EDITORIALS

Bringing a Generalist Approach to the Problems of Older Patients

This issue of JGIM has three articles dealing with issues principally affecting the care of older patients: functional decline after hospitalization, end-of-life decision making, and reporting of impaired drivers.¹⁻³ It may seem unusual that a journal for general internists would have so much geriatrics content. However, it is appropriate that general internists view geriatrics as part of our domain. In fact, leaders in geriatrics are increasingly recognizing that geriatrics is fundamentally different from the traditional subspecialties of internal medicine, and is part and parcel of primary care.⁴⁻⁶

There are few areas of internal medicine in as much need of a generalist approach as geriatrics. The problems of older patients, who often have chronic and disabling multisystem problems, are not well addressed using disease-oriented or organ-specific approaches. Generally, attention to the effects of illness on a patient's functioning and quality of life is paramount, and usually more important than the effect of the illness on physiologic measures. Further, it is important to consider the patient in a larger context, including their psychosocial characteristics and the characteristics of their environment, because these factors may have a more important influence on outcomes than traditional biomedical markers. Each of the three "geriatrics" articles in this issue benefits from generalist approaches. None are disease focused, but instead focus on fundamental issues that transcend specific diseases. All consider the patient within a larger social context. By using the wider frame of reference that is typical of generalist scholarship, all three articles have made substantial contributions to the care of older patients.

In the first article, Mahoney and colleagues demonstrate a strong relation between living alone and lack of functional recovery after hospitalization.¹ In older patients, functional deterioration is a common and dreaded outcome of hospitalization.^{7,8} Understanding the determinants of this syndrome is essential if we are to improve outcomes in hospitalized elders. However, typical biomedical measures such as laboratory abnormalities and comorbid diagnoses poorly predict adverse functional outcomes. For example, other work suggests that depressive symptoms and abnormal cognitive function may be important mediators of functional outcomes.^{9,10}

While other work suggests that lack of social support may be associated with increased mortality,^{11,12} Mahoney presents the most compelling evidence to date that social support is a critical mediator of functional deterioration in hospitalized elders.¹ She found that among discharged

patients dependent in activities of daily living, the odds of functional recovery in the month after hospitalization was 3 times greater in patients who lived with someone than in patients who lived alone. Strikingly, most of the risk attributable to living alone was attributable to patients who were visited less than daily by someone else. These results provide a compelling reason why clinicians caring for hospitalized elders should seek to learn about the social support networks of their patients. They also provide a rationale for developing interventions aimed at improving outcomes in high-risk elders who live alone.

In the second article, Berger and colleagues, on behalf of the Medical Society of the State of New York, discuss the ethical issues involved in the reporting of potentially unsafe drivers.² This is an issue that predominantly affects our older patients. This article captures many of the tensions a physician should feel when faced with a patient who is an unsafe driver. Such a patient may present a true conflict between our obligations to the patient and our obligations to society.

Physicians who view themselves as behaving in a beneficent fashion toward a patient should truly feel conflicted when faced with a potentially dangerous driver. The loss of driving privileges can be devastating to an older patient. Many patients have no other legitimate transportation options. As a result, the loss of driving privileges can lead to social isolation and is strongly correlated with the development of depressive symptoms.¹³

Clearly, situations exist where the threat to public safety is high enough that physicians should report unsafe drivers who continue to drive in spite of recommendations to the contrary. However, as Berger describes, reporting guidelines should account for the principle that a physician's primary responsibility is to act in a patient's best interest—not to serve as an agent of the state. As for any other health issue, physicians' primary role with respect to driving should be to educate and counsel their patients. Reporting should be reserved for those situations where the threat to public safety, and to the patient, is compelling.

Berger and colleagues allude to what may be a more important ethical issue than reporting of impaired drivers; society's obligation to compassionately care for its oldest and most vulnerable citizens. The lack of adequate transportation options for the old and disabled should be a source of national shame. Public strategies to get medically unsafe drivers off the road should be matched with strategies to provide reasonable, cost-effective alternative

transportation options for those no longer able to drive. Physicians and medical societies should take an active role in lobbying for transportation services for our vulnerable patients. The ability to fully function as a member of society should not be dependent on the ability to maintain a driver's license.

In the third article, Rosenfeld challenges many traditional beliefs and practices with regard to end-of-life care. The use of in-depth interviews with qualitative methods of analysis made it possible for this study to develop a deeper understanding of older patients' beliefs and values about end-of-life decision making. Several findings are notable. First, in contrast to many current practices and recommendations, older patients are much more concerned about the expected outcomes of treatment than the treatments themselves. This suggests that physicians who wish to provide care congruent with their patients' values would be better served by learning how their patients feel about possible outcome states, rather than trying to force yes or no answers about specific treatments. For example, learning about the patient's general goals of care, such as whether a patient prefers a primary focus on extending life or a primary focus on palliation, may be more worthwhile than focusing on CPR preferences.¹⁴

Second, many patients prefer a collaborative model of decision making that includes both their family and their physician. This parallels other research demonstrating that many patients are willing to let their family override their previously stated preferences.¹⁵ While autonomy has been a central principle of medical ethics for the past decade, these findings suggest that in our quest for patient autonomy, we have too often forgotten to ask the patient how much autonomy they want. Many patients do not view themselves as "autonomous" from their families and want their families actively involved in medical decision making. Many patients may prefer a collaborative model of decision making that includes themselves, their families, and their physicians.

