

**PRESENTATION TO THE STANDING SENATE COMMITTEE ON  
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY**

**FUTURE OF HEALTH CARE FOR  
FRAIL OLDER ADULTS**

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Thank you for the opportunity to present to the Standing Senate Committee on Social Affairs, Science and Technology. As an active clinician and Professor of Medicine in the Division of Geriatric Medicine at Dalhousie University and as a Canadian Institutes of Health Research Investigator, I would like to offer two points for your consideration: our health-care system needs to adapt itself to provide care for older adults who are frail; and we need to discover new and better ways of how to do this.

**CURRENT PROBLEMS IN THE TREATMENT  
OF FRAIL OLDER ADULTS**

Within the health-care system, there is a lot of unhappiness felt from the front-lines to the health-care planners, about the challenges posed by having to care for large numbers of older adults. A nurse in a Hamilton emergency-room, quoted in a newspaper article, summed it up nicely when she said *We trained for 'ER' and instead we get 'The Golden Girls'*\*. The sense of poor morale that health-care workers feel is only rarely from the demand of caring for young adults or even older adults with single system illness. For such people we are prepared to go flat out, so that for some conditions the "treatment of choice" is organ transplantation. In this, we all take great pride. However, just ask front-line workers about caring for frail older adults, especially those who are cognitively impaired, and the chances are that you will hear a different story.

From the health-care worker's point of view, the interaction is unsatisfactory on a number of grounds. These frail elderly patients often cannot give a clear account of what is wrong. Many of the things that they

do complain about (such as falling or not being able to carry out household chores) do not seem properly "medical". Often, they have more than one thing wrong at once, so it is hard to focus on that part which is wrong and which corresponds to the particular health-care expertise on offer. Even when there is a match between what is needed and what is offered (e.g. operative repair of a broken hip), the patients will not go home on time. And despite the protestations of the Canadian Institutes of Health Information that they measure many things, and are not accountable for how hospitals interpret their data, at the end of the day there are few offenses which patients can commit that are worse than increasing the average length of stay. The challenges of caring for older adults who are frail and ill do not end with these few considerations, but they are enough to illustrate an inarguable point. We serve these people badly if we do not have the right skill-set to care for them.

From the patients' and families' point of view, the situation is even more unsatisfactory; they cannot seem to get people to listen to them. Families even have trouble persuading health-care professionals that a man who they bring to the hospital who suddenly cannot walk is not there because they cannot cope, but because he cannot walk. Patients and families expect this to be seen as a medical problem, and be treated in a way that does not just make x-rays look better, or restore laboratory values to normal, but actually allows the patient to walk again.

**Frail Elderly with Complex Problems**

Elsewhere I have detailed some information that spells these problems out in more detail, and also outlines some solutions.<sup>1-3</sup> Briefly, the problems (understood as atypical disease presentation, chronic multi-organ system failure, altered pharmacodynamics and pharmacokinetics, precarious function and complex prob-

The above presentation was made before the Senate Committee November 6, 2001.

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\*A TV sitcom about older women

lems of social support) each challenge the usual approach to patients. Health-care professionals are taught to listen to patients, examine them carefully, and order special investigations judiciously based on what is learned from the history and physical examination. Diseases are followed by their progression in recognizable patterns. The professionals are taught that patients with more than one problem should have each one addressed in the same manner.

However, what we are learning in Geriatric Medicine is that this tried and true approach does not work for frail older adults, who have multiple, interacting, medical and social problems. Although the usual approach to care is based on single system illness, the situation is more complicated when more than one illness is present, and when a patient's function is compromised. Such patients are what systems analysts call *complex*, meaning that their "overall problem" is not simply the sum of their individual ones: you cannot intervene on just one problem without it affecting the others, and it is important to pay attention to large, over-reaching issues (like the patient's interaction with their environment) that often are seen as being outside the scope of traditional medical concern.

Unfortunately, these lessons are not known widely enough, and we persist in organizing many aspects of health-care around the "chief complaint" and "most responsible diagnosis". From the way we organize hospitals, train health-care professionals, measure and reward system performance and pay physicians, we persist in this "one-thing-at-a-time" approach. In consequence, when frail older people come to hospital, or see their doctors, or even, to a considerable extent, apply for community or institutional long-term care, we see them through these lenses.

Very often, we do not like what we see. These people do not fit. They are out of step with the care that we are organized to provide. Too often, the view amongst health-care professionals is to denigrate the older person for being there. For example, a common term in the medical lexicon is "gomer". It stands for "Get out of my Emergency Room". Its more polite synonyms are "social admissions" and "poor historians". These are some nasty truths about modern health-care, but we need to face up to them if we are to understand what needs to be done.

The response to dealing with people with complex problems is not to pack them into the emergency-rooms, or admit them straight to nursing homes, or to call them names, but to recognize that they have complex problems and to understand and promulgate how to treat these problems. Mostly, this consists of imple-

menting what we already know but are ill-organized to provide.

## RESEARCH TO DISCOVER MEANS OF IMPROVEMENT

We can always know more, and thus I turn to a second point. We need to undertake systematic research into the problems of older adults who are frail and ill. In the last few years, we have seen the revitalization of a Federal role in the funding of health-care research in Canada. With the Canadian Institutes of Health Research has come about a Canadian Institute on Healthy Aging. This is a valuable innovation, and one that, we hope, will also result in peer review committees with a specific mandate to evaluate research proposals on aging, something that has yet to happen. However, even with this initiative, Canada lags far behind in per capita expenditures on health research in general and in research on aging in particular.

Health care of the elderly, especially those who are frail, is something in which we need to excel. While data from other countries will be of help, we need homegrown solutions that take into account Canada's unique health-care system. We cannot rely on others' coat-tails in this vital area of national concern.

### Health Expenditures and Frail Elderly

As a final point, let me note that many people seem to see private health expenditure as the only salvation for health care. Self-evidently, there is no profit in providing comprehensive care of older people who are frail. Under two-tier health care, these people, already vulnerable, are certain to be abandoned, while services are set up to skim patients with single-system illness. The problem of frailty is a central threat to our health-care system, and it will not be fixed by doing more of the same (and certainly not by doing less of the same). We need to implement definite developed reward comprehensive models of care for people with complex medical and social problems.

## REFERENCES

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