Section I General Approach to the Care of the Elderly

Chapter 1

Essential Principles in the Care of the Elderly

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The world is aging. In 2020, the US Bureau of the Census reported that 54.1 million citizens (16.5%) were 65 years or older.[1] The first baby boomers turned 65 in 2011, and 80.8 million adults will be over the age of 65 by 2040. The fastest-growing segment of the population, those aged 85 to 99, will reach 14.4 million in 2040. Centenarians numbered 100,322 in 2020; this group will continue to grow. Further, 23% of older adults have diverse racial and ethnic backgrounds. This percentage is projected to increase to 34% (27.7 million) of older adults in 2040. Nearly 1 in 10 people aged 65 and older (8.9% or 4.9 million) in 2020 lived below the poverty level. Another 2.6 million (4.4%) were classified as "near-poor." The poverty threshold in 2018 was $12,261 for householders aged 65 and older who lived alone.[1]

Advances in chronic disease management, new medical therapies, diffusion of "best practices," and increased attention to maintaining physical, cognitive, and psychological function are likely to extend average life expectancy and years of active life. However, it must be noted that 19% of adults aged 65 and older reported they could not function at all or had a lot of difficulty with at least one of six functioning domains (vision, hearing, mobility, communication, cognition, and/or self-care).[1] Other forces that impede progress toward healthy aging include persistent health equity issues in our health-care system, a decreasing ratio of workers to support older adults, and an increasing burden on family caregivers.

Everyone wants good health care in the "golden years." But what is good care? In the care of the elderly patient, 11 essential principles should be considered: (1) the role of the physician as the integrator of the biopsychosocial-spiritual model; (2) continuity of care; (3) bolstering the family and home; (4) good communication skills; (5) building a sound doctor–patient relationship; (6) the need for appropriate evaluation and assessment; (7) prevention and health maintenance; (8) intelligent treatment with attention to ethical decision-making; (9) interprofessional collaboration; (10) respect for the usefulness and value of the aged individual; and (11) compassionate care.

These 11 principles are consistent with the new framework for creating Age-Friendly Health Systems, a movement led by the John A. Hartford Foundation and the Institute for Healthcare Improvement in partnership with the American Hospitals Association and the Catholic Health Association of the United States.[2] The 4Ms are the essential initial elements that health-care systems need in order to provide older adults with the best care possible: What Matters, Medication, Mentation, and Mobility.[2] This framework is a new way to organize care for older adults to ensure consistency in all health-care settings. Following the 11 principles, in concert with the 4Ms, will enable health-care practitioners to provide optimal care.

The Physician as Integrator of the Biopsychosocial-Spiritual Model

The past 50 years have witnessed enormous growth in technology and options to cure acute illness and manage chronic conditions. However, one result of this trend has been increasingly complex, specialized care. Good care requires having a physician who provides leadership in the integration and coordination of the health care of the elderly patient. The current generation of older adults has witnessed amazing advances in research and diagnostic and curative medicine, but it has also seen that a reductionist approach to human disease can result in fragmented and poorly coordinated medical care. It is imperative that the health-care professional responsible for the care of older adults keeps the "big picture" firmly in mind – never forgetting that the patient is much more than the sum of his/her organ systems.[3,4]

Society is calling for physicians with a commitment to the person, not just specific disease states or mechanisms. The person is part of a family and a larger community, or sadly, without family and/or community. An essential role for the physician is to act as integrator for the elder

within a biopsychosocial and spiritual model. To accomplish this, the physician must know the patient thoroughly. This does not diminish the importance of specialties and subspecialties within this model. But ideally, holistic health care not only considers the contribution of specialists to elder health care but also includes full consideration of the individual's physiological, functional, emotional, and psychosocial state, informed by continuity of experience with the patient over time.

