HEALTHCARE OF THE ELDERLY

Elective Report

A Reflection of my Elective Experience in Geriatric Medicine at St. Luke's Hospital, New York City

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Learning Objectives

1) *Describe the pattern of disease/illness in the population with which you will be working and discuss this in the context of global health*

2) *Describe the pattern of health provision in relation to the country in which you will be working and contrast this with other countries, or with the UK*

3) *To interact with the locals to learn about their lifestyle and beliefs and to understand how these factors influence their roles and expectations as patients*

4) *To appreciate the workings of a different healthcare system and its effects on the population*

5) *To gain an understanding how demographics may influence patient care*

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New York is home to 3.4 million individuals aged 60 and older, ranking New York third in the nation in the number of older adults. Like the rest of the country, and the world, New York's baby boomer cohort will only add to the increasing older population[3]. Chronic conditions such as obesity, heart disease, stroke, cancer, diabetes, and arthritis are the major causes of illness, disability, and death in the United States[2]. It is estimated that the cost of chronic conditions will reach $864 billion by 2040, with chronic conditions among older adults being more costly, disabling, and difficult to treat[3]. Although chronic conditions are among the most prevalent and costly diseases, they are also among the most preventable. There is a global need to promote health education and prevention strategies, to help the society develop accurate expectations for aging, coupled with effective treatments and best practices to improve the general health of the aging population and minimize hospitalizations.

My elective attachment started on Wednesday, 3rd May 2011, in St. Luke's Hospital, after an induction session with Dr Brenda Matti, the Chief MD of the Geriatric division, earlier in the week. The day started with a morning meeting which resembled a paper round. This was attended by the attending (the consultant in the UK), a fellow (the specialist registrar, on a part-time PhD), a resident (the senior house officer in core medical training), and two first-year interns (the foundation year doctors).

Following the paper round, the attending reviewed the new and patients whom the junior doctors were concerned about. The attending did not review the other patients who were in his care. This daily routine differs from the UK where rounds took place once-weekly, when the consultant would review all patients with his team, comprising of a specialist registrar, senior house officer, house officer and medical student(s).

In comparison, I prefer the US system as the attending is given daily updates about his patients, which allows him to be a better judge of the patient's recovery. In UK, the consultant sees a snapshot of the patient during the rounds and has to rely on documentation by other doctors, which can compromise patient care. I feel this is important especially in Geriatrics as patients may have deteriorated in hospital as a result of an acute condition, rather than a deterioration of their chronic diseases. This may not be picked up by the junior doctors and such patients run the risk of being managed palliatively instead of actively and vice versa.

I also note that on these short rounds, there was no need for the junior doctors to document in the patient's case notes. Documentation was done by the doctor who had reviewed the patient, in this case, the attending. I believe this form of documentation is optimal as it would give rise to lesser documentation errors as compared to the UK, where the junior doctor would have to document in the notes based on his interpretation of the consultant's actions or being dictated by the consultant.

The geriatric teams in both UK and US receive their patients in the same way. Patients are referred from the ER/A&E or through inpatient referrals from other specialties. However, their referral criteria differ.

In St. Luke's hospital, geriatric medicine is based on the needs-related model. Patients are selected by non-geriatricians, medical staff in the ER, for referral to geriatrics. This model is based on the premise that Geriatric Medicine is the specialty which best deals with older people who present in a certain way i.e. non-specific symptoms combined with cognitive or functional decline, on a background of multiple pathology and complex social care needs.

During my four weeks, the average age of a geriatric patient is about 80 years and about a third of the patients are Spanish-speaking. The more common reasons for admission include recurrent falls and altered mental status. Occasionally, there were few admissions for COPD exacerbation, stroke/TIA and leg edema.

On the other hand, in UK, geriatric medicine is largely based on the age-defined model. Medical patients above 78 years are admitted to geriatrics. This model is of much controversy as its existence has not been adequately justified. According to the British Geriatric Society Good Practice Guide[1], biological distinction between younger and older adults is difficult to substantiate medically and age has not been shown to be a valid screening variable for identifying patients who would do better under geriatric care. Surveys of age-defined services have also revealed that the defining age is often determined, by the number of patients the service can accommodate within its current allocation of acute care beds. In essence, I feel this model has been established more to deal with the issue of resource availability than to improve care of the geriatric patient.

In an ideal world, I feel the geriatric care model should be a combination of the above two models. Geriatricians should be present in the ER/A&E to accept patients to geriatrics. Guidelines for the referral of patients to geriatrics need to be established based on valid variables that distinguish the geriatric patient. Age should not be the sole determining factor, as geriatrics is the care of physiologically aged body, regardless of age but more of how the body has been strained and stressed over the patient's lifetime.

