Cominsky as aggressive and overbearing. They see her as riding roughshod over her mother’s wishes, and they regard themselves as defenders of Mrs. Burke’s

autonomy. Physicians often interpret the behavior of family members as disruptive or even dysfunctional, particularly in the acute care setting when the patient is seriously ill [2]. It is difficult for the team to appreciate that Mrs. Burke's daughter has been her primary caregiver, that she knows her mother better than any one on the medical team, and that the two may well have shared values. Dr. Lawrence needs to move from seeing Mrs. Cominsky as an adversary to viewing her as an ally.

The intensely individualistic model of Western biomedical ethics contributes to the tendency to regard family as problematic and an impediment to care. Physicians are taught to focus on the needs of patients in isolation from their families or communities even though patients almost always function in a social context. Frail older individuals seldom make decisions without the input of those closest to them, and they are rarely in a position to implement their decisions without the help of others.

Older, sick patients typically want their families to be involved in medical decision making. Sometimes, as when Mrs. Burke says "my daughter takes care of me at home; she knows what's best," they are eager to transfer authority to a surrogate, even if they are cognitively able to make their own decisions. In a classic study of community-dwelling older patients, the vast majority expected their families to make decisions for them and regarded this as a form of extended autonomy [3]. Even though family caregivers often find their responsibilities burdensome—suffering financial strain, experiencing resentment and guilt, and sacrificing their own health for their loved one [4]—they often also enjoy profound satisfaction from that role [5].

Cultural factors may also shape patients' preferences for the locus of decision making. We are not told anything about Mrs. Burke's ethnic background, but in many cultures, particularly among Asian Americans, patients do not wish to be told their prognoses and defer decision making to a spouse or adult child [6]. Physicians must be sensitive to this possibility and ask patients what role they wish their families to play [7].

The Emotional Overlay and its Consequences

The readiness of Mrs. Burke's physicians to accept her statement about wanting to go home as a wish for comfort-oriented care is a reflection of their dedication to supporting her autonomy, but also of their own emotional state. Caring for an older person who suffers one complication after another, with little prospect for recovery to her baseline level of function, is draining for the medical team. They question their competence; they wonder what they have missed and whether their resources would be better used elsewhere. Mrs. Cominsky's strident tone leads them to worry they will be sued if the outcome is death.

These factors contribute to feelings of anger, resentment, and inadequacy, which are common in physicians who care for seriously ill patients. Unfortunately, these emotions can also adversely affect patient care, leading physicians to avoid the

patient or family, to make dismissive comments about the family to other doctors, and to further impair already strained lines of communication. An article by Meier and colleagues describes the cascade of behaviors generated by physician emotions and argues that the medical team should name the feelings they are experiencing, accept them as normal, reflect on their emotions and possible consequences, and seek peer support [8].

Resolution

When Dr. Lawrence and the medical team sit down to talk about next steps with the patient, Mrs. Cominsky, and (ideally) other involved family members, they should begin by acknowledging that it is a difficult time for Mrs. Burke and her family. They may also want to acknowledge that seeing her do poorly is hard for them, too. Saying “I wish medicine had the power to turn things around” can go a long way toward creating a badly needed alliance among the stakeholders in this drama [9].

Having said that things are not going well, the team needs to explicitly address Mrs. Burke’s prognosis. They should be prepared to explain that, even without a single, unifying terminal diagnosis, older patients often succumb to the combined burden of multiple comorbidities [10]. They also should take seriously the implicit concern raised by Mrs. Cominsky that her mother’s discouragement at her lack of progress is getting in the way of sound decision making. One way to demonstrate an understanding of Mrs. Cominsky’s concern is to evaluate Mrs. Burke for depression. By acknowledging Mrs. Cominsky’s sensitivity to her mother’s mood, they are implicitly legitimizing her participation in discussions about her mother’s medical care. They should accept that decision making is familial rather than exclusively patient-centered and explore cultural and ethnic factors if appropriate.

At the same time, the physicians would do well to discuss their sense of frustration with their colleagues. Seeking a second opinion from a geriatrician (not just from the infectious disease specialists or orthopedists who are apt to focus on a single organ system rather than on the whole patient) may confirm that shifting from care focused on life-prolongation to care focused on comfort is appropriate at this juncture.

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CLINICAL CASE

Assessing Senior Patients' Ability to Drive Safely

Commentary by Richard A. Marottoli, MD, MPH

"How are you, Mr. Wagner?" asked Dr. Shore as he entered the exam room and greeted the elderly patient he had been seeing for over 15 years.

"I'm doing fine, Dr. Shore. My wife's arthritis has been flaring up occasionally, so I help her and we get by. She takes her mind off the pain by staying involved with our church functions, the parties at the senior center, and babysitting our grandchildren. We have more of a social life now than we did when we were 25!"

"It's great to hear that you're so active. Before we discuss your diabetes and hypertension, do you have any particular concerns today?"

"No...," Mr. Wagner responded, his voice trailing off. "Well, the biggest worry on my mind right now is working out insurance issues after a fender bender I was involved in last week."

"Oh? What happened?"

"Lately I've been getting a little mixed up with directions. We go to church at least once a week and we always take the same route. I mean, I know where I'm going. It's just that, for a second or two, I don't know where we are. My wife hasn't driven in years because of her arthritis, so I'm always the one behind the wheel. Usually I'm fine, but sometimes I wonder if my memory is going...it must be old age!" chuckled Mr. Wagner.

"Anyway," Mr. Wagner continued, "it was one of those times when I was trying to figure out where we were. I thought I was paying close attention to the road, but somehow I ended up with this minor, but particularly annoying, fender bender. Luckily no one got hurt."

Commentary

This case highlights a number of important points that arise when the safety of the general public must be balanced with the quality of life for a senior patient with some memory loss. Mr. Wagner is active and enjoys the social benefits of his lifestyle. His wife has arthritis, which imposes some physical limitations on her, and Mr. Wagner is the sole driver in the household. He is aware of some difficulties with his memory and driving, and he brings this up for discussion with Dr. Shore.

Transportation is essential for participating in a variety of out-of-the-home activities that can improve a person's mood, self-efficacy, cognition, quality of life, and longevity. Driving is often synonymous with transportation in our society and remains the primary source of getting from place to place anywhere but in a large city, even for those in advanced age [1]. People who no longer drive are able to participate in fewer outside-the-home activities and have been shown to exhibit more depressive symptoms than their peers who drive [2, 3]. Despite the advantages of pursuing activities outside of the home, there may come a time when people need to make the transition to driving less frequently or not at all.

Safety

There is great variability in the factors that affect driving safety among aging individuals and no readily available way to identify them. Nevertheless there is much clinicians can do to become more aware of possible risk factors for unsafe driving and to make patients and families more conscious of the challenges that older drivers face. Signs that driving safety may be a problem include changes in health and in physical and mental function.

Physicians must be mindful of the functional manifestations of the underlying medical conditions their older patients have. Among *medical conditions* that contribute to driving risk are dementia, neurodegenerative disorders, vision disorders, sleep disorders, and conditions that adversely affect blood supply to the brain. The *functions* that most profoundly affect safe vehicle operations are vision, cognition (information processing speed), and physical ability. A number of widely available resources, such as those published by the American Medical Association and the Canadian Medical Association, enumerate relevant conditions and functional abilities, explain how to assess them, and list the reporting requirements in different jurisdictions [4, 5]. Algorithms for assessing the physical fitness of an aging driver are available in the AMA article and elsewhere [4, 6].

Physicians should also consider the medications a patient is taking—particularly those that might affect vision, cognition, or physical ability—when determining whether a patient is capable of operating a vehicle safely. When prescribing such medications doctors should discuss the potential effects and side effects with the patient and assign doses that are medically beneficial but minimize the effect on driving ability. Finally, doctors should document discussions in the patient's medical record and provide the patient with a copy of instructions and care plans.

Improving Driver Safety

Recent studies have demonstrated that medical interventions can improve vision, cognition, and physical ability (flexibility and speed of movement) [7-9]. Evidence also suggests that educational programs including classroom and on-road training can enhance driving performance [10]. In older patients whose functional impairments are manifestations of underlying medical conditions, only small improvements may be possible.

As with any intervention, the first step is the patient's recognition of the problem and his or her willingness to change. Mr. Wagner displays commendable insight into his possible deficits and seems open to examining the problem and changing what he can. Dr. Shore should address the factors that are most remediable first. If these initial interventions do not ameliorate the problem sufficiently, the next step is to phase out driving. In this particular case, it would be helpful to know whether Mr. Wagner's wife is able to drive when her arthritis is not flaring up and whether they have other transportation resources available. It may be helpful to contact other family members, a social worker, or agencies like the Chamber of Commerce to find out about local transportation resources. If the patient is reluctant to consider driving alternatives, the physician must make clear why he or she is concerned. Mr. Wagner's episode of getting lost is an indicator of cognitive difficulty. It would be worthwhile to review his medical conditions, vision, cognition, physical ability, and medications, with the idea of fitness for driving in mind. Physicians can also ask a patient or a family member about adverse driving events and can request that the family member ride with the patient and look for difficulties in vehicle operation and interaction with traffic. If this is not possible, professional assessments of driving performance can be obtained from community agencies that provide such evaluations or by licensing agencies (i.e., Department of Motor Vehicles). Family members can also help monitor and reinforce the need for recommended changes in driving practices.

