


Teaching Our Doctors to Care for the Elderly: A Geriatrics Needs Assessment Targeting Internal Medicine Residents

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Ramy Sedhom, MD¹ and David Barile, MD²

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Dear Editor:

Estimates of the number of aging adult Americans who need specialized care and the number of physicians trained to provide it tell of a serious disparity. Public health and epidemiologic data project that people in America will live to be very old, with a declining number contributing to the workforce and the role of caregiving. The impact of the rising number of older adults poses a great demand on the health care system, as their use of health care is disproportionately great. In the United States, patients older than 75 years have the highest emergency department (ED) visit rates after infants less than 1 year of age (Niska, Bhuiya, & Xu, 2007).

The health care needs of older adults differ substantially from younger patients. The physical, social, and behavioral effects of aging are often occurring simultaneously to both acute and chronic illnesses. The synergistic effects are often debilitating. In addition, fewer physicians are entering the field of geriatrics. As a result, internists and residents in training assume much of their care. Both the presentation of illness and its response are altered in advanced age (Girard & Ely, 2007). Frailty, a common phenomenon in older adults, is often accompanied with urinary incontinence, falls, and altered mental states.

Currently, inadequate numbers of geriatricians place much of the specialized care in the hands of internists who have little specialized training in the care of older adults. Although most medical schools offer training in some aspect of geriatrics and palliative care, it is nearly universally inadequate. In many U.S. medical schools, geriatrics is an elective, one which medical students rarely take. Only 25% of U.S. medicine residences require geriatric rotations (Billings & Bernacki, 2014). Medical students are deficient in their understanding of aging and the social issues of older adults. As a result, it is no surprise that many physicians find it difficult to manage the common problems of the aged. Numerous studies have demonstrated that internists and resident house staff were less likely to diagnose atypical presentation of common illness, were less judicious with use of

available resources, and less frequently used family support and accessible social services compared with geriatricians (Sorbero, Saul, Liu, & Resnick, 2012).

Most physicians will be directly involved in the cultural and social aspects of aging, especially those in internal medicine. Many problems experienced by older adults are not amenable to medical solutions alone but require understanding of social aspects of aging, psychiatric comorbidities, and available resources for elders. Skilled understanding and proficiency in caring for older adults is particularly important for trainees who spend much of their time practicing hospitalist medicine. Those over aged 65 years old suffer acute illnesses about half as often as young adults. Yet, illness leads to more days of restricted activity (Conroy, Stevens, Parker, & Gladman, 2011). Older adults are more prone to have multiple functional and chronic medical problems. It takes only minimal changes to exhaust their narrow margin of reserve.

Proper knowledge of the interplay of the physical, psychological, social, and economic determinants in older adults and its role in disease and disability management is not something that can be acquired in the short term. We propose that focused interventions be used to increase the awareness of resident physicians in the care of older adults. We specifically recommend targeting high-yield domains affecting geriatric patients, including a focus on end-of-life training and advance care plans. The outdated diagnose and treat model should be revised to incorporate both prognosticated tools and goals of care discussions to guide treatment strategies. Particularly important for medical trainees is the ability to recognize the early signs of a downward trajectory of health. When older adults approach their

¹Rutgers Robert Wood Johnson Medical School, New Brunswick, NJ, USA

²University Medical Center of Princeton at Plainsboro, NJ, USA

Corresponding Author:

Ramy Sedhom, Department of Internal Medicine, Rutgers Robert Wood Johnson Medical School, New Brunswick, NJ 08901, USA.
Email: sedhomr@gmail.com



final chapter of life, we advocate for a solemn discussion regarding the role of hospice.

Introduced in the United States initially as a grass-roots movement more than 30 years ago and added as a Medicare entitlement in 1983, hospice care is now a part of mainstream medicine (Gazelle, 2007). In 2014, more than 1.6 million Americans received hospice care. Despite its increased use, both physicians and patients misunderstand many aspects of hospice care. For instance, consider the case of a patient we will call Mrs. Smith. Many residents and senior physicians would not consider her a candidate for hospice. Despite multiple hospital admissions in the past year, she did not have a cancer diagnosis, and her death seemed months, not days away. Less than half of hospice patients have terminal cancer; nearly 40% of admissions to hospice care are for end-stage cardiac disease, end-stage dementia, severe debility, pulmonary disease, and stroke. Even more concerning is the median length of hospice service of only 19 days (Coyle, 2014). There are many factors contributing to late referral, including application of the curative model to end-stage incurable illness and the lack of physician training in geriatric care. There is also an overwhelmingly mistaken view that patients must have a do-not-resuscitate order to initiate palliative and/or hospice care. Despite the aforementioned misunderstandings, we believe that the single most important factor responsible for delayed referrals is related to physician attitudes.

The American Society of Clinical Oncology (2016) acknowledged that many oncologists and other physicians regard the death of patients as personal failure. A survey of internal medicine residents at our academic training institution showed similar results. It is likely that many physicians fear to destroy patient hope. A misconception exists that efforts to increase the quantity rather than the quality of life is what matters most. Furthermore, and of most interest to us as investigators, is the lack of training in compassionate discussion of bad news.

Paradoxically, despite the common knowledge that life expectancy decreases with advancing age, physicians rarely discuss goals of care or prognosis with elderly patients, particularly those without terminal illness (Fried, Bradley, & O'Leary, 2003). Our survey study showed that less than 10% of residents across five different training institutions routinely discussed goals of care and prognosis for admissions of cancer, chronic obstructive pulmonary disease, heart failure, stroke, and dementia-related illness. We call for medical educators to offer innovative interventions to alter the paradigm of clinician–patient communication: Offering to discuss overall prognosis with very elderly patients should be the norm, not the exception. In patients with whom life expectancy and overall prognosis are less than 10 years, conversations

regarding goals of care should be routine. Cancer screening, intensive blood pressure, and glucose management should no longer have high priority, but instead focus should be given to advance care plans and reducing pill burden. This has an overall greater benefit in the patient's functional abilities and quality of life (Cunningham, 2001).

A key limitation in physician discussion regarding prognostic estimates is the inability to adeptly discuss epidemiologic data with precision and accuracy, such as the poor functional recovery after debilitating falls. Perhaps these conversations are withheld because of fear of seeming threatening to patients. However, one study of frail elderly patients, with a mean age of 73 and a life-limiting illness, showed that 55% had a physician who never discussed prognosis or goals of care and wanted to (Fried et al., 2003). A majority of elderly patients may want to discuss prognosis, whereas a few do not. We suggest that clinicians should offer to discuss overall prognosis with elderly patients. To make care more patient-centered, we hope that goals of care conversations take overall prognosis into account. In fact, it is now recommended as a topic of national conversation.

The Institute of Medicine (IOM) released a report, *Dying in America*, recommending measures to improve end-of-life care by improving advance care plans. The report proposes that all patients, including children with decision-making capacity, take active role in their medical decision making throughout their lives ("Dying in America," 2015). Targeting patients too late, as often occurs in the hospital and even worse after intubation in the medical intensive care unit, adds distress to patients and their families, often precluding and making impossible other kinds of care, such as hospice, which may have been better aligned with patients' wishes (Hallenbeck, 2006).

Although medical knowledge is essential, a proper attitude is equally important when taking care of older adults. Our fascination with the diagnose and treat model is a reflection of our unwillingness to address our own mortality. The lack of proper education of medical trainees in care of older adults is detrimental to our health care system as a whole. If we are serious about improving care for all patients, it is time to adopt a model in medical education that allows for prognostication and advance care planning. It is our duty to do so.

Authors' Note

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