In recent years, medical specialty organizations, purchasers of care, and third-party payers have recognized the need to reintegrate coordinated, person-centered, primary care as the foundation of an effective healthcare system. Further, the palliative care and hospice movement, public calls to support dignity in aging and during the dying process, and an increased focus on shared decision-making all depend on enhanced integration of person-centered care. The 4Ms framework provides a way to achieve these goals.[2]

In addition, effective primary care must recognize and incorporate social determinants of health into the overall care for individuals and populations.[5] The Patient-Centered Medical Home is designed to achieve this integration and has been embraced by family medicine, internal medicine, and geriatric medicine as a framework for "continuous, caring relationships" and to restore a robust primary care infrastructure in the USA. Other developed nations such as Canada, the United Kingdom, and Australia have already made significant strides in reinvigorating primary care and generalist practice.[6] No population will benefit more from effective, coordinated, well-resourced primary care than older adults.

The primary care provider must also ensure the coordination, supervision, and integration of care that is vital for the older patient to navigate a complex system that often provides conflicting recommendations and is not always organized to meet the needs of the patient. The primary physician, then, acts as advocate to obtain needed services, and as adviser. At times, the best advice is to avoid tests or treatments that have little potential benefit, but significant potential to harm. Perhaps most importantly, the physician will come to know the patient as an individual, within a family and a community, with particular values, beliefs, and priorities. Thus, the physician comes to serve as interpreter, integrator, and advocate, helping patients to obtain health care that is most consistent with their preferences and needs. This role will most often be a family physician, general internist, geriatrician, or nurse practitioner. However, for some patients, it may be a trusted oncologist, cardiologist, or other specialist. The key factors are the interest and ability to see the patient as a whole person and the commitment in time and expertise to serve in this critical role.

In the coming years, research will hopefully clarify the interaction of biological, psychological, social, and spiritual components to health. For example, clinical distrust, chronic stress, and depression have been linked with increased inflammatory markers that may result in higher rates of cardiovascular disease.[7] There is now overwhelming evidence that depression coexisting with diabetes leads to poor outcomes, including increased mortality.[8] One study has demonstrated that social support may play a protective effect with respect to interleukin-6 (IL-6) elevation, and thus might result in a survival benefit in ovarian cancer patients.[9] There is much to learn about the dynamic relationships between wellness and disease, psychosocial factors, and the spiritual state. The clinician in practice is aware of the higher mortality in the first year after widowhood, more pronounced in the surviving widower than in the widow, and the higher morbidity and mortality seen in elderly persons upon relocation.[10]

Continuity of Care

The ideal longitudinal clinical relationship is often one that is warm and supportive, with the same personal physician serving as adviser, advocate, and friend. However, the realities of today's complex medical environment, with the patient moving between clinic, home, hospital, specialized care units (coronary care units, intensive care units [ICUs], stroke units, or oncology centers), nursing home, and hospice care, often make this ideal impossible. In fact, patients often receive the best care from physicians and other health professionals who focus their practice in these specialized environments. The medical intensivist provides the most skilled care in the ICU; the physician in regular nursing home practice will be more available to patients, staff, and families than one who has a few nursing home patients scattered among several facilities.

The failure of physicians to make visits as necessary in the home and long-term care facilities is related to several factors in the United States, including training, physician attitudes, and reimbursement systems. Our medical schools and residencies for generalist physicians continue to struggle with incorporating meaningful house call and nursing home care as part of their training. Although reimbursement for visits to the home and nursing home has improved in recent years, high office overhead and productivity expectations continue to limit the ability of

physicians to practice in these relatively time-inefficient sites. Physician attitudes are also problematic, in that doctors of recent decades have been more interested in the acute aspects of care than in chronic and long-term care. These attitudes are reinforced by the educational environments and reimbursement systems. Fortunately, there is an increased push for research and educational initiatives designed to address this gap in chronic care knowledge and these attitudes of our students and residents.[11,12]

Nevertheless, continuity of care remains an essential principle in the care of the older patient.[13] A wealth of literature documenting the critical importance of adequate communication among health professionals around transitions in care lends support to the notion that safe, effective, efficient, and patient-centered care can only occur when the in-depth knowledge and understanding of the personal physician is communicated to and incorporated by the specialized teams in the ICU, general hospital, long-term care, and even hospice settings.[14,15,16] While electronic health records offer the promise of more effective and efficient communication within and across care teams and settings, that vision is not yet fully realized.