Advice for Physicians

When discussing driving abilities with patients, you should be frank but supportive. Explain clearly why you are concerned and review these points with the patient and, if the patient will allow, with the family. Gather the information about the patient's medical conditions, functional abilities, medications, driving performance, and driving safety—all that it takes to convince you, the patient, and the family either that the patient can continue to drive safely or that he or she cannot. If, in fact, the patient cannot continue to drive safely, present your recommendations as advice and allow the patient to decide how to proceed; follow up with the patient and family about whether changes have occurred.

Depending on the jurisdiction, and the severity of your recommendations, you may be required to report the patient to the licensing agency. The AMA's *Code of Medical Ethics* directs the physician to report "medical conditions that would impair safe driving as dictated by his or her state's mandatory reporting laws and standards of medical practice" [11]. When patients are reported to the licensing agency, the final determination regarding fitness to drive is made by the Department of Motor Vehicles.

Before reporting a patient, understand, disclose, and explain your responsibility to report to the patient. If you are not required to report, you may elect to allow the patient to act on your advice before involving the state. If, however, you believe that the patient is unlikely to follow your advice or that he or she poses a significant safety hazard to self and others, you may still want to report. Be sure to document all

discussions in the medical record. Many states have medical advisory boards that are valuable sources of information on this topic. Print resources that outline potential approaches to discussing driving safety with patients are also available [4, 12].

In summary, this case features a patient who is aware of potential difficulties both in functional abilities and driving performance and raises these to his physician. As physicians, our goal should be to advise and support the patient, optimizing both mobility and safety, and work to achieve acceptable compromises when one or both of these is affected.

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CLINICAL CASE

When Home Care Is Not Enough

Commentary by Mitchell T. Heflin, MD, MHS

“Good morning Mr. and Mrs. Frank,” said Dr. Woods as he greeted his patient’s family. “Glad you could come in with your mother. Her blood pressure is fine and her heart and lungs sound good. Are you noticing much change in her ability to get around or her mental status?”

“Well,” replied Mrs. Frank, “that’s something we wanted to talk to you about today. We now have an aide who comes in five times a week for an hour or so, and she helps bathe and dress my mother-in-law. I’m there most evenings and every night, so I can watch her then. She’s doing okay, I guess. She gets confused more easily now, and when she gets up to walk, I worry about her balance.”

“Don’t get us wrong—mother’s okay, all things considered—we’re doing the best we can.” Mr. Frank continued, “I’m not sure what to do about her wandering off. I sleep during the day since I work nights now, and once last week I found her wandering down the street. A while back, I was awakened by the smell when she put a piece of chicken wrapped in foil in the microwave.”

Dr. Woods looked at his patient and her caregivers. He knew he was about to raise a sensitive subject. “It sounds as though you are well taken care of,” he said to his patient who smiled pleasantly. Then he addressed Mr. and Mrs. Frank. “As we discussed before, your mother’s Parkinson’s is fairly advanced, and she will require more supervision and care as time goes on. What are you planning to do when she needs round-the-clock companionship? Have you given any more thought to finding her a good nursing home?”

Mr. Frank sat straight up. “I know you mean well, Dr. Woods, but where my mother lives is *our* business. When we told you about my mother’s problems, we just wanted to share with you what was going on. We thought maybe you could help us a little. We did the home evaluation like you wanted; home health care has helped a bit, but we can’t afford to have someone there all the time. My wife skips most of her Monday and Thursday bingo nights, and I work nights so that mother’s never in the house alone. She took care of me, and now I’m taking care of her. We’re *never* going to abandon her to some strangers!”

Dr. Woods paused and responded calmly, “As her physician, it’s my job to let you know what her needs will be, probably in the near future. Her care isn’t going to get any easier.”

After the Franks left, Dr. Woods stepped out of the room and consulted a colleague. “This family is obviously doing the best they can for my patient, and, in the earlier stages of her dementia, she did state several times that she never wanted to go to a nursing home. But with each visit, I’m more and more concerned for her safety. I’ve tried to make her family aware of my concerns, but they are sort of stuck. They can’t afford the home care their mother needs and they’re determined not to have her in any kind of skilled nursing facility. I would hate to alert the adult protective services, but I’m wondering if that’s the route I’ll have to take. I don’t think this living arrangement is very safe for my patient.”

Commentary

The dilemma faced by Dr. Woods and the Frank family is familiar to anyone practicing medicine in the modern era. Like the senior Mrs. Frank, many older adults suffer from chronic conditions that, over time, result in progressive loss of the ability to live independently and to provide basic self-care. Heart disease, stroke, COPD (chronic obstructive pulmonary disease), arthritis, dementia, and Parkinson’s disease are all progressive conditions that ultimately threaten function and quality of life. Eighty percent of adults over the age of 65 are afflicted with at least one chronic condition, and 50 percent, by at least two [1]. Concurrent with this decline, caregivers—usually spouses and children—face a number of challenges such as acquiring the skills needed to help their older relatives with daily activities, balancing their personal and professional demands with their caregiving, and, as in the Franks’ case, determining the level of care and attention their loved one needs.

As physicians, we encounter our own set of challenges with these patients and their families, trying to assess the patient’s safety and negotiating the complex and often emotion-laden issues surrounding level of care. In the end, of course, each case is unique, and there are no formulae for solving these problems. A few basic guidelines, however, can help Dr. Woods navigate this difficult course.

Maintain respect for the patient. Regardless of her disease process, Mrs. Frank is still the patient here, and it is important for Dr. Woods to demonstrate that in his interactions. In visits with her and her family, he should engage Mrs. Frank first, assess her comfort and concerns, and obtain her “blessing” to discuss her care with her family. For patients with Parkinson’s disease this can be difficult, inasmuch as they often appear disengaged, with masked expressions, hypophonia, and bradyphrenia [2]. Even with patients who suffer from cognitive decline, physicians should still display respect by making them the center of the visit.

Assess the patient’s capacity to make decisions. Before accepting a patient’s choices at face value, physicians must have some understanding of their decision-making capacity. This can be difficult to do in a brief encounter, and capacity can change over time with acute illness, medication, mood, and, most importantly, the nature of the decision at hand. Brief cognitive tests, particularly those for executive functions like clock-drawing, verbal fluency, or Trail B Test (a neurocognitive test) can help

the physician appreciate the patient's ability to process information and solve problems. In addition to considering cognitive ability, the nature of the decision being made must be weighed. Mrs. Frank may not have the capacity to manage her finances or a complex medication regimen safely but may still be able to discuss general preferences for end-of-life care [3].

Offer the family the option to talk more openly away from the patient or via phone. Families are sometimes uncomfortable sharing their true concerns in the presence of loved ones, but they still need opportunities to express their worries, frustrations, and challenges. Simply inviting the family to wait in a conference room during the exam and then providing them time away from the patient may decrease tension and improve their ability to speak openly. If time does not allow for a separate conversation, then offering a phone appointment may suffice.

Acknowledge the stress experienced by the family. In our case scenario, Dr. Woods briefly recognizes the family's efforts to provide Mrs. Frank's care before he begins addressing the level of care he believes his patient needs. The son reacts defensively and emotionally. Indeed, these can be highly charged conversations that demand careful management by the physician.

An alternative way to begin the conversation about the appropriate levels of care is to start by "checking in." Families need time to decompress and often bring pent-up emotions—including anger, frustration, anxiety, and depression—to the visit. Give the family you are meeting with time to tell you how they see the situation and how it's going for them. Caregivers are usually willing to open up about problems and ask for solutions, but this is less likely to happen if they are put on the defensive. Dr. Woods may have had a more successful interaction if he had started the conversation with "So tell me, how things are going for you?" "What concerns do you have about your mother's health?" "What do you see happening in the future?" or "How have you planned for this situation?" The Duke Family Support Program offers language and strategies for conducting these important but difficult conversations [4].

Talk in terms of specific needs before discussing solutions. Determining the needed level of care for older adults is complex. Discussions about assisted-living facilities and nursing homes can trigger images of musty, dark institutions or remembered stories from the press about neglect. Physicians sometimes stumble in conversations about level of care because they do not think about the patient's specific needs before declaring what they believe ought to be provided. Rather than treating care as a dichotomous decision (either skilled nursing facility *or* home care), conversations with patients about activities of daily living—bathing, eating, dressing, using the toilet, and ambulation—provide a framework for discussion about needs and safety. Patients and caregivers may be more likely to acknowledge that "I need help with X" before they declare that "I need to move to a nursing home." This type of dialogue also gives physicians insight into the specific challenges a patient and family members are facing and allows him to either build a case for a change in level of care

or to offer a menu of solutions that may allow the patient to remain in his or her current living situation.

