Better care for some elderly patients means less intervention, says geriatrics specialist

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(Medical Xpress) -- To provide elderly, hospitalized patients with the best care possible, the medical community needs to reevaluate its reliance on medical technologies, says Bruce J. Naughton, MD, associate professor of medicine at the University at Buffalo and a specialist in geriatrics, which deals specifically with the problems of aging.

Naughton teaches geriatrics at the UB School of Medicine and Biomedical Sciences, and is head of geriatrics at Buffalo General Hospital. In 2004, he established a Geriatric Center of Excellence at UB to strengthen training in geriatrics across the medical spectrum, from medical students to physicians practicing in the community. While that program is changing how physicians approach the elderly, there is still much to be done, Naughton says.

"The reliance on overly aggressive, often high-tech treatments in elderly patients with multiple illnesses ends up providing, in the end, poor care: the exact opposite of what physicians are trained to do," says Naughton.

He notes, for example, there are multiple studies showing that for patients with several illnesses and advanced age, a stay in the Intensive Care Unit is often associated with a lower satisfaction with care by patients and families.

"Our current studies based on preliminary data also show that patients over 80 years of age who spend more than four days in the medical (as opposed to surgical) Intensive Care Unit could have as high as a 75

percent chance of dying in the hospital," says Naughton, referring to studies he is conducting in Western New York hospitals.

In addition, he says, published studies from throughout the U.S. show that a number of markers of poor care, such as late admission to hospice and transfer from one institution to another within three days of dying, are associated with high-tech care for patients with serious illness and advanced age.

"We have an aging society, access to advanced technology, a very high expectation of what health care can accomplish and a culture that denies that we won't live forever," Naughton says. "It turns out that more care and more technology doesn't necessarily translate to the best care."

Naughton says it can be difficult for physicians and families to decline aggressive, disease-fighting options, even when that option severely compromises the patient's immediate quality of life and, under many circumstances, cannot be expected to provide long-term benefit.

"We need to acknowledge that non-beneficial care is also wasteful care," says Naughton. "As physicians, we often feel that it is our responsibility to provide all possible interventions, but really our job is to provide the best care, which in some situations is not going to be the high-tech option.

"Older adults are a diverse group, and require individualized treatment," he continues. "The outcomes expected for one person may not be the same for another."

It is time, he says, for the health care community to begin a dialogue with the public about what technology can and cannot do for the elderly.

"We need to find a way to open that dialogue," he says. "Hospitals need

to start writing policies that address these issues, especially CPR and ventilators."

In some important ways, he says, that dialogue is beginning; for example, in 2011, two pieces of legislation took effect in New York State requiring hospital health care providers to discuss palliative care with patients who have a prognosis of six months or less. The laws are the Palliative Care Access Act and the Palliative Care Information Act.

Key partners in these discussions are geriatricians, who are trained to deal with the specific problems of elderly patients, and palliative care specialists, who focus on relieving the pain and suffering of any patient with a serious disease.

"In addition, our colleagues in the health ministries also are trying to lead families on this journey," says Naughton. "This is a frontline issue and Western New York clergy are supporting health-care providers as we deal with these issues everyday."

For families of elderly patients facing high-risk procedures, Naughton suggests the following:

--Ask your doctor to discuss life expectancy, in terms of both quantity and quality.

--Ask, what are the alternatives to this procedure? What will happen if the surgery isn't done?"

--Always get a second opinion.

--Request a meeting with the hospital's geriatrics or palliative care specialist as soon as possible. "The role of the geriatrician is to discuss what the medical technology involves and what are the outcomes," says

Naughton. "In some cases, once elderly patients and their families fully understand the risks, they may opt not to undergo surgeries that might prolong their lives but seriously compromise their quality of life."

--Consider, where possible, a time-limited trial to assess potential gains from interventions, such as dialysis.

"I want older adults to think more about their goals," says Naughton. "I ask my patients, what is the most important thing to you?"

For some patients, it is carrying out basic daily tasks like dressing and bathing or continuing to live independently.

And families can take steps while their elderly relatives are still healthy, by discussing with them what their goals would be if faced with a serious illness.

"Physicians are rarely criticized when they go ahead with a procedure, such as surgery, but they often get criticized when they don't do the procedure or test," Naughton says."We need to better align medical care with the ability to help our patients achieve their goals. Sometimes excessive interventions don't provide any benefit and may even increase the person's suffering. We have to be respectful. We have to do no harm."

Provided by University at Buffalo