The physician caring for older adults must recognize that optimal health care often requires a team of professionals, including primary care and specialty physicians, hospitalists, nurses, pharmacists, therapists, and social workers. This does not abrogate, but rather highlights, the need for continuity in care. Physicians, nurse practitioners, and others with a long-term relationship with a patient may remain active advocates and sounding boards, even when they are not the "provider of record" at any point in time. Equally important to patient safety is attention to continuity at transition points in the care of the older patient – from home to hospital, and from hospital to rehabilitation unit or nursing home. The physician responsible for the care of patients at each juncture must communicate fully and accurately with the patient, family, and receiving health-care team, to ensure that the patient's treatment plan, values, expectations, and preferences are known and honored.

Bolstering Family and Home

Every physician should enlist those means that assist elderly persons, whenever possible and consistent with their goals of care, to maintain their independence, either in their own home or other setting. The physician should use the prescription for a nursing home as specifically as a prescription for any other intervention, with consideration of all of the potential benefits and harms.

A number of forces have resulted in patients going to institutional settings when other alternatives might have been possible. Between 1960 and 1975, a massive push toward institutionalization took place, creating hundreds of thousands of nursing home beds. What forces have contributed to overutilization of institutional care? One factor is funding that has disproportionately directed reimbursement for institutional care away from other alternatives. Another is increased mobility of families, smaller families, and increased numbers of women moving into the workforce, therefore limiting the number of family members able to participate in the care of their elders. In spite of these forces, rates of institutionalization have declined slightly in recent years, as older adults and their families have chosen to overcome obstacles to keep loved ones at home. Additionally, a rapid growth in largely privately funded assisted living facilities has provided an option for older adults with less extensive care needs and the financial resources to pay for lower-acuity, more home-like living environments.[17]

What alternative can the physician recommend? The list includes home health aides, other types of homecare, daycare, aftercare, specialized housing settings, visiting nurses, friendly visitors, foster homecare, chore services, home renovation and repair services, congregate and home-delivered meal programs, transportation programs, and shopping services.[18] Personal physicians should also understand and utilize legal and protective services for older patients whenever indicated.

Publicly financed programs such as the Program of All-Inclusive Care for the Elderly (PACE) and home-based Medicaid waiver programs that support nursing home-eligible elders to remain in their homes have grown in recent years, as federal and state governments have recognized that supporting seniors' desire to stay in their own homes is not only better, but actually less expensive care.[19] States have explored options to provide services in the homes of nursing home-eligible patients through a combination of Medical Assistance waivers and other programs. In addition, a growing body of research demonstrates the benefits of home-based interventions that target patient and caregiver priorities and teach problem-solving skills to maintain physically frail and demented individuals in their homes.[20]

In spite of the pressure to contain institutional long-term care costs, funds have not been available for adequate expansion of publicly funded programs to support frail older adults in their own homes. Further, many of

the evidence-based interventions that might provide cost-effective strategies for supporting older persons in the community are not reimbursed by insurance. Thus, resources remain limited and disjointed. The role of health-care providers is to facilitate referrals, coordinate services, and become knowledgeable about general resources available and appropriate referral sources (i.e., care manager, area agency on aging) with expertise to help patients and families navigate the system effectively.

Who are the caregivers in American society? Data from the American Association of Retired Persons Caregiving in the U.S. 2020 report cites that 41.2 million Americans are providing care to someone who is 50-plus years old.[21] In 2018, the percentage of older adults over age 85 requiring personal care assistance (21%) was five times the percentage of adults aged 65–74 (4%).[1]

More women than men are caregivers, and women continue to provide more of the most difficult personal care tasks such as bathing. A majority of caregivers have spent an average of 20.4 hours per week on caregiving tasks for three or more years. This average increases to 39.3 hours per week for live-in caregivers. The average age of a caregiver is 63 years, and one third of all caregivers rate their own health as fair to poor: 40–70% of caregivers experience depression. Caring for a person with dementia may negatively impact the caregiver's immune function for up to three years after the experience ends.[22] Despite the very real burdens of caregiving, however, at least five population-based studies have found reduced mortality and extended longevity for caregivers compared with non-caregivers. Many caregivers in fact report benefits from their role.[23]