Talk about specific safety concerns. Dr. Woods' major concern, of course, is his patient's personal safety. Given the unfortunately high prevalence of elder abuse and neglect, and the patient's risk of personal injury from a fall or an accident, this is a valid concern [5]. Again, inquiring about the patient's and family's current living situation is important. Ask the patient—without the family present—about feelings of neglect or abuse and look for signs and symptoms like unexplained weight loss, contusions, pressure sores, or poor hygiene that might indicate an unsafe home environment. Ask the family about safety and monitoring in the daily routine, including medication management, use of heat-generating appliances, driving, and availability of firearms. Detailed information provided by nurses and social workers who make home visits, such as the one requested by Dr. Woods, can be useful in this circumstance. If there are concerns about the patient's wandering, then recognizing the triggers (such as anxiety, boredom, loneliness, restlessness, pain, and discomfort) and providing an environment with reliable monitoring and outlets (e.g., exercise or activity) may suffice. Patients may also be enrolled in the Safe Return Program through the Alzheimer's Association. If concern for abuse or neglect remains, then an assessment by a licensed social worker or a call to Adult Protective Services may be in order.

Refer to community-based resources including social work and health agencies. Perhaps most importantly, Dr. Woods should recognize the limits of his own knowledge and training and should recruit other health care professionals to assist him. Social workers, particularly those experienced in the care of older adults, are trained to assess self-care capacity, caregiver strain, and personal safety. They are knowledgeable about professional and community resources for respite care, long-term care, and caregiver support. Social workers can also assist in the financial aspects of home care and, if agreed upon, skilled nursing facilities, by assisting the family in navigating the complex process of assessing Mrs. Frank's financial status and submitting applications for assistance programs, including Medicaid. While few—if any—of these problems are ever easily solved, most communities have low- or no-cost options for companionship or day care, which may provide the Franks with key respite time.

Provide anticipatory guidance and encourage advance care planning. With any chronic condition, but particularly with neurodegenerative conditions such as Parkinson's disease and dementia, advance care planning is essential. From the physician's perspective, this involves discussions about prognosis and treatment preferences early in the disease process. This affords patients and families the opportunity not only to discuss their preferences but to gain a better understanding of what to expect and how to prepare. These discussions often take place when a patient is writing a living will and designating a health care power of attorney. For physicians like Dr. Woods, such discussions may help to avoid a confrontation like the one he encountered with the Franks. Early referral to caregiver resources and

support groups may help patients and their families deal with the stress, strain, and grief these diseases present.

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Relevant Web Sites

Duke Family Support Program, <http://www.geri.duke.edu/service/dfsp/index.htm>.

National Alliance for Caregiving, <http://www.caregiving.org/>.

National Family Caregiver Association, <http://www.thefamilycaregiver.org>.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

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MEDICAL EDUCATION

Geriatrics in Primary Care Residency Training

Mukaila A. Raji, MD, MSc

To treat the rapidly growing population of people aged 65 and older, residents and medical students need to know how aging and age-associated conditions affect the autonomy and quality of life of elderly patients [1]. Old age does not always mean frailty and senility. Indeed the majority of adults aged 65 and older remain healthy even to their eighties. For some seniors, however, old age comes with disease, limited social and economic resources, and physical and mental impairments.

Most elderly patients are cared for by nongeriatricians, usually internal medicine and family medicine physicians. Thus, residents in these specialties need to know the physiologic changes associated with aging and other common geriatric syndromes [2, 3] and how those changes affect medication and treatment plans. Elder care occurs in various settings, including the patient's home, inpatient geriatric units, postacute care units, hospice care facilities, assisted living facilities, outpatient clinics, and nursing homes. At a minimum, residents and students should participate in elder care in the settings of an outpatient clinic and nursing home to acquire the clinical geriatric skills necessary for managing common age-related syndromes such as delirium, dementia, and drug misuse. Work at an outpatient clinic and nursing home can be integrated into an existing 4-week medicine rotation. The University of Texas Medical Branch (UTMB) in Galveston currently offers a community gerontology elective during which students see patients in a nursing home, in a home-care setting, and in the clinics. More specialized knowledge of the geriatric population is gained through a 1-week compulsory rotation during the neurology clerkship. The settings for this course are outpatient clinics and the inpatient geriatric unit known as the acute care for elders (ACE) unit.

Geriatric Outpatient Clinics Rotation

By spending 1 half day per week in a general geriatrics clinic, residents and students see a range of aging patients from the relatively healthy to the frail. The experience gives them the opportunity to learn to do a comprehensive geriatric assessment (CGA), collecting information on the mental, functional, social, and biological status of older persons [4]. Residents and students then learn to use that information when planning and implementing evidence-based interventions for common geriatric syndromes such as dementia, delirium, drug misuse, depression, falls, incontinence, pressure ulcers, and functional decline.

Dementia and delirium, frequently seen in the outpatient clinic setting, adversely impact the autonomy and the decision-making capacity of seniors [4-7]. Found in as

many as 40 to 50 percent of patients aged 85 or older, dementia is acquired chronic brain dysfunction that manifests as memory loss, disorientation, aphasia, and other cognitive deficits [8]. Delirium, on the other hand, is the acute onset of confusion, poor attention, drowsiness or agitation, and fluctuation in alertness level and is generally treated by addressing the underlying causes of the confusion. Both disorders can have depression as a comorbidity. By helping to manage these and other geriatric conditions, residents and students acquire valuable skills that are key to effective interprofessional working relationships with others on the CGA team: nurses, social workers, physical and occupational therapists, pharmacists, and dietitians.

Nursing Home Rotations

During their 1-day-a-week rotation in a nursing home, learners meet a patient population that is generally more frail and disabled in a non-community-based setting. Here they gain additional knowledge and skill in managing disorders common in the elderly and observe how the members of the CGA team work together in this environment.

A typical nursing home has two groups of elderly residents—the permanent and the temporary. The permanent, long-term care residents (LTC) live there because they are incapable of independent living. The nursing home staff provides support for their basic activities of daily living such as ambulation, bathing, using the toilet, and eating. The cost of long-term care is covered by Medicaid or private funding. Patients with dementia account for about half of all long-term care admissions [9].

The temporary, short-term residents are usually at the nursing home for physical rehabilitation, wound care, administration of intravenous antibiotics, or speech therapy. This section of the nursing home is also known as the skilled nursing facility (SNF) or skilled nursing unit (SNU). The needs of SNF residents vary. Most are there to receive physical and occupational therapy (PT/OT) aimed at restoring and preserving their mobility and function following a stroke, for example, or hip fracture repair. The cost of an elderly patient's stay in SNF is fully covered by Medicare for up to 20 days per benefit period [10].

Drug Misuse

Polypharmacy is a real concern for the geriatric population, regardless of the setting [11-14]. Polypharmacy, literally “many drugs,” occurs when a patient is prescribed—and takes—more than three medications. Polypharmacy may be clinically necessary in certain situations, e.g., congestive heart failure; in other circumstances, it reflects unnecessary or inappropriate prescription use. This often happens when clinicians prescribe new medications to treat side effects of other medications, creating a phenomenon known as a prescribing cascade [13]. Physicians-in-training need to know that the risk of drug toxicity rises as patients take more prescribed and over-the-counter medications and that the highest prevalence of polypharmacy is in adults aged 65 years or older. In one large community-based study, for example, 12 percent of older women took 10 or more

drugs, while 23 percent took 5 or more [15]. Drug misuse is particularly worrisome in this population because older adults metabolize and eliminate drugs more slowly than younger adults due to decreased renal and hepatic functions. Slow clearance and multiple drug use increase the risk of harmful interactions, which are a major cause of emergency room visits and hospitalizations [16].

Most drugs need to be started at low doses and titrated up slowly in elderly patients, and any new symptom in an older person can be due to an adverse drug event. Residents should become familiar with the Beers list of drugs that are potentially inappropriate for use in older people [12], for example, diphenhydramine. Chronic use of diphenhydramine for insomnia can contribute to delirium, dementia, falls, incontinence, unsteady gait, and constipation.

Summary

The training in nursing homes and clinics described above constitutes a bare minimum of geriatric knowledge and skills needed by students and residents in internal medicine and family medicine. These lessons can be integrated into undergraduate medical school curriculum without changing current curricular structure by infusing geriatric themes and content into existing courses and clerkships. An example of a successful infusion was described by Newell and colleagues in the *Journal of Gerontology and Geriatrics Education* [17]. Effective curricular infusion into courses and clerkships requires institutional financial commitment and interdepartmental collaboration across a school of medicine.

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JOURNAL DISCUSSION

Managing Difficult Behaviors in Patients with Dementia

Richard Hwang

Buhr GT, White HK. Difficult behaviors in long-term care patients with dementia. *J Am Med Dir Assoc.* 2006;7:180-192.

Dementia is a condition in which individuals progressively lose cognitive function and, as a result, often develop difficult behaviors that cause stress for both patients and their caregivers. These behaviors, collectively known as behavioral and psychological symptoms of dementia (BPSD), include screaming, wandering, resisting care, hitting, and psychological symptoms such as depression, psychosis, and sexual disinhibition [1]. BPSD is prevalent in nursing homes where 67-78 percent of patients have dementia and, of them, 76 percent exhibit BPSD [1]. In fact, it is common for patients to be institutionalized because of BPSD, so clinicians must become proficient in assessing and managing these symptoms.