The geriatric doctors in St. Luke's hospital also practise palliative medicine, unlike in UK where there is a separate palliative care team. Being an observer on palliative consults, it seems as though most doctors and patients in the US are less willing to accept death and dying and hence, less receptive to palliative medicine, often leaving that option to the very end. Doctors also tend to avoid breaking bad news to patients, leaving these matters to the palliative care doctors. This has led me to generalize that the palliative care doctors are the best communicators, whereas in the UK, all doctors have the responsibility to communicate with their patients be it gaining consent for a procedure or breaking bad news.

In this aspect, I would prefer the UK system as I feel communication is crucial to establishing a good doctor-patient relationship which has been proven to help both patients and doctors. Some positive outcomes from a good doctor-patient relationship include better health outcomes, higher compliance to therapeutic regimens in patients, higher patient and clinician satisfaction and a decrease in malpractice risk[7].

Through my observations in family meetings and in discussion with the doctors, it seems that US has the mindset of active management, choosing to prolong suffering instead of ending life peacefully. Few patients have advance directives and the end-of-life decisions are left to the next-of-kin, often a son or daughter. Family members are unwilling to make the decision to let their loved ones go and instead, make extensive use of resources to keep them around, despite the poor prognosis. Some even use religion to justify keeping the life support machine, claiming that death is in God's will. One questions how is it in God's will when a decision has been made to put the patient on the life support machine in the first place? Are you not already interfering with God's will? By keeping the patient alive, is it benefitting the patient or simply appeasing the conscience of the family? There is a need to take into consideration the culture and diversity of the patient population in the US, especially when dealing with matters of death and dying.

New York (NY) is a multiracial city. From the US Census bureau of 2009[4], 60% of the NY population is White, 17% are Black, 17% are Hispanics, and the remaining includes Asians, American Indians and Hawaiians. As Hispanics make up almost one-fifth of the population, the most common spoken languages in the hospital are English and Spanish.

As compared to London, from the office for National Statistics[5], 69% of the population is White, 13% are South Asians, inclusive of Indians, Bangladeshis and Pakistanis, 11% are Black, while the remaining includes Chinese and the mixed races. Despite the presence of non-white population, the most common spoken language is still English. However, depending on the hospital location, for example, The Royal London hospital in Whitechapel, an area heavily populated by the South Asians, there is a need for interpreters to facilitate the medical consultation as some of the older patients often do not speak English.

Despite the differences in patient population, the two cities are unique in that home to individuals of many, very different cultures, ethnicities, and languages. This has significant implications on healthcare provision as healthcare professionals need to communicate and deliver in a culturally sensitive and appropriate manner.

I am fortunate to be able to experience New York where the patients' incomes vary widely on a spectrum. In 2005, the median household income was $49,480; yet 14.5 per cent of the population still lives in poverty. Older adults with health problems and have lower incomes face very difficult choices in terms of affording their care and financing other important household-related expenses.

This gives me the opportunity to learn about the different policies available to such patients and to understand financial considerations that the doctors and social workers are faced with when they make decisions regarding treatment plans and post-hospital care and rehabilitation. Unlike in the UK where the National Health Service (NHS) is government-funded and provides free healthcare for all, in the US, patients pay for their medical expenses through private and/or social health insurance. There are two forms of social health insurance – Medicare and Medicaid.

Medicare[6] is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end stage renal disease. It covers hospital bills and prescription drugs. Medicaid is not an entitlement program; Medicaid[6] is a means-tested, needs-based social welfare or social protection program rather than a social insurance program. The main criterion for Medicaid eligibility is limited income and financial resources.

Apart from understanding how the US system works, I have also had the chance to look after patients and present their daily progress to the attending each morning. I have also attended clinics and have learnt how to work the online patient records both on the wards and in the outpatient clinics.

In conclusion, I have had a wonderful time. It was an enriching four weeks to be exposed to the medical system in US, which has allowed me to compare and contrast the differences in healthcare provision between the US and UK. This experience has also allowed me to hone my adaptation skills, where I had to learn the software system to access patients' records, the hierarchy in the hospital, to be aware my surroundings and be flexible to the different work culture. I have also had the opportunity to improve my communication skills, to use non-verbal communicative tools such as subtle changes in facial expressions or body language, to read patients when communicating them, especially since they are from a different continent, with its unique culture and background.

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