Family/informal caregiver services were valued at $470 billion in 2013, exceeding the value of paid homecare and total Medicaid spending in that year, and almost matching the value of the sales of Walmart ($477 billion).[24] Caregivers may experience adverse economic impacts, with many having to reduce working hours or even stop working. Those caring for older adults lost an estimated $13 trillion in wages, pensions, retirement funds, and benefits. Employers of caregivers experience an average of 6.6 lost work days and an 18.5% reduction in work productivity among employees who are caregivers.[25]

Many families feel the burden of caregiving, sandwiched between the demands of their parents and of their children and grandchildren. It has been said that the empty nest syndrome has been replaced by a crowded nest syndrome. In 2019, approximately 1.1 million grandparents aged 60 and older were responsible for the basic needs of one or more grandchildren under age 18 living with them.[1] The physician will often see a caregiver who is in more distress than the patient, and who develops serious physical and emotional problems as a result of the burden and stress encountered.[22]

Communication Skills

Specific communication skills are critical in good management of the elderly patient. Most important is listening and allowing patients to express themselves. Ideally, the physician should employ open-ended questions, both interpreting what the patient says and "reading between the lines." The physician might rely on intuition to interpret the patient's meaning. What motivated the patient's visit? For example, the elderly patient may speak about somatic symptoms that originate from grief or depression. Often nonverbal clues such as posture, grooming, or sighing communicate as much as or more than verbal content.

Leaving the door open for other questions or comments by the patient, both at the conclusion of the visit and for the future, is important. It is worth saying: "Are there other questions or concerns that you have at this time?" A physician that anticipates a specific problem can make it easier for the patient to discuss the issue. For example, "You are doing well, but I know that you are concerned about your arthritis and whether or not you will be able to climb the stairs in your home. At some point, we may want to discuss options that are open to you."

An important feature of American demography is the increasing diversity of older adults.[1] In the past, white English-speaking individuals have comprised the vast majority of older adults. However, increasingly, health-care providers care for a racially, ethnically, and linguistically diverse population of elders. Physicians and other professionals caring for older patients must provide culturally sensitive care, recognizing the unique and varied cultural contexts of their patients. Further, groups including the federal government have recognized the critical role of appropriate health translators in order to provide appropriate care to patients who are not proficient in English. All of these issues may be magnified in the care of older patients with sensory or cognitive disabilities.

Frequently, physicians providing care to elderly patients must include the considerations of adult children in their parents' care. These children may play a vital role in decision-making and support, and the physician must,

therefore, possess skill in communicating with them and in dealing with their emotional reactions, such as guilt or grief. Respecting the older adult's independence, autonomy, and capacity for decisions is paramount. Managing parent-child relationships in the context of the patient's care requires skill and knowledge of ethical and legal considerations.

In this age of increasing technology and subspecialization, the patient's recovery and coping with illness may still depend on the physician's ability to reduce panic and fear, and to raise the prospect of hope. Cousins describes the "quality beyond pure medical competence that patients need and look for in their physicians. They want reassurance. They want to be looked after and not just over. They want to be listened to. They want to feel that it makes a difference to the physician, a very big difference, whether they live or die. They want to feel that they are in the physician's thoughts." [26] For example, picking up the phone and calling the patient to say: "I was thinking about your problem. How are you doing?" can be a powerful step in cementing the relationship between the doctor and patient.

Jules Pfeiffer's cartoon character, the "modern Diogenes," carries on the following discourse upon meeting an inquisitive fellow traveler through the sands of time:

"What are you doing with the lantern?" asks the traveler.

"I'm searching," replies Diogenes.

"For an honest man?" he asks.

"I gave that up long ago!" exclaims Diogenes.

"For hope?"

"Lots of luck."

"For love?"

"Forget it!"

"For tranquility?"

"No way."

"For happiness?"

"Fat chance."

"For justice?"

"Are you kidding?"

"Then what are you looking for?" he implores of Diogenes.

"Someone to talk to."