Assessment

Buhr and White state that the first critical step in managing BPSD is taking a detailed patient history and physical [2], which can uncover treatable medical illnesses, such as delirium, urinary tract infection, medication side effects, depression, and changeable environmental factors that contribute to the symptoms. Physicians must also look beyond the history for connections between patient experiences and behavior. The authors provide an example in which an 80-year-old woman with Alzheimer's disease was agitated and yelled at the staff [3]. When asked why she was angry, her answers did not address the question. Over time the staff realized that the patient grimaced and yelled out whenever her knees were manipulated. The lesson of this case was that pain and discomfort are not always reported by a patient and may only manifest behaviorally (e.g., in grimacing). When behavior suggests that pain may be present, though unreported by the patient, regular doses of acetaminophen can be scheduled to alleviate the pain. BPSD may also be exacerbated by auditory or visual misinterpretations and can be lessened by the appropriate use of hearing aids or glasses [2].

In attempting to identify patterns or triggers of BPSD, physicians should ask that detailed records be kept of the frequency, duration, intensity, time of day, and antecedents [2]. Examples of BPSD-associated patterns are over- and understimulation; an environment that lacks activity can cause a patient to be lethargic, whereas an environment with too much activity (such as noise) may trigger BPSD. Medications, caregivers, or even hunger can also be triggers [1].

Nonpharmacological Treatments

Buhr and White state that treatment should begin with nonpharmacological approaches [2]. They cite five care goals for the patient with dementia: “to feel safe, to feel comfortable, to experience a sense of control, to experience minimal stress with adequate positive stimulation, and to experience pleasure” [2, 4].

The authors suggest several techniques for achieving the above care goals, all of which center on patient-caregiver or patient-environment interactions. First, they recommend that caregivers be relaxed and flexible and that they smile and maintain eye contact with the patient [2, 5]. Another technique, coined “hand under hand,” refers to the caregiver’s placing his or her hand underneath the patient’s hand while guiding the patient through an activity. This hand-under-hand position reduces the patient’s resistance to direction and provides adequate support. When a patient does show resistance, caregivers should remember that arguing or reasoning will not change the unwanted behavior. Instead, the caregiver should acknowledge the patient’s emotions and employ strategies of distraction and redirection [5-7]. Consistency in routines and staff assignments are critical.

In support of these care strategies, Buhr and White cite a study examining the effects of behavior management skills training on nursing home staff. The investigators found that the training reduced the use of ineffective strategies (such as arguing with patients) and that the improved skills were maintained 6 months later [6].

BPSD events often occur during bathing, an activity that is very personal for the patient and, in an institutional setting, can be one in which the patient feels particularly exposed. Buhr and White relate the case of a 75-year-old woman with moderate dementia who was combative toward nursing home staff whenever they attempted to give her a bath. After communicating with the patient’s daughter, the staff learned that the daughter typically washed her mother with a wet cloth (versus placing her in a tub or shower). The message here was that learning the preferences of the patient and respecting them when possible can reduce the incidence of obstructive behaviors [8].

In addition to modifying patient-caregiver interactions, the authors discuss beneficial environmental changes. Stimulated presence therapy, a technique that uses a recorded audiotape of a family member discussing happy memories with the patient, has been shown to reduce agitation [2]. Other studies have shown that calming music, 10-minute hand massages, and decorating specific areas of a nursing home can be beneficial.

Finally, Buhr and White suggest that not all behaviors require “treatment.” To illustrate this point, the authors describe the case of an 82-year-old nursing home resident with moderate to severe Alzheimer’s dementia who wrapped her stool in toilet paper and placed it in her dresser drawer. What staff action is appropriate? The authors believe that since her actions were not dangerous (and reasoning will not

help), staff should not “treat” (or attempt to change) her behavior. Rather they should check regularly for stool and dispose of it properly [8].

Pharmacological Treatments

In situations where none of these techniques adequately controls BPSD and the patient’s behavior is putting himself or others at risk, trials of pharmacological interventions are appropriate. A recently formed guideline panel of the American Academy of Family Physicians and the American College of Physicians (AAFP-ACP) reviewed the five FDA-approved drugs for treatment of dementia and found that, while some clinical trials reported *statistically* significant improvements in behavior, the improvements often were not *clinically* significant or their significance could not be determined [9]. Considering the cost and potential side effects associated with these drugs, their use should be evaluated on a case-by-case basis.

Discussion

This article advocates the use of nonpharmacological treatments for patients with dementia, but it also recognizes the need for pharmacological interventions in certain situations. This approach seems reasonable, but it also raises certain questions. While we know there is a growing focus on patient-centered treatments [10], it is difficult to identify, for example, the specific predictors or variables for successful interventions. As illustrated by the towel bath example, a successful patient-specific intervention depends on many factors, ranging from the patient’s environment (particular caregiver, particular time of day, etc.) to exactly how the intervention is carried out (towel bath technique, type of soap, particular towel, etc.).

Next, how practical and efficient is it for nursing homes to focus predominantly on nonpharmacological treatments? In the behavior management training study that Buhr and White cite, staff decreased their use of ineffective behavior management techniques but did *not* increase their use of effective strategies [6], suggesting that implementation of new techniques may be difficult in certain situations. In a nursing home with high staff turnover, education and implementation are even more difficult, especially with techniques that require a substantial amount of training.

Finally, a significant—but unaddressed—concern is the lack of financial resources for nonpharmacological treatments. Drugs have the benefit of being directly reimbursed; training and time for the types of interventions proposed by the authors are frequently not reimbursed. Similarly, devices that can help prevent difficult behaviors—hearing aids, for example—do not qualify for reimbursement [11].

In light of the number and variety of nonpharmacological treatments being endorsed—from standard (e.g., behavioral) therapies to alternative (e.g., aromatherapy) strategies to brief, interpersonal psychotherapies [12]—professionals who care for the elderly could use a standardized guide to nonpharmacological treatments, similar to the American College of Physicians’ current Pharmacological Treatment of Dementia [9]. An overview of nonpharmacological treatments that are most effective in specific situations and those that are ineffective and even

potentially harmful would be helpful. Yet this idea of standardization does not conform completely to the idea of patient-centered management because different patients may warrant different nonpharmacological treatments based on their clinical stories. A compromise must then be made to generate guidelines that combine standardized treatment for minimum safety and quality assurance with the flexibility that allows for personalized care for each patient.

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CLINICAL PEARL

Differentiating among Depression, Delirium, and Dementia in Elderly Patients

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Elderly patients are at high risk for depression and cognitive disorders, the latter of which can be chronic (as in dementia) or acute (as in delirium). Some patients have both affective (mood) and cognitive disorders. Clarifying the diagnosis is the first step to effective treatment, but this can be particularly difficult because elderly patients often have medical comorbidities that can contribute to cognitive and affective changes.

When evaluating elderly patients, it is important to assess cognitive status and determine their baseline ability to function and perform activities of daily living (ADLs). ADLs relate to personal care including bathing or showering, dressing, getting in or out of bed or a chair, using the toilet, and eating [1]. Instrumental activities of daily living (IADLs) include the individual's ability to prepare food, manage finances, shop for groceries, do housework, and use the telephone [2]. Having a baseline for a patient's ADLs and IADLs allows the physician to recognize and act upon changes. Though it is tempting to make assumptions based on a patient's appearance, contacting family members or staff at the facility where a patient resides can provide valuable information about his or her cognitive and functional status that may otherwise be missed.

Elderly patients who experience memory impairment should be screened for depressive symptoms, since they may be suffering from depression with "pseudodementia," that is, cognitive impairment traditionally believed to be related to the presence of depressive disorder. There is increasing evidence that dementia itself may be associated with or preceded by a period of depressive symptomatology, so it is important to screen patients thoroughly for cognitive function and the neurovegetative and affective symptoms of depression [3]. On the basis of clinical presentation alone, it can be difficult to sort out the primary problem. Patients with depression are more likely to bring concerns about cognitive impairment to the attention of their physicians than are patients with underlying cognitive decline or dementia, who may actually be unaware of their impairments [4].

Major Depressive Disorder

Major depressive disorder is thought to affect 1-2 percent of elderly people in the community at any one time; significant depressive symptoms affect up to 20 percent of elderly adults [5] and have been associated with poor outcomes for underlying medical problems and increased risk for suicide [6]. Depression is common following stroke, with an estimated 25-50 percent of poststroke patients meeting

criteria for major depressive disorder [7]. Parkinson's disease, coronary artery disease, cancer, and other medical problems have also been associated with a higher incidence of depression.

Here again, some patients who report memory problems, on further evaluation of mood and neurovegetative symptoms (sleep, energy, appetite, motivation), meet criteria for major depressive disorder. While evaluating for underlying medical illnesses that may cause physical symptoms similar to the neurovegetative symptoms of major depressive disorder, physicians can simultaneously screen for depression using, for example, the short form of the Geriatric Depression Scale [8]. Other screening strategies include the PRIME-MD Patient Health Questionnaire (PHQ-9) [9]. In any patient with depression it is also imperative to assess for suicidality. Elderly patients and those with multiple medical conditions comprise the highest risk group for completed suicide [10].