There is surprisingly little information on how patients themselves believe age should affect medical decision making. Rosenfeld's findings suggest that older patients may view their age as a relevant consideration in end-of-life decision making. In some cases this was explained by the belief of older patients that they had already lived a long life. This may have led to a belief on the part of patients that care should be focused more on maintaining quality of life rather than longevity. This finding may explain prior work demonstrating that older patients often desire less aggressive treatment, even after adjusting for illness severity.¹⁶

The problems of preventing functional decline in hospitalized patients, how to best care for older patients at the end of life, and how to ethically manage potentially unsafe drivers are examples of pressing issues in geriatrics that defy typical disease-oriented approaches. Many critical issues in geriatrics such as these have not been

adequately studied. This is in part because academic geriatrics has not been sufficiently influenced by generalist approaches. The articles in this issue of the *Journal* demonstrate how the use of a generalist approach can yield important insights into how to improve outcomes of older people. Increasing the number of generalists who think about old people, and increasing the number of geriatricians who think like generalists, will significantly advance the care of older patients.—**KENNETH E. COVINSKY, MD, MPH**, *San Francisco Veterans Affairs Medical Center, San Francisco, CA.*

REFERENCES

1. Mahoney JE, Eisner J, Havighurst T, Gray S, Palta M. Problems of older adults living alone after hospitalization. *J Gen Intern Med.* 2000;15:611–619.
2. Berger JT, Rosner F, Kark P, Bennett AJ. Reporting by physicians of impaired drivers and potentially impaired drivers. *J Gen Intern Med.* 2000;15:667–672.
3. Rosenfeld KE, Wenger NS, Kagawa-Singer M. End-of-life decision making: a qualitative study of elderly individuals. *J Gen Intern Med.* 2000;15:620–625.
4. Hazzard WR. To build an academic geriatric program of distinction: lessons from experience at three U.S. and two British academic centers. *Am J Med.* 1994;9(suppl 4A):6S–7S.
5. Hazzard WR, Woolard N, Regenstein DI. Integrating geriatrics into the subspecialties of internal medicine: the Hartford Foundation American Geriatrics Society Wake Forest University Bowman Gray School of Medicine Initiative. *J Am Geriatr Soc.* 1997;45:638–40.
6. Reuben D, Zwanziger J, Bradley T, Beck J. Is geriatrics a primary care or a specialty discipline? *J Am Geriatr Soc.* 1994;42:363–7.
7. Landefeld CS, Palmer RM, Kresevic DM, Fortinsky RH, Kowal J. A randomized trial of care in a hospital medical unit especially designed to improve the functional outcomes of acutely ill older patients. *N Engl J Med.* 1995;332:1338–44.
8. Sager MA, Franke T, Inouye SK, et al. Functional outcomes of acute medical illness and hospitalization in older persons. *Arch Intern Med.* 1996;156:645–52.
9. Covinsky KE, Fortinsky RH, Palmer RM, Kresevic DM, Landefeld CS. The relationship of depressive symptoms to health status outcomes in acutely ill hospitalized elders. *Ann Intern Med.* 1997;126:417–25.
10. Inouye SK, Rushing JT, Foreman MD, Palmer RM, Pompei P. Does delirium contribute to poor hospital outcomes? A three-site epidemiologic study. *J Gen Intern Med.* 1998;13:234–42.
11. Gordon HS, Rosenthal GE. Impact of marital status on outcomes in hospitalized patients. Evidence from an academic medical center. *Arch Intern Med.* 1995;155:2465–71.
12. Bucher HC. Social support and prognosis following first myocardial infarction. *J Gen Intern Med.* 1994;9:409–17.
13. Marottoli RA, Mendes de Leon CF, Glass TA, et al. Driving cessation and increased depressive symptoms: prospective evidence from the New Haven EPESE. *J Am Geriatr Soc.* 1997;45:202–6.
14. Covinsky KE, Fuller JD, Yaffe K, et al. Communication and decision making in seriously ill patients: findings of the SUPPORT Project. *J Am Geriatr Soc.* 2000;48:S187–S193.
15. Sehgal A, Galbraith A, Chesney M, Schoenfeld P, Charles G, Lo B. How strictly do dialysis patients want their advance directives followed? *JAMA.* 1992;267:59–63.
16. Hamel MB, Teno JM, Goldman L, et al. Patient age and decisions to withhold life-sustaining treatments. *Ann Intern Med.* 1999;130:116–25.