Help comes from feeling that one has been heard and understood.[27]

Knowing the Patient

Several steps are recommended in building a sound doctor-patient relationship, particularly applicable to the elderly patient.[28] The first rule is that the physician should know the patient thoroughly. The interested physician performs this step by gathering a complete history, including personal and social history, and performing a complete physical. The physician should be a good listener, warm and sensitive, providing patients ample opportunity to express their concerns, and to prioritize what matters most to them. This approach embodies the 4Ms framework.[2] But forces in contemporary health care oftentimes prevent the physician from being a good and engaged listener. The physician cannot be attentive while at the same time entering information into an electronic health record. Understandably, patients often feel that physicians who are facing a computer and typing on a keyboard are not present for them.[29]

Family and friends represent the principal support system for the elderly and usually call for nursing home placement only as a last resort, after all alternatives have failed. However, the physician must be able to recognize the dysfunctional family. There are elderly people who have been rejected by their children. There are elderly people who have rejected a child for a variety of reasons. There are families with members estranged from each other for many years. The patient may have had a stable and supportive marriage or other relationship, but increasingly, older adults have had multiple marriages, or may be divorced, or partnered in a same-sex relationship. It is critical for the practitioner to understand family or other social dynamics when engaging family or friends in support of an elder, and also to recognize when dysfunctional family or friends are harming the patient.

Creating a Partnership with the Patient

In most instances, the physician should be honest and share information truthfully with the patient, which is the foundation for building an effective partnership. The doctor should first review his/her perception of the patient's problems. Then, for each problem, alternative choices are considered, and decision-making is shared with the patient. Frankness is essential to creating and maintaining trust with patients, although there are situations in which this approach is counterproductive. There are also situations in which the elderly patient does not want to share in decision-making, but prefers to surrender autonomy to a relative such as a spouse or adult child, or to the physician.

The experience of dying in America is too often dehumanizing, and there is broad recognition that end-of-life care can be improved. Isolation, unrelieved pain, and

anxiety during the dying process are too common and compel some to call for assisted suicide. But there are alternatives to assisted suicide that can address these shortcomings in the care of dying patients. The greatest danger posed by assisted suicide or euthanasia is a slippery slope that places unwarranted judgment as to the value of human life, and puts frail, debilitated elderly persons in jeopardy.

Some consider physician-assisted suicide as the ultimate act of patient autonomy – the opportunity to define the conditions and time of one's own death. However, it is critical that discussions with the patient or family members be presented in a positive manner that addresses pain and fear.

The physician should be cautious that discussions with family members be held with the patient's consent. If the patient lacks decision-making capacity, then it might be appropriate to deal with the closest relative or identified surrogate decision-maker. Complex ethical and legal questions can arise in the matter of confidentiality and decision-making when the presence or absence of capacity is not absolute. As with other clinical decisions, judgment and consultation with ethicist and legal counsel is advisable.

Need for Thorough Evaluation and Assessment

The physician must avoid prejudging the patient. One must not allow preconceived notions of common patterns of illness to preclude the most careful individualized assessment of each patient. Conscientious history and physical examination are essential. Treatment choices should be considered only following a thorough evaluation. Judicious consideration of all factors may result in a decision to treat or not to treat certain problems in certain patients. Attention to lesser problems may be postponed according to the priorities of the moment, rather than complicating an already complex therapeutic plan.

Physicians must avoid "wastebasket" diagnoses. The past concept of "senile dementia" is one such example. Not all mental disturbance represents dementia, and not all dementias in older people are Alzheimer's disease. Neuropsychiatric disturbance in older adults might be casually accepted as both inevitable and untreatable when, in reality, a very treatable cause may be present. The physician must consider and seek out treatable disease.

For example, neuropsychiatric disturbance, including a dementia syndrome, may be caused by severe depression that is a treatable disorder. Neuropsychiatric disturbance may also include delirium secondary to medical illness or drug toxicity. Delirium can resolve if the primary disorder is recognized and treated; failure to do so may lead to the hastened death of the patient.

It is often difficult to disentangle the physical from the emotional. Emotional disorder such as depression may present primarily as somatic symptoms. Conversely, physical disease might present as a mental disorder with confusion, disorientation, or delirium being the first sign of common medical ailments, including myocardial infarction, pulmonary embolism, occult cancer, pneumonia, urosepsis, or dehydration. For this reason, it cannot be emphasized enough that proper diagnosis is essential in order to make specific treatment plans.