After a patient has been identified as having depression, the physician should assess for a lifetime history of mania (periods of time in which the patient had decreased need for sleep and still felt energetic and productive, for example, or actual episodes of impaired judgment, impulsivity, spending, or recklessness). The Mood Disorder Questionnaire [11] is a 13-item scale that can help elicit a history of mania in patients in the primary care setting, though it has not been explicitly validated in the geriatric population. Physicians should also remember that mania sometimes manifests as an acute confusional or delirious state, particularly in elderly patients.

Delirium

Delirium, or acute confusional state, is underrecognized. Delirium is thought to be reversible (with correction of the underlying medical problem) and is present in 10-30 percent of hospitalized elderly patients. It contributes to less desirable outcomes including longer hospitalization, higher rates of nursing home placement, and possibly higher mortality [12]. Elderly patients with apathy, lethargy, or low mood should be evaluated for delirium. In hospitalized elderly patients, the presence of dysphoria may also be a manifestation of delirium [13]. The Confusion Assessment Method (CAM) [14] is a four-question screening tool that can be useful in detecting delirium. The CAM can be implemented for screening on an inpatient service, and those using the tool—nurses, physicians, or researchers—should be educated and trained to optimize its sensitivity [15].

The hallmark of delirium is the presence of an underlying medical disorder, so it is imperative to discover its cause. Urinary tract infection is a common cause of delirium in elderly patients, but other possible causes include thyroid dysfunction, coronary event, stroke, electrolyte imbalance, and renal insufficiency. Medications can contribute to acute confusional states, particularly anticholinergic medications such as diphenhydramine [16], as well as benzodiazepines and narcotic pain medications.

The optimal way to treat delirium is to identify and correct the underlying medical etiology, avoid unnecessary interventions (medications, medical devices), provide frequent reorientation and optimize the sleep-wake cycle, and avoid the use of restraints whenever possible. The role of pharmacology—specifically antipsychotics and cholinesterase inhibitors—is unclear, though antipsychotics may be helpful for acute agitation or in regulating the sleep-wake cycle. This use, however, is off-label, and the most important aspect in managing delirium is identifying and treating the underlying medical cause.

Dementia

Dementia is an age-associated illness estimated to affect 5 percent of people between the ages of 71 and 80 and more than 37 percent of people over the age of 90 in the United States [17]. Because progressive cognitive impairment is thought to be a normal consequence of aging, and patients frequently do not self-report cognitive impairment, early or mild dementia can go undetected. Families may only notice deficits when the level of functional impairment warrants increased assistance from or reliance upon others. For the physician, signs of cognitive impairment include missed appointments, difficulty understanding or remembering instructions, car accidents, or poor hygiene and grooming.

Once cognitive impairment is suspected, screening can be undertaken [18] using the widely known Folstein Mini-Mental State Examination (MMSE) [19] or the Memory Impairment Screen [20]. There are many subtypes of dementia; Alzheimer's dementia and vascular dementia are most common. At present, we do not know which strategy for treating dementia is most effective. Though cholinesterase inhibitors and memantine have demonstrated statistically significant improvements in cognitive functioning in clinical trials, the clinical relevance of these findings is not clearly demonstrated [21].

Practical Advice for Differentiating Depression, Delirium, and Dementia

Generally speaking, an acute behavioral or mood change is suggestive of delirium. Once medical contributors have been ruled out, depression, characterized by a more pervasive or chronic low-mood state with or without cognitive impairment should be considered. Patients with dementia are less likely to self-report their cognitive problems than are patients with depression (see table 1) [22, 23].

Table 1. Characteristics of depression, delirium and dementia

	Depression	Delirium	Dementia
Onset	Weeks to months	Hours to days	Months to years
Mood	Low/apathetic	Fluctuates	Fluctuates
Course	Chronic; responds to treatment.	Acute; responds to treatment	Chronic, with deterioration over time
Self-Awareness	Likely to be concerned about memory impairment	May be aware of changes in cognition; fluctuates	Likely to hide or be unaware of cognitive deficits
Activities of Daily Living (ADLs)	May neglect basic self-care	May be intact or impaired	May be intact early, impaired as disease progresses
Instrumental Activities of Daily Living (IADLs)	May be intact or impaired	May be intact or impaired	May be intact early, impaired before ADLs as disease progresses

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CLINICAL PEARL

Preventing and Detecting Elder Mistreatment

Solomon Liao, MD

A 73-year-old man with severe Alzheimer's dementia is admitted to the hospital for the fourth time in 3 months for dehydration. During the physical exam, the admitting medicine team discovers a 1-cm round, full-thickness skin ulcer on the dorsum of his left hand. They question the patient's primary caregiver—his nephew—who says that the patient burned himself with a cigarette. A geriatric consult reveals that the patient has the mental capacity of a 4-year-old and should not be allowed to light a cigarette or handle matches. An Adult Protective Services report is filed, and the patient is discharged to another relative's home.

Why did the health care team not recognize the mistreatment that the patient was enduring during the previous admissions for dehydration? Several possible reasons for this will be explored in the following discussion.

A Medical Problem

Until the late 1970s elder mistreatment was considered a social or family problem, not a medical one. This attitude is reflected in the 1974 legislation that created the Adult Protective Services (APS), a social service agency, to investigate elder mistreatment. The fact that responsibility for investigating mistreatment of elders was assigned to social workers demonstrates that the legislators considered the problem to be a family/social issue. The absence of elder mistreatment from the medical literature before 1975 shows that even health professionals did not consider elder mistreatment to be a medical concern.

When a ground-breaking case report of “granny battering” was published in the *British Medical Journal* in 1975, the mindset of the medical profession began to change [1]. Twelve years later, the American Medical Association (AMA) released a consensus report establishing elder mistreatment as a matter of medical concern [2]. (The AMA Council on Science and Public Health is currently revising this report.) The National Academies' report on the subject, published in 2002, further defined the problem as a complex interplay between medical, social, financial, and legal issues [3]. Elder mistreatment is now recognized as a public health problem.

Adults with Autonomy

Medical professionals can make a significant contribution in suspected cases of elder mistreatment by determining the patient's level of capacity to make decisions. Under the U.S. Constitution, adults are presumed to have the ability to make autonomous decisions until they are proven not to. Children, on the other hand, do not have these

rights, and therefore society gives government agencies much greater authority to protect children. In the above case example, the severity of the patient's cognitive impairment was the key piece in establishing mistreatment.

Studies show that victims of mistreatment have a high prevalence of dementia and depression [4] and are therefore likely to have some impairments in decision making. Unfortunately these vulnerable patients are also the least able to report on their living conditions and the least likely to be believed.

What's Love (or Intention) Got To Do with It?

A common misconception is that most elder mistreatment occurs in nursing homes and by strangers. The National Elder Abuse Incidence Study, the largest U.S. study to date, showed that most abuse occurs at home, at the hands of family members and loved ones [5]. Performed in the late 1990s, this study also showed that the most common form of mistreatment was neglect (49 percent), which, however, frequently overlapped with abuse. Because most physicians think first of physical abuse when they think of elder mistreatment, neglect cases are often missed until, as in the scenario above, there are signs of physical abuse. It is estimated that, for every reported case, five to seven cases go unreported [6].

Families and caregivers who are involved in neglect cases are often well-intentioned, but overwhelmed or burnt-out. Good intentions do not change the fact that the patient was put in harm's way, and should not be a factor in determining whether an elderly patient has been mistreated.

Physicians Can Make a Difference

A landmark study by Lachs and colleagues, published in the *Journal of the American Medical Association* in 1998, showed that elder mistreatment was an independent risk factor for mortality with more than a threefold increase in the risk of death [7]. Approximately 90 percent of the subjects of the study were victims of neglect. Interventions by health professionals, including reporting patients to Adult Protective Services, have the potential to reduce the early mortality of these victims.

The most successful approaches to elder abuse and neglect have been interdisciplinary efforts [8]. Because the problem is multifaceted, many disciplines and agencies are involved in its investigation, intervention, and prevention. Through improved communication and collaboration, interdisciplinary teams are able to act more effectively and efficiently than individual physicians. Examples of these teams include financial abuse specialist teams, medical intervention teams [9], forensic centers [10], and elder death review teams [11].

It's Not "Just Old Age"

Indicators of mistreatment may be mistakenly attributed to the aging process, but, while elderly patients are more susceptible to such problems as bruising and dehydration, these are not a normal part of aging. Common patterns of accidental bruising occur in locations that are different from those of inflicted bruises [12].

Distinguishing signs of mistreatment from common indicators of decline can be challenging. For example, when is a pressure ulcer due to poor care rather than to the natural process of functional decline? More research is needed on these types of forensic issues [13].

Medical Education

The most significant reason given for underreporting by health professionals is the lack of education and training they receive on the topic [14]. In a 2005 study, primary care physicians cited denial of abuse by the patient (23 percent), uncertainty about reporting procedures (21 percent), uncertainty about reporting laws (10 percent), and the subtlety of the signs of abuse (44 percent) as reasons for failing to report suspected elder mistreatment [15]. Few medical schools in the U.S. incorporate the topic into their curricula [16].

