



Perspective

Age, Complexity, and Crisis — A Prescription for Progress in Pandemic

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It's a sunny Sunday in San Francisco as I tackle overdue clinic notes and Covid-19 sweeps the planet. I am scheduled to speak in 10 other states over the coming weeks, and as a healthy,

middle-aged physician from a region with growing numbers of infections, I'm as likely to be a vector as a victim. Over the next 48 hours, I or my hosts will cancel all my long-planned trips. Meanwhile, I obsessively check the news, trying to decide the safest course of action for me, my family, my patients, and my fellow human beings around the globe.

Surprisingly, what gives me greatest pause has nothing to do with the pandemic — at least overtly. I fear that a septuagenarian patient's recent hospital stay is a harbinger of what may befall older adults throughout the country during the pandemic, even as I hope her experience might serve as inspiration for much-needed health system improvements. Al-

ready, I'm acutely aware of the perverse poignancy with which the outsized impact of Covid-19 on elders has laid bare medicine's outdated, frequently ineffective or injurious approach to the care of patients who are the planet's fastest-growing age group and the generations most often requiring health care.

Reviewing Sally's chart (she insists that I call her by her first name), I learn about her many visits and e-messages to our medical center over the weeks leading up to an elective, come-and-go procedure that turned into a 4-day hospitalization. I'd only had time to glance through her chart before her serendipitously scheduled routine follow-up geriatrics consultation with me a few days after

her discharge. Now I read more carefully, piecing together a story that's unique yet all too familiar. My concern for Sally rapidly transmogrifies into mortal fear for the patient population at highest risk for hospitalization and death, whether from Covid-19 or most anything else.

Here is how clinicians might see Sally: morbidly obese elderly female with heart, lung, and kidney disease, atrial fibrillation, sleep apnea, depression, and polyarthritis. If you look only at her chart, the familiar picture of a high-risk elder with multiple health conditions emerges.

But here is another, equally accurate portrait of Sally: witty, smart, curious older woman with many friends, who recently retired from a social service career and moved to California to be near her supportive children, a smartphone addict, leader in her church, political activist, free-livetheater aficionado, and resident

of a continuing care community she chose as much for its low cost and social opportunities as for its ability to manage her future care needs.

Many of Sally's clinicians appear unaware of these personal details, even though it's impossible to provide patient-centered care without them. But treating the social history as extraneous is common,¹ and she has clearly received outstanding care and regular follow-up from our acute care clinic for her recent pneumonia and exacerbation of chronic obstructive pulmonary disease. Less laudable was a specialist's decision to proceed with an elective procedure when her breathing had not returned to baseline and his note calling that procedure "successful" and "without complications." Though the procedure was detailed, the note only briefly mentioned Sally's unplanned hospital stay, new heart failure, respiratory and functional decompensation, and aftercare needs — from home health care to the rapid follow-up most likely to prevent a costly readmission.

On the day of Sally's appointment with me, having skimmed the proceduralist's discharge summary, I felt only minor concern as I entered the examination room.

I didn't recognize Sally until she smiled.

Her face was bloated, her hair disheveled, and her countenance lacked its previous vitality, humor, and confidence. She seemed physically and psychologically diminished. Her history and exam only reinforced this impression. Worst of all, after 25 years as a geriatrician, I am as close to certain as a clinician without a crystal ball can be that she will never return to her previous health,

functional, and social status — that her life will become what her long-standing advance directive describes as "not worth living."

During a pandemic in which 80% of U.S. deaths are in people over 65, especially affecting those who are around 80 with underlying conditions,² health leaders and clinicians might reasonably conclude that they're too busy saving lives to also consider preventing the hazards of hospitalization for elders or their postdischarge lives. In a crisis, they might argue, different rules apply.

This unprecedented crisis is exactly why we need to think now about how best to manage the care of sick elders — for their sake and in consideration of near- and longer-term costs and stresses to the health care system. Sally's recent hospitalization didn't just ruin her life; it's the reason she now needs long-term respiratory and other services that might otherwise be available to patients with Covid-19.

Several straightforward strategic additions to current pandemic management will save lives and essential resources.

We can start by sticking to the facts. The *Wall Street Journal* quoted a pulmonologist as saying that the patients on the Princess Cruise ship were not like the average septuagenarian because "They are not bedridden." The average 70-something is not bedridden. People in their 70s run two of the three branches of our government and represent the most rapidly growing segment of the U.S. labor force. If the pandemic doesn't change life expectancy, half the U.S. population will live past 80 years of age.

Second, we can harness the expertise and person-power of the

many clinicians and clinician-researchers who can't currently do their usual work to develop crisis-related protocols for ambulatory, institutionalized, homebound, and hospitalized patients, with special attention to elders and other populations with predictably high health care needs. Such protocols will allow optimal triage and care of patients with and without Covid-19, thereby reducing pressures on crisis-focused clinicians and the health system.

Third, we can acknowledge the particular presentations, needs, and risks of elders in our protocols and planning. The Centers for Disease Control and Prevention did not create a Covid-19 Web page directed to elders until mid-March, nearly 2 months after we learned of that group's extraordinarily high risk for critical illness and death. Most medical centers have protocols for children and adults, but nothing for elders. Basic standards of health equity demand protocols with elder-specific diagnostic, treatment, and outcome-prediction tools, addressing lower baseline and illness-related body temperatures, atypical disease presentations, and care options geared to the life stage, health status, and life expectancy of older patients.

Such an approach would have prevented Sally from being offered a "routine," "elective," "low-risk" procedure that ended, predictably, as an expensive medical fiasco with ongoing costs and consequences. In medicine's current framing of old age, Sally's age and multiple conditions are blamed for this outcome. In truth, an approach recognizing her life priorities, functional status, and age-specific medical risks and needs would have prevented her from

receiving low-value care. Risk assessment and high-quality care cannot be accomplished by looking only at age and diagnoses. Sally would still be a vibrant, active member of society but for her recent medical care.

Fourth, we can help prevent or delay rationing by prioritizing advance care planning. As a geriatrician and an octogenarian's daughter, I know many happy, engaged elders in their 70s, 80s, 90s, and 100s — including Sally — who would not want to be put on a respirator if they become critically ill from Covid-19. Patients and our health system would be better served if all adults and elders use some of the spare time created by our new, home-confined lives to discuss and document their care preferences,³ whether their goal is aggressive, supportive, or palliative care. The absence of such planning increas-

es suffering at the end of life, and its presence helps people with serious or life-limiting illness to live and die according to their personal priorities.⁴

If we ignore age, we too often provide costly, ineffective care. We undertreat — seeing only “elderly” or “multimorbidity” — or overtreat, as recently happened to Sally. But if we make age the sole criterion for rationing, we take a giant step toward overt valuing of some lives over others. Not only does that approach defy the core tenets of medicine, but a glance at the U.S. Department of Health and Human Services definition of “special populations” reveals that it would put most of us at risk for second-class care.⁵ We must do everything possible to avoid the first step down that slippery slope.

The patient's name has been changed to protect her privacy.

Disclosure forms provided by the author are available at NEJM.org.

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