Knowing the organic, anatomic, or psychiatric diagnosis is often not sufficient; rather, the physician should seek a more complete understanding of the elderly patient. Many times, precise assessment of the older patient's functional status contributes more to the patient's care than the diagnostic or anatomic label. For example, in the case of a cerebrovascular accident, knowing whether the patient can walk or climb stairs; handle his/her own bathing, eating, and dressing; get out of bed and sit in a chair; handle a wheelchair; or whether he/she requires a cane or walker conveys more information relevant to the patient's care than identifying the anatomic lesion via MRI angiography. All these functional concerns must be considered in evaluating an elderly patient.

Polypharmacy is a major problem in the care of the elderly patient. Many medications considered benign in younger individuals may cause significant side effects in elders. Changes in body-mass composition and altered renal, cardiac, and hepatic functions can affect drug distribution and elimination. In general, older individuals demonstrate greater variability and idiosyncrasy in drug response in comparison to younger persons. Prudence, therefore, is extremely important in prescribing drugs for the older individual. The physician must determine if the patient's overall function will be enhanced or harmed with pharmacologic treatment. Is this medication absolutely necessary? Has its efficacy been reassessed? Might a new or chronic symptom in fact be an adverse drug reaction? Does the absolute benefit over a time interval that is meaningful to the patient outweigh the absolute risk of harm – remembering that the benefit-to-risk ratio is often less for older patients than for younger people? The physician must attempt to keep the total number of medications as low as possible. The Beers Criteria for

Potentially Inappropriate Medication Use in Older Adults identify medications that typically should not be prescribed in older patients. Of note, adverse events are common even with appropriately used medications such as diuretics, anticoagulants, and hypoglycemic agents.[30]

Signs and symptoms of disease in elders may be slight or nonspecific (e.g., delirium in patients with myocardial infarction). Pain, white blood cell response, and fever and chills are examples of defense mechanisms that may be diminished in older persons. The aged person may have pneumonia or pyelonephritis without chills or a rise in temperature.[31] Myocardial infarction, ruptured abdominal aorta, perforated appendix, or mesenteric infarction may be present without pain in the elderly patient.[32]

Multiple clinical, psychologic, and social problems are characteristic of older people. Clinically and pathologically, an elderly patient may have 10 or 15 problems. Geriatric patients should benefit from the use of a problem-oriented approach to medical records. Medical records should not only include medical conditions but also record functional, psychologic, social, and family problems. The key feature of the problem-oriented record is the problem list, which serves as a table of contents of the patient's total medical history. Current electronic health records provide structured formats for the problem list, but it falls to the clinical care team to develop a comprehensive list of current and past conditions and concerns. Without a detailed problem list, one can easily lose track of past problems that remain relevant, such as a psychiatric hospitalization a decade or more ago. In addition, an up-to-date medication list is crucial to patient care and safety.

Prevention and Health Maintenance

In the United States there is growing emphasis on prevention, health maintenance, and wellness. Unfortunately, strong evidence supporting most primary and secondary preventive care recommendations is lacking for adults over 75 who have multiple chronic illnesses or who are frail.[33] For example, few studies of primary and secondary prevention for heart disease and stroke include patients over 75. Still, clinicians caring for these patients should be prepared to consider preventive and screening recommendations with older adults in light of their healthcare goals and preferences, and assist them in interpreting potential risks and benefits in the context of their function and overall health.

There is much that clinicians can achieve by focusing on health maintenance and wellness in their practice and in their community educational programs. The personal physician has an opportunity to encourage preventive medicine and health maintenance at every age level and at each level of functional ability or disability.

Research has revealed the important role of nutrition, exercise, and strength training in the prevention or reversibility of frailty, physiologic decline, and recovery from surgery or trauma.[34] The health of many elders is improved by regular prescriptions of exercise and physical activity. Continued advances in nutrition and exercise are likely to reduce the risks of disease, improve function, and compress years spent with disability.