Conclusion

Physicians must remain engaged in preventing, detecting, and intervening in elder abuse and neglect, and, because elder mistreatment typically involves a complex interplay between medical, psychosocial, and financial factors, physicians should work with other professional disciplines to address this public health problem.

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HEALTH LAW

Physicians' Legal Responsibility to Report Impaired Drivers

Lee Black, JD, LLM

There are times when the danger that a driver poses to other people and property outweighs the significant benefits of driving. Sometimes drivers act voluntarily in ways that make them unsafe, such as driving while intoxicated or exhausted. In these circumstances, we rightfully hold them responsible for injury or damage caused by their choices. At other times, though, one's ability to drive is impaired by a medical condition. Even in these instances where the impairment is involuntary, individuals may lose their privilege to drive. To ensure the safety of all who share the roads, health professionals and caregivers are called upon to identify conditions that might compromise the driving abilities of patients and people they care for.

Generally, physicians have a legal and ethical obligation to maintain the confidentiality of patient information [1, 2], but there are recognized exceptions to this responsibility when the health of the public is concerned. Although driving is not typically a "public health" threat, many states provide exceptions to the rule of patient-physician confidentiality in cases where impairments pose potential danger. In our aging society, whose drivers may include more people "with physiological changes of normal aging as well as diseases and disabilities common in the elderly," these laws are especially applicable [3].

Laws Concerning Disclosure of Impaired Drivers

Many states have enacted laws to address the problem of impaired drivers. Some of these laws mandate disclosure to motor vehicle authorities, while, in others, disclosure is voluntary. Some states require reporting for specific conditions but not for others [4]. And the legal protection provided to physicians who report also varies from state to state.

Oregon, for example, has broad regulations. Its laws require physicians (especially primary care physicians) to report conditions that impair sensory, motor, and cognitive functioning to state authorities [5], and they provide comprehensive standards for determining when a driver is impaired. Oregon physicians who report potential problems in good faith are immune from civil claims made by patients they have reported [6]. Likewise, physicians who *do not* report are protected from liability they might otherwise face if an unreported patient causes injury to himself, others, or property [7].

Pennsylvania has strict reporting requirements on the books that have been interpreted more leniently by the courts. Physicians are obligated to report every

person over 15 years of age who has been diagnosed with certain specified disorders and disabilities (defined by the Medical Advisory Board) [8]. Pennsylvania physicians, unlike those in Oregon, are exempted from liability under the statute only if they report the impairment [9]. Despite the wording of the legislation, however, the courts have decided that the law does not impose a duty on physicians to protect third parties from the actions of patients; therefore, no physician has been held liable for failure to report [10].

Other states' physician reporting laws are more permissive. Montana's statute says that a "physician who diagnoses a physical or mental condition that, in the physician's judgment, will significantly impair a person's ability to safely operate a motor vehicle may *voluntarily* report [italics added]" the patient [11]. Like Oregon, Montana's statutes protect physicians from liability whether or not they report [12]. A recent Montana Supreme Court case affirmed the liability exemption when a plaintiff alleged that the physician-defendant was *negligent* for failing to diagnose and report impairment [13].

When Reporting Is not Required or Permitted

Although a number of states mandate or permit physician reporting of diseases or illness that may impair driving abilities, those that don't address the physicians' role in reporting put physicians in a peculiar position. On the one hand, the American Medical Association's *Code of Medical Ethics* explicitly acknowledges that physicians have a responsibility "to recognize impairments in patients' driving ability that pose a strong threat to public safety and which ultimately may need to be reported to the Department of Motor Vehicles" [14]. On the other hand, the law may prohibit physicians from disclosing confidential information without an explicit exception. In other words, if informing driver's licensing agencies (i.e., the Department of Motor Vehicles) about potentially dangerous drivers is not a legally sanctioned reason for breaching confidentiality, physicians may be unable to disclose. So, if they follow their professional obligation to report patients (pursuant to detailed guidelines [14]), doctors may face civil and criminal liability for unauthorized disclosure under some state laws [15].

The other side of that confidentiality protection, of course, is that, where reporting is not authorized by law, physicians are unlikely to face civil liability for failing to disclose a potentially dangerous patient. There is some similarity between these laws and the duty to report under the rulings in *Tarasoff*, which require physicians to report a clear, significant danger to an identifiable party [16]. The difference with impaired driver legislation is that no identifiable person is in danger. Courts, therefore, are unlikely to find the physician civilly liable if a third party is injured due to a patient's impairment, even when the physician knew about it.

What Should Physicians Do?

Physicians should be aware of their professional responsibilities and the legal requirements of the states in which they practice. When determining whether to report a patient's medical condition that may impair driving, physicians may have to

weigh conflicting guidelines: a professional obligation to report and a legal requirement to maintain confidentiality, even in the face of danger to the public.

Where obligated to report, physicians must do so. When reporting is voluntary, they should also consider their professional obligations before deciding on a course of action. Certainly, limited criminal and civil liability protections that place the physician at legal risk should be a factor in cases where reporting is not mandated.

Whether they mandate reporting, prohibit it, or make it voluntary, the laws have much room for improvement. Ethically and professionally physicians' duties do not stop with existing laws; they are encouraged to "work with their state medical societies to create statutes that uphold the best interests of patients and community and that safeguard physicians from liability when reporting in good faith" [14].

A report to the relevant driver's licensing authority may be a service to the patient as well as to the public. While loss of driving privileges is almost certainly an inconvenience and can even be detrimental to a patient's well-being, the risk of injury or death to both the patient and third parties due to a medical impairment is too great a risk to ignore. Physicians should consider the options in their jurisdictions and keep the best interests of the patient—and the public—in mind.

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POLICY FORUM

The Strains and Drains of Long-Term Care

Richard W. Johnson, PhD

Before the end of their lives, nearly 7 in 10 of today's 65-year-olds will need help with basic personal care—bathing, dressing, and eating—and with household responsibilities essential for independent living, like shopping and preparing hot meals [1]. The financial, emotional, and physical costs of providing long-term care often overwhelm families; unpaid family members supply most of it, struggling to balance these duties with work and other responsibilities. The most common alternative to home care is a nursing home, but a year's stay averaged about \$78,000 in 2007 [2], and public assistance is not generally available until the residents have exhausted all of their financial resources. As the nation grows older, it's time to find a better way to care for those who need help as they age.

In 2004 Americans spent \$135 billion on long-term care for older adults [3]. Medicaid, the largest single payer, currently finances 35 percent of the institutional care and home health services for eligible adults who cannot pay the full cost themselves. Although Medicaid also offers home- and community-based services and a variety of nonmedical and social supports designed to keep people with disabilities in the community, most of the program's spending on the aged and disabled is for institutional care [4].

Medicaid provides a fairly comprehensive package of services, but individuals must meet strict income and asset tests to qualify for coverage. Eligibility rules are complex and vary by state, but nursing home residents must generally surrender all of their assets, except for about \$2,000, and all of their income, except for a small personal needs allowance that may not exceed \$90 per month. Participants in special Medicaid programs may protect more of their income to cover community living expenses, but some states do not allow them to keep more than \$637 per month [5], barely enough to live on. Medicaid beneficiaries with community-dwelling spouses are able to shield additional income. By requiring beneficiaries to turn nearly all of their savings over to the state, Medicaid discourages people from putting aside money to cover future long-term care costs.

Medicare is the other major federal program that finances long-term care, but it does so only under certain conditions. Medicare covers the first 100 days in a certified skilled nursing facility after hospitalizations and provides limited home health benefits, including medically necessary skilled nursing care, physical therapy, speech language services, and occupational therapy for homebound beneficiaries.

Given the limitations of public benefits, seniors and their families bear much of the cost. At \$45 billion, out-of-pocket spending accounted for about one-third of all long-term care spending for older Americans in 2004 [3]. This number would be even higher if family members—about 34 million in 2004—were not supplying much of the care for free [6]. This responsibility usually falls to adult children: daughters and daughters-in-law account for about 36 percent of unpaid caregivers to all older Americans, and sons and sons-in-law account for another 16 percent [7]. Nearly three-quarters of unmarried, older care recipients, most of whom are widowed, receive some assistance from their children.

The benefits of unpaid family care to older Americans are enormous, enhancing the lives of millions of frail adults and permitting many to live in their own homes instead of in nursing homes. In fact, a federally funded study found that, over a 2-year period, older adults who received frequent help with basic personal care from their children were about 60 percent less likely to enter nursing homes than those who received less support [8]. The value of unpaid help from all family and friends totaled about \$103 billion in 2005 [9].

Care responsibilities for older adults are time consuming. On average, daughters who serve as primary caregivers to their frail older parents spend about 266 hours assisting with basic personal care and household chores each month [7], more than most people spend at full-time jobs. Caregiving typically lasts about 4 years [6].

About one-half of those caring for their aged parents are employed full time [7], and about 57 percent of those who are employed report that they sometimes have to go to work late, leave early, or take time off to attend to their care duties [6]. Another 17 percent found it necessary to take leaves of absence. Only about one-quarter of companies with 100 or more employees have programs to support elder care [10].

