# Doctors should tell patients the realities of aging

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Dr. Alexander K. Smith hopes to provoke a national discussion about being frank with the very elderly about their individual medical prognosis.

In his recent paper on the issue published by the New England Journal of Medicine, he makes a strong case for outlining the future in frank terms - provided the elder wants to hear it.

"Studies show patients want to discuss the realities of aging but they may be waiting for the physician to bring it up," says Smith, who is an assistant professor of medicine at the University of California San Francisco and an associate of the San Francisco Veterans Affairs Medical Center.

"Often it's the doctor who doesn't want to talk about it," he says.

Here Smith discusses the issue:

Q: You admit not all patients want to know the details of their future, medically. For those who are interested, what's the problem?

A: As I write in this paper, co-authored by Dr. Brie A. Williams and Dr. Bernard Lo, despite knowing that life expectancy inexorably decreases with advancing age, we tend to avoid discussing overall prognosis with elderly patients, particularly those with no dominant terminal illness. By avoiding such discussions, however, we may undercut the ability of

patients and their caregivers to make informed choices for their future.

Q: You say discussing these individual issues with elderly patients should be the norm. Seems this should already be routine and not the topic of such serious debate.

A: Well, the idea of patient activism is relatively new. There has been, in the past, strong pressure to deny the realities of aging. We know a substantial number of patients want to talk about this now. But we have to respect those who don't. It depends on the person. I have patients who are 100 who won't admit their time is limited.

Q: Is this a way to reduce overall health costs? I mean, if I know that the cancer I have is going to kill me eventually, why bother to spend the money to treat it in the end days of life? By denying treatment to those it will not substantially benefit with many more years of good health, we could reduce Medicare costs significantly.

A: When patients are aware of the options, they often make choices themselves that reduce the cost of care. But it is our job to support the patient's goals and aspirations. I absolutely am not suggesting we tell people that the eventual outcome of this treatment will not benefit them so we aren't going to do it because of the expense.

Right now, we are doing a study to find out why patients will talk about a short-term prognosis but generally aren't willing to talk about five or 10 years ahead.

We need to set a balance but we also must give hope. So many are living longer comfortably with disabilities that once were painful.

Q: In your paper you suggest that clinicians should routinely offer to discuss the overall prognosis for elderly patients with a life expectancy

of less than 10 years Â- or at least by the time a patient reaches 85 - and that the older and frail should be encouraged to talk about reducing the pill burden and engaging in advanced care planning.

A: Most of the very elderly patients place great emphasis on the harms as well as the benefits of medications (but) clinicians may fear talking about or even raising the topic of overall prognosis because it may seem threatening to patients and family members....

Whereas clinicians consider overall prognosis in order to inform medial decision-making, in our experience, many very elderly patients are interested in it because it affects personal life choices Â- motivating them, for instance, to arrange finances for long-term care or to prioritize spending time with grandchildren and other family members while they are active.

Q: Some of the common medical decisions and life choices that you say offer opportunities to discuss overall prognosis with the elderly are assessing the appropriateness of high-risk surgery or initiating renal dialysis in an elderly patient.

A: Not withstanding large current gaps in evidence, we believe we should start talking about overall prognosis now, even as we carry out more research on patient preferences and ways of improving such discussions. To make our care more patient-centered, we need to start helping our very elderly patients set goals of care that take their overall prognosis into account. We should do so in the ordinary course of clinical practice, letting our patients be our guides.