Intelligent Treatment with Attention to Ethical Decision-Making: Choosing Wisely

The aphorism "First, do no harm" paraphrases the Hippocratic Oath and provides a guidepost to the practice of medicine. It is particularly important in the care of older adults, where interventions may easily disturb a delicate homeostasis maintaining physiology and function. A similar concept was articulated over 50 years ago by Seegal as the "principle of minimal interference" in the management of the elderly patient.[35] "First, do no harm" and the principle of minimal interference should be remembered when one considers the multiple potential paths to iatrogenic injury.[36,37]

The principle of minimal interference can be applied not only to diagnostic and treatment decisions but also in regard to hospitalization or placement in a long-term care facility. It may result in recommendations that are both humanistic and cost-effective; for example, it may be prudent for patients to remain in their own homes where family and friends can more easily visit and food preferences are more easily accommodated, in contrast to moving into a long-term care facility where nursing care is available. Similarly, the recommendation to forgo a gastrointestinal workup to evaluate anemia may be wise when, in the physician's judgment, the findings are unlikely to change management based on frailty or competing illness.

However, medical nihilism is never justified; there are times when aggressive intervention is needed. Certainly, the patient with dementia caused by myxedema deserves skillful replacement of thyroid hormone. The elderly patient with depression deserves specific intervention for this very treatable disorder. Also, more and more elderly patients are benefiting from minimally invasive

surgery, including complex procedures such as cardiac valve replacement.

Increasingly, national attention has been focused on these challenging decisions at the interface of clinical and ethical decision-making. The Triple Aim (improving the experience of care, improving the health of populations, and reducing the per capita cost of care) has become widely accepted as a definition of successful health system redesign.[38] The Choosing Wisely initiative of the American Board of Internal Medicine (ABIM) Foundation has leveraged the concept of the Triple Aim and encouraged specialty societies to define key opportunities "to promote conversations between providers and patients by helping patients choose care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary."[39] To date, over 80 organizations have adopted and publicized Choosing Wisely guidelines that specifically address issues of importance to older adults. For instance, the American Geriatrics Society advises hand-feeding patients with advanced dementia rather than using feeding tubes, which are associated with significant potential harms. Another recommendation is to avoid a hemoglobin A1c goal of less than 7.5% with medication other than metformin in most adults aged 65 and older because of the increased risk of hypoglycemia with tight control.[40] Many national medical and nursing organizations have responded to the ABIM Foundation's call to adopt more evidence-based, cost-effective, and patient-centered practice for all patients, including elders.

In the future, we will be faced with more and more difficult decisions of an ethical nature. For example, an 80-year-old gentleman may present with a past history of resection of an abdominal aneurysm 15 years ago, multiple myocardial infarctions, and multiple strokes causing severe dementia. His main problem in the current hospitalization is pneumonia, causing a worsening of his confused state. Because of periods of sinus arrest, a pacemaker is considered. Should a pacemaker be utilized in patients with significant dementia? Should pneumonia be treated in patients with severe dementia or terminal carcinoma? Difficult and ambiguous clinical problems such as these will face the personal physician with increasing frequency. The physician in the future will be called upon to make complex decisions according to the accepted traditions and values of the specific society, culture, religion, or nation, with major guidance from the patient's stated wishes that were affirmed at a time when the patient was fully competent. In regard to all therapeutic decisions, a personal physician is at an advantage if his/her understanding of the patient is based on continuity of care.

Interprofessional Collaboration

The physician must understand when to call upon other health professionals, including nutritionists, pharmacists, visiting home nurses, social workers, psychologists, and representatives of community agencies. One must know when to recommend legal or financial counseling, and when and how to consult with the patient's or family's clergy or spiritual adviser.

The physician should know when to recommend specific rehabilitative therapies. Specific use of physical, occupational, recreational, and speech therapies is vital for the proper care of certain problems. For example, the elderly patient with diabetic neuropathy and foot drop might benefit from bilateral leg braces. Another patient recovering from stroke might benefit from occupational therapy that should be used as a reintroduction of the patient to the activities of normal daily living, and not simply as a recreational or diversionary therapy.