Re-Thinking the Current Payment System

The system I've just described barely works now, and will be under greater strain as the nation ages. The number of Americans age 85 and older—and at greatest risk for needing long-term care—will quadruple between 2000 and 2050 [11]. The ongoing decline in family sizes, combined with historically high rates of divorce and employment among women, will reduce the availability of future, unpaid family caregivers and increase the need for paid services [12].

Policymakers can encourage Americans to prepare for their own long-term care needs or create a larger role for government financing or both. For example, Congress could enhance tax incentives for purchase of private long-term care insurance. Only about 9 percent of Americans age 55 and older currently have private coverage [13], and it covered only about 4 percent of older adults' long-term care spending in 2004 [3]. Tax incentives could boost these rates by lowering policyholders' after-tax premiums. Recent evidence suggests, however, that such incentives would not significantly increase enrollment among low- and moderate-income adults [14].

The private market for long-term care insurance is beset by problems. First, the fact that Medicaid pays for expenses that exceed a care recipient's financial resources discourages potential buyers, as does the inherent uncertainty involved in purchasing coverage for an event that will probably not materialize for 30 years, if at all. If consumers are able to look past these uncertainties and choose to enroll in long term care, they often find that benefits are inadequate to cover expenses. The private market also suffers serious adverse selection problems; that is, people who expect to need long-term care are more likely to purchase coverage and draw benefits, which drives up premiums and discourages those who don't expect to need the coverage from buying it. Lastly, the system has high administrative costs.

These marketplace limitations suggest a role for the public sector. My colleague Leonard Burman, director of the Urban-Brookings Tax Policy Center, and I have proposed expanding Medicare to cover comprehensive long-term care services, including home and custodial nursing home care [15]. Medicare expansions of this kind, however, would have to be properly funded through higher taxes.

We also need better supports for family caregivers. Additional funding for the National Family Caregiver Support Program, which offers information, counseling, and respite, and for Medicaid's home- and community-based services would benefit many overwhelmed caregivers.

It's not too late yet to create a workable long-term care financing system for the 78 million baby boomers because the oldest of them will not reach their 80s for another 20 years. Time is running out, however. The best solution would be to set aside money now, either publicly or privately or both, to cover these large, looming costs, reducing the financial and physical burden on the next generation of frail older Americans and those who care for them.

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MEDICINE AND SOCIETY

Physician Responsibility for Patients' Quality of Life

Philip M. Rosoff, MD

One of the tasks of modern medicine is to endeavor to ensure that patients' quality of life is, at least, no worse when they leave our care than when they entered, and, at best, that it is better, according to recognized index quality indicators. To be sure, doctors who treat patients with life-threatening conditions focus quite rightly on instituting therapeutic measures to preserve life, and often they are not able to address the impact of medical care on quality of life (QOL) until after the life-saving intervention. Social factors (e.g., poverty, nutrition, housing, the support of others) significantly influence the way people live and how they derive pleasure and worth from their lives and, though they affect treatment, may ultimately be beyond the power of physicians to influence.

This observation should not imply that physicians have either an anodyne or a conscious disregard for the conditions of life that shape so much of a person's experience and the pleasure derived from living. A perceived inability to influence what may appear to be intractable social ills outside of the clinic and beyond the scope of medicine is not a justification for failing to try. Bearing all of this mind, we can then ask whether physicians who work with the elderly have a responsibility to commit to safeguarding their patients' quality of life, to the degree that doing so is physically or fiscally reasonable.

Extending Life

Medicine has been outstandingly successful in lengthening the lives of Americans; "from 1900 through 2004, life expectancy at birth increased from 46 to 75 years for men and from 48 to 80 years for women" [1]. As a consequence, the percentage of the U.S. population over the age of 65 in that same time period grew from 4.1 to 12.4 percent [2].

In this light we can pose some fundamental ethical questions. Should doctors be concerned only with curing disease (i.e., extending life), or do we also have a corollary social responsibility to attempt to ensure that the extra years that medicine has given our patients are of the best possible quality? This question has been answered in the affirmative by Michel and his colleagues, who believe that physicians now face the dual challenge of helping preserve an acceptable quality of life and managing chronic disease among the aging population in Western societies [3]. That leads us to the next question: if there is—or should be—such a responsibility, how can it be realized? If we claim to have scant influence on the social factors that contribute so heavily to QOL, especially for the very young and

the very old, then we must face a far more serious and challenging question: should we refrain from offering certain life-preserving (or life-saving) therapies when we know that, as a result, the patient's extended existence may not be a "life worth living"?

Of course doctors, consciously or unconsciously, take social factors and QOL into consideration all the time when making decisions about whether to institute or even continue therapies that may extend biological life, though not necessarily improve it. If one is caring for an elderly, partially demented man with recurrent urosepsis and a large Stage 3 or 4 decubitus ulcer, who lives in a nursing home with marginal resident conditions and care, how are we helping him or enhancing his QOL by curing his infection and healing his wound, only to send him back to the environment that promoted the problems in the first place? Naturally, we would do everything we could to see whether it was possible to place him in a more healthful setting, but the fact of the matter is that we would probably not succeed in finding him a home that was significantly better than the original, given the resources available for his care [4]. It goes without saying that the decision about a patient's quality of life—whether he would prefer being dead to living under the described conditions—belongs to the patient and his family. It is not up to the doctor to decide.

This is a common and dramatic example. We can also consider some equally important nonmedical contributors to quality of life, such as social connections, activities, and physical independence. The complex interactions between organic disease and personal well-being are extensively documented as, for instance, in data suggesting that married people live longer and remain more self-sufficient than their unmarried peers (both single and widowed) [5]. Can we make a meaningful distinction between our duty to ensure that patients have the wherewithal to obtain the drugs or other treatments we prescribe and our duty to look out for the social factors and milieu that contribute so heavily to the success that we hope to achieve by medical intervention?

Such a Herculean task may be beyond the scope or power of physicians in the absence of a commitment on society's part to provide adequate resources to care for an aging population. That should not stop us from attempting to change social policies that directly affect patients' quality of life; surely the poor state of institutionalized elder care is one outstanding example. But we may need to acknowledge that, while we have some power to influence immediate outcomes, our ability to affect pervasive social problems that impact individual patients may stop at the clinic door. This may be the reality for a medical practice in a society that does not regard health care as a guaranteed right and has yet to address seriously many of the social challenges that compound the anguish of illness. Under these circumstances, we may wish to ask the morally troubling question of whether it is better, even more compassionate, to offer not to treat even when we can, if treatment brings prolongation of suffering and a diminished quality of life. This callous-sounding question should ring out as a clarion call to physicians to become aware of

their role in framing and shaping the social policies that affect our patients and contribute to the success of our treatments outside of the clinic.

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Op-Ed

Medical Care for the Elderly: Should Limits Be Set?

Responses by Daniel Callahan, PhD, and Kenneth Prager, MD

Editor's note: Predictions abound that, when baby boomers become eligible for Medicare, the program—which pays for medical goods and services for the elderly—will go broke. Here two experts examine the weaknesses of the Medicare system and suggest how it might be made viable.

Response 1

Daniel Callahan, PhD

The trustees of the Medicare program have projected that Medicare will, in effect, go bankrupt in 10 years [1]. It faces a projected annual cost increase of some 7 percent, which will raise the program's cost from \$427 billion in 2007 to \$844 billion in 2117 [2]. Many policy analysts have determined that, for the program to survive in a viable way, the government will need to double the taxation for it, cut its benefits in half, or combine these two approaches in some way [3]. Doubling the taxation would be a great burden on the young, who will have to pay those taxes, while cutting benefits in half would harm the old, whose medical treatment Medicare reimburses.

How do we get out of this dilemma, particularly in the context of (a) a bipartisan resistance these days to large tax increases of any kind, and (b) the imminent retirement of the baby boom generation—one that has shown every inclination to expect generous medical care of the highest quality. If that is not enough of a dilemma, consider the fact that Congress has resolutely refused, since Medicare's initiation in 1965, to allow actual costs to be taken into account when determining the medical benefits the program will provide. "Reasonable and necessary" has been the only acceptable standard.

But those are not the only problems. Thirty or 40 years ago it was taken for granted that the elderly were not good candidates for organ transplantation, dialysis, or advanced surgical procedures. That has changed. Age alone is no longer considered a reason to deny necessary care. It is widely assumed that equity demands that the elderly be treated like everyone else; that is, age has become irrelevant in treatment decisions.

Unfortunately that last sentence must be qualified in light of Medicare's financial situation. Under the best of circumstances, age should be irrelevant in the Medicare program. But so far, cost of care has not been considered, and it can hardly remain irrelevant in a program strapped for money; cuts will have to be made. There are a

number of ways the program can put off making cuts that would directly limit the medical care of individual beneficiaries.

- A universal health care system might well lower the overall costs of health care by means of strong regulatory interventions, as has been done successfully in Europe.
- Congress could allow the program to take cost into consideration when it creates the benefit structure—and refuse to cover expensive treatments that have marginal benefits.
- Medicare beneficiaries with large incomes could be forced to pay high deductibles and copayments (already being done with Part B coverage for physician services and proposed for pharmaceutical coverage).
- Higher deductibles and copays could be extended to those in the middle range of income.
- Cuts could be made in physician and hospital reimbursements.

