

Virtual Mentor

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FROM THE EDITOR

Medicine's New Breed of Patients

The shifting age distribution in the US has led to an increase in the geriatric population—those over 65—that will continue for nearly two decades. Physicians and other health professionals must rise to meet the challenges this new demographic presents. In the past, the medical community did not differentiate between the needs of adults in general and the needs of those in the geriatric population. In recent decades, however, it has become evident that caring for the geriatric population poses medical, social, and ethical issues that often differ from those posed by younger adults—they are living longer with more chronic conditions, they are more engaged in their own care, and they want medicine to help them remain healthy and active for longer than people of their age did in years past. Moreover, certain approaches of geriatric medicine run counter to the training and treatment orientation of physicians who have been in practice for some time. Goals in treating older adults, for example, include reducing medication, testing, and invasive procedures as much as clinically prudent. This issue of *Virtual Mentor* explores the questions that physicians must consider and resolve as they care for their recently reclassified “older adult” patients.

The ethics cases this month look not only at the elderly patient but at his or her caregivers. Confidentiality of the patient-physician encounter and respect for patient autonomy are foundational aspects of medical ethics. How can those principles be balanced against the well-being of caregivers, when a patient's decision directly—and adversely—affects the caregiver? What are the responsibilities of the physician to his or her patient and to that patient's caregivers? Those are the questions the first ethics case poses. David Barnard explains that, because caregivers are an integral part of a patient's care, physicians are obligated to advocate for their well-being, even if doing so means overriding a patient request. In a slightly different take on the situation, Mark J. Yaffe believes that respect for the patient's autonomy must supersede other concerns, so the patient must be convinced to consider his or her caregiver's well-being before the physician can intervene on the caregiver's behalf.

The second ethics case brings up the discomfiting topic of age-based rationing. Haavi Morreim believes that age is far less important than other aspects of a patient's life and health in determining what services that patient should receive, and she questions the legality of age-based rationing. A second commentary provided by Ryan M. Antiel, David G. Zacharias, and Daniel E. Hall points to two examples in which end-of-life decision making took decidedly different courses. In one instance, futile interventions failed to save “John,” who had a massive ruptured abdominal aortic aneurysm and many comorbidities. In the second example, this one fictional,

Nathan decides to forgo treatments that would prolong but not improve his life and to “let death take care of itself.” These authors look forward to a time when there are more “Nathans” than “Johns.”

The third ethics case illustrates a common dilemma for those of us taking care of older adults—how to best honor a patient’s wishes when he or she is no longer able to make decisions and last expressed those wishes during a time of very different health status. Bernard J. Hammes and Thomas D. Harter comment on the importance of proper advance care planning and what physicians should do in its absence. Commenting on the same case scenario, Meera Balasubramaniam and Yesne Alici summarize the existing ethical guidelines for working through this challenging situation. Two opinions from the AMA’s *Code of Medical Ethics* offer guidelines on advance care planning and the consideration of quality of life when making treatment decisions at the end of life.

Becoming recognized as a specialty (the American Board of Internal Medicine began offering a certification of added qualification in geriatrics in 1988) does more than improve clinical care for the population the specialty serves. Specialty status brings the needs of that population to public notice. Mary Ann Forciea summarizes the twentieth-century history of geriatrics, which got its start in England. Jerry H. Gurwitz advocates for including older persons in clinical drug trials, inasmuch as the elderly comprise the largest number of beneficiaries of many drugs, particularly those for patients with cardiovascular conditions. And Richard Weinmeyer explains how recognition of the growing numbers of elderly in nursing homes has led to legislation to combat abuse in those homes. Richard G. Stefanacci gives an overview of Medicare means testing and tells what our society and policy makers must do in order to optimally apply means-based adjustments in fees for medical services.

But recognition as a group that deserves special clinical attention does not resolve all the medicine-related concerns posed by the aging baby boomer generation. This cohort of patients, Eva Kahana and Boaz Kahana say, has expectations of medicine and health care that older people of the past did not have. The present-day elderly have adopted health-promoting lifestyles, expect to share in decisions about their care, and demand their physicians’ personal attention, sometimes rejecting e-monitoring and other physician-replacing technology. Moreover, in “Who’s Responsible for Granny?” Carol Levine explains that our independence-valuing society, while ever-eager to help out in crises across the planet, offers strong resistance to suggestions that the public assist families in the financial and caregiving duties they face in caring for the elderly. In fact, says Nancy S. Jecker, the prevailing US culture of self-sufficiency and the attendant loathing of “becoming a burden” causes many old people to view “a good death” as one in which they don’t make demands on anyone. These elderly people feel there is a duty to die once one is no longer productive and independent. Jecker says emphatically: there is no duty to die.

Many of the questions raised and discussed in this month’s *Virtual Mentor* are just coming to public awareness. We don’t answer them here, but hope that the hard

thinking continues and that no one gives up searching for reasonable solutions. It's trite, but, if we are lucky, we will all be part of this patient group.

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