The improvement of health care of the chronically ill elderly patient requires that health professionals work together for the best interests of the patient. A genuine collaborative effort is required to bring about a coordinated approach that best meets the needs of frail elders. There is increasing evidence that effective collaborative practice improves patient outcomes.[41] Competencies for effective collaborative practice have been defined and are actively being promoted in health professions education.[42]

Respect for the Usefulness and Value of the Aged Individual

Much in nontraditional societies devalues older adults. In modern culture, where so much marketing is youth-oriented, the physician must guard against unwarranted judgment that an elderly patient is less than capable and autonomous (ageism). Lack of respect for and devaluation of older adults are frequently communicated by society at large, in the workplace, in the family, and in entertainment media, but it should not occur in the doctor's office or other clinical settings. Fortunately, in some societies older adults continue to have valued roles within the family and community structure.

Most countries are witnessing an unprecedented growth in their aging populations, especially in the cohort

over age 85. Accompanying social and economic changes may allow elders to function as a continuing resource to society. It is possible that reduced restrictions on older workers may occur, with particular reference to mandatory retirement. More educational programs may be enacted that provide skilled training, job counseling, and placement for older men and women in order to initiate, enhance, and continue their voluntary participation in the workforce. Hopefully, the breakdown of stereotypes and greater recognition of the value of the elderly person as a human resource will occur.

Already, more and more older adults are choosing to remain in the workforce. In 1930, 54% of males aged 65 and over were in the workforce. By 1985, only 15.8% of older men were working. Compare this to 2018, when 24% of men and 16% of women were working, representing 5% of the US labor force.[43] Interestingly, participation in the workforce by men aged 65 and over declined steadily from 1900 through the 1980s. After remaining level for nearly two decades, participation of older adults in the workforce has been steadily increasing since 2002.[1]

Evaluation of workers aged 51–56 in 1992 and 2004 as part of the Health and Retirement Study suggests that lower rates of retiree health insurance from employers, higher levels of educational attainment, and lower rates of defined benefit pension coverage have led significantly more workers from the 2004 cohort to expect to work past age 65, compared to the 1992 cohort.[44] Many older workers indicate that they would prefer phasing down, and continuing to do some paid work when they retire. Others approaching or in retirement opt for a retirement career. There are many in good health and who have financial stability or a satisfactory pension who would prefer to pursue a part-time or full-time retirement career with passion. The person retiring today at age 65 or younger may enjoy a retirement career that might span 10–20 years. Society must allow elders to fulfill such roles, and to retain the wisdom that has accumulated with time. At the same time, there are those approaching retirement who would not want or be able to continue employment, whether in their former role or a new one. All of these variations need to be considered in counseling our patients.

Compassionate Care

Care and compassion mean that the physician must spend sufficient time with elderly patients. One study reported that physicians spent less time with elderly patients than with younger ones, even before current pressures to increase clinical productivity.[45] Fifteen to twenty minutes may be the minimal time needed to carry out a visit in the office, home, hospital, or long-term care facility. One and a half hours, not necessarily in one sitting, may be required to complete an examination of a new patient, particularly in the presence of multiple complex problems. More time will be required in each encounter or more frequent encounters scheduled if the various functions of counseling, psychologic support, health maintenance, and prevention are to be carried out, in addition to making decisions about treatment and possible rehabilitation.

The physician should be a good listener. Often, by nonverbal means, the physician can express warmth, understanding, or empathy. Staying close to the patient and maintaining eye contact is helpful. Sitting adjacent to the patient's bed or sitting on the edge of the bed in the hospital or long-term care facility brings the doctor right into the patient's personal universe. The physician might put a hand on the patient's shoulder and pat or touch the patient or hold hands at appropriate points during the visit. In primary care practices that transition to Patient-Centered Medical Homes, the expanded team can contribute to the care of older patients and their families, bringing not only additional skills and expertise but also additional time to get to know the patient and understand the context and priorities for their care.

Changing Times in Health Care

Although the organization of health-care delivery will undoubtedly change, society will ultimately demand a quality of care that we would each want for ourselves. Social pressure will enforce the maintenance of quality of care, patient satisfaction, and the fulfillment of the professional ethics of medicine and other health-care professions. Health systems that embrace the 4Ms framework to become Age-Friendly Health Systems will emerge as leaders in providing outstanding health care for all older adults.

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