With the possible exception of universal health care, none of these suggestions would be sufficient to keep the Medicare inflationary costs in line with the projected growth of the GDP (gross domestic product), that is, in the vicinity of 3-4 percent a year—a significant drop from Medicare’s present 7 percent annual rate of inflation. But nothing less than such a drop would keep Medicare financially sustainable. There are no good solutions in sight, and little is served by unrealistic talk about cutting waste and inefficiency (a 30-year failed refrain), hoping for research breakthroughs that will eliminate costly diseases such as cancer and heart disease (which would have a much less dramatic effect than most people think), or more consumer-directed medicine, which forces patients to make more cost-savvy choices (of little use for complex multi-organ failures common to the elderly).

Given all those obstacles, I believe we need to confront three questions. The first is a matter of the philosophy of modern medicine: is there an obligation to keep the elderly alive as long as possible, regardless of the cost of doing so? I would argue that, in the face of such economic pressure, there is a duty to help young people to become old people, but not to help the old become still older indefinitely. A more reasonable goal is maintaining a high quality of life within a finite lifespan.

One may well ask what counts as “old” and what is a decently long lifespan? We can generally agree that the present Medicare and Social Security eligibility criteria of 65 years is quickly becoming outdated. My own answer is that someone is old when it can be said that he or she has had a “full life,” by which I mean enough time to do most (though not necessarily all) of the things that a life makes possible: education, family, work, and so on. As I have listened to people speak of a “full life,” often heard at funerals, I would say that by 75-80 most people have lived a full life, and most of us do not feel it a tragedy that someone in that age group has died (as we do with the death of a child).

A second question might be a matter of justice: since it is the young who pay the taxes used to care for the old, are there some limits to what they should be asked to pay? As matters now stand, there are about four working people for every retired person (known as the dependency ratio). As the baby boomers retire, that ratio will decline to 2.5 younger workers for every retiree. To keep the Medicare program at its present level of benefits would require a tax increase for the young of a magnitude that would threaten their ability to care for their families and children [3]. No doubt more of the elderly can continue to work and thus be less dependent, but there are likely limits to how far that can be pushed. There are some, like me at age 77, who continue to work, but the numbers drop off rapidly by 80 (and of course those who do hard manual labor rarely continue into their 70s).

The third question is a matter of broad health care policy: can we deal with the Medicare cost problem separately from the overall costs of our health care system? The answer is no, a point agreed upon by every health policy expert [4]. The costs of Medicare are, in great part, caused by the cost of overall health care in this country—and Medicare's coverage benefits affect those overall costs. The reason for this symbiotic relationship is simply that Medicare finances coverage benefits, but it is the private sector that mainly provides the actual care.

We are left then with the question of universal care. The American private sector has historically been unable to control costs and shows little potential for being able to do so. The European universal health care systems manage to control costs by heavy government regulation—limits on technology, negotiated physician fees, national and hospital budget caps, and price controls on pharmaceuticals. All of this sounds obnoxious to many Americans, but the hard truth is that what sounds acceptable in the U.S.—rejecting strong government interventions—simply won't work to control costs. There are, to be sure, many happy-face scenarios available that say otherwise, but few if any have a track record of success.

I add a caveat. The European systems themselves are now under economic strain, though far less than our own. Their strain comes from the underlying dynamic of developed countries: aging societies, rising technology costs, and increased public demand. Those factors are just exacerbated in our country. In the long run, all countries will have to rethink the idea of endless medical progress and technological innovation, aspirations that are turning out to be incompatible with finite budgets.

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Response 2

Kenneth Prager, MD

“Elderly people who are terminally ill have a duty to die and get out of the way.”
—Colorado Governor Richard D. Lamm in a 1984 address to the Colorado Health Lawyers Association

“Do not cast me off in old age; When my strength fails, do not forsake me!”
—Psalms 71:9

When the baby boomer generation reaches senior citizenship in 3 years, their growing appetite for the health care dollar and the increasing pressure it puts on the American economy will surface in an ever more dramatic form. The U.S., already strained by the world's highest per capita spending for health care, is about to inherit a huge wave of elderly citizens who will need (and want) their share of the health care dollar. The explosion of this demographic time bomb, coupled with the cost of increasingly sophisticated and expensive medical technology, will result in an unsustainable economic burden that might not only bankrupt Medicare but also have a devastating impact on the American economy.

It is doubtful that any politician will have the temerity Governor Lamm had when he stated in 1984 that old, terminally ill Americans “have a duty to die and get out of the way.” But underlying Lamm's heartless statement is a feeling probably held by many Americans: old folks who have lived their lives should not be allowed to place a huge economic burden on the young by using a disproportionate amount of limited financial resources for medical care.

There is an implied and fallacious assumption in this line of reasoning, which is that by spending less on the aged we will have more money for those who might put the funds to “better” use. Medicare money is not fungible, and a decrease in its budget will not result in more money being allocated elsewhere. This does not exclude the

possibility, however, that the Medicare budget could be spent more wisely on the elderly, a point I will get to later.

Not too long ago, some societies actually treated their elders as second-class citizens when it came to health care. During a trip to the Soviet Union in 1986, I was told that elderly patients in Soviet hospitals were badly neglected because they were felt to be nonproductive elements of society. I was also told how, in an Eastern European communist country, people lied about their ages when calling an ambulance because emergency services were not dispatched to older patients.

These extreme and repugnant examples of ageism should serve as dramatic reminders that age should not be used as the sole criterion for allocating health care resources. Whereas age may play *a* role in selecting recipients for certain treatments, for example scarce organ transplants, it is difficult to think of instances where age *by itself* should play an exclusionary role.

Besides, how would such determinations be made (and by whom)? Should patients above a certain age be excluded from ICU care? Should octogenarians not be offered coronary bypass surgery? Should we withhold aggressive chemotherapy from patients above a certain age? The inhumanity of such suggestions is self-evident.

The reason elderly patients use a disproportionate share of medical resources is obvious—they are sicker and need the care. They are also entitled to the care, inasmuch as most have paid Medicare taxes all their working lives on the understanding that this program would provide for them when they needed it.

The real question isn't whether our elderly are entitled to these resources, but how the money can be spent wisely, and whether there are reforms that, if carried out, would decrease expenditures that do not promote the health of Medicare recipients.

It is often stated that 27-30 percent of all annual Medicare expenditures are spent on caring for people in their last year of life [1], with the implication that this is too large a portion of the Medicare budget and that much of this money should be spent on health care for the non-dying. Firstly, this percentage has been remarkably stable over many years [2]. Secondly, the suggestion that this is excessive assumes that we can know ahead of time which patients will die so that less money would be “wasted” on their terminal care. This, of course, is incorrect. Many elderly patients, treated aggressively, survive for years with a good quality of life. And even if we could reasonably predict which of these patients were in their last year of life, we would still have to provide them with palliative care that is not inexpensive.

Medicare statistics do, however, point to glaring discrepancies that call for further investigation and corrective measures. A 2003 study found that per-capita Medicare expenditures in certain areas of the country were more than double those in others, without any appreciable difference in the quality of care. In fact, the data showed that “low-use [Medicare services] states tend to have higher quality services relative

to high-use states” [3]. The reasons for such variability may lie in a complex mix of differences in beneficiaries’ propensities for seeking care, area-specific practice patterns, and the racial and ethnic mix of the over-65 population. Finding explanations for these data holds a promise of decreasing medical expenditures without sacrificing the health care of the elderly.

Another topic that should be mentioned is the medically responsible use of technology. For example, the finding that life expectancy of patients with severe heart failure can be prolonged with the placement of implantable cardiac defibrillators has resulted in thousands of elderly patients with CHF receiving these very expensive, sophisticated devices without corresponding evidence that people in this advanced age group benefit from them.

A third reform that might save Medicare funds without sacrificing the quality of health care is reversal of the trend towards specialization among medical school graduates. By closing the income gap between medical practices that are procedure-based and the so-called cognitive specialties, we might encourage more graduates to become general internists, whom geriatric patients depend upon most. Skilled geriatricians can not only prevent excess expenditures on the unnecessary tests and procedures favored by specialists, they might also provide better overall care for the elderly than the fractionated pattern of specialist-centered care that many senior citizens receive.

Finally, one promising statistic is that Medicare expenditures in the last year of life decreases for those aged 85 years or older [4], in large part because the aggressiveness of medical care decreases with advanced age. As a greater percentage of the elderly population reaches their mid-80s (and if they have not had expensive, life saving interventions up until then), Medicare expenditures may actually drop.

In short, the proper approach to an aging population that consumes ever more health care dollars is not to cut their access to care arbitrarily but to develop a multifaceted approach that emphasizes patient and physician education about what medical care is helpful and what is not; promotes research into which procedures help the elderly and which do not; and endeavors to revive the increasingly neglected practice of general internal medicine with a focus on the geriatric population.

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Suggested Readings and Resources

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Virtual Mentor

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June 2